## Reducing maternal mortality and accessing sexual and reproductive health services and reproductive rights (targets 3.1, 3.7 and 5.6)

This chapter reviews the current situation of sexual and reproductive health and reproductive rights for persons with disabilities, in the context of targets 3.1, 3.7 and 5.6. Target 3.1 calls for reducing maternal mortality, target 3.7 calls for universal access to sexual and reproductive health services, including for family planning, and Target 5.6 calls for ensuring access to sexual and reproductive health and ensuring reproductive rights. The Convention on the Rights of Persons with Disabilities (CPRD) was the first international treaty to explicitly recognize the need for sexual and reproductive health for persons with disabilities, with article 25 underscoring the need to provide persons with disabilities with the same range, quality and standard of free or affordable sexual and reproductive healthcare and programmes as provided to other persons. Moreover, article 23 calls on States Parties (i) to recognize the right of persons with disabilities to decide freely and responsibly on the number and spacing of their children; (ii) to recognize the right of persons with disabilities to have access to age-appropriate information, and reproductive and family planning education; (iii) to provide the means necessary to enable persons with disabilities to exercise these rights; and (iv) to ensure that persons with disabilities, including children, retain their fertility on an equal basis with others. Other important articles to sexual and reproductive health are article 6 (women and girls with disabilities), article 12 (legal recognition before the law), article 16 (freedom from exploitation, violence and abuse) and article 21 (access to information).

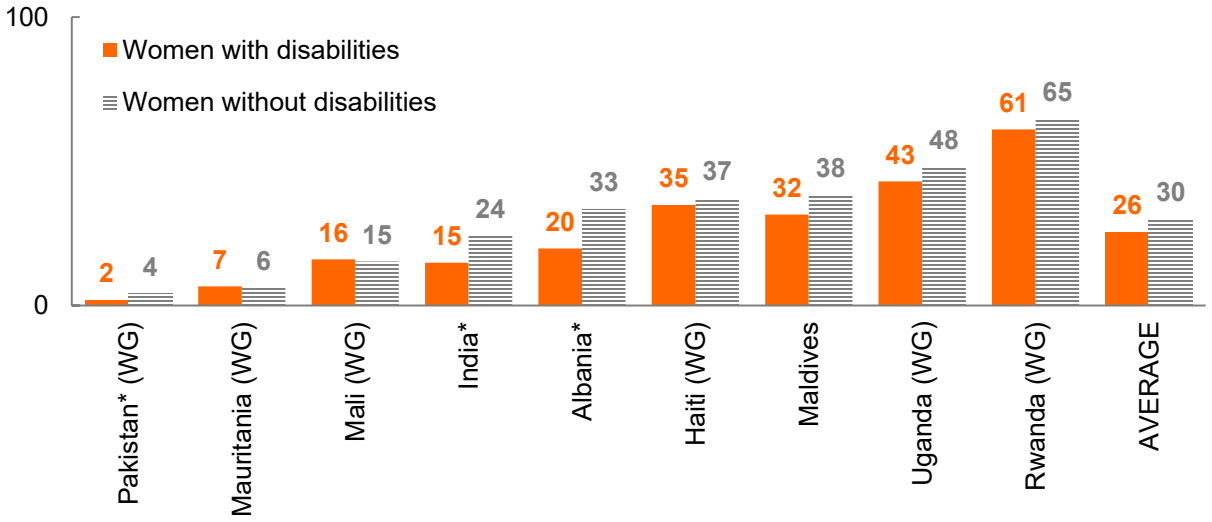
Sexual and reproductive health and reproductive rights are defined by three concepts: the right to make decisions on reproduction and sexuality free from discrimination, coercion and violence; the right to the highest standard of sexual and reproductive health; and the right to access a range of sexual and reproductive health facilities, services, goods and information.[156,157] Sexual and reproductive health services include contraceptive counselling information, education, communication and services; education and services for prenatal care, safe delivery and postnatal care; the prevention and appropriate treatment of infertility; safe abortion services; the prevention and treatment of sexually transmitted and reproductive tract infections; and sexual and reproductive health information, education and counselling.[158,159,160] While sexual and reproductive health is often discussed in terms of women's health, boys and men with disabilities also are entitled to sexual and reproductive health and often remain excluded from sexual and reproductive health services.

This chapter presents an overview of the current situation of persons with disabilities regarding their right to make decisions on reproduction and sexuality, access to sexual and reproductive healthcare and services and the realization of their reproductive rights. The chapter concludes with recommendations for moving towards the realization of targets 3.1, 3.7 and 5.6 for persons with disabilities.

## Current situation and progress so far

Persons with disabilities have typically been excluded from sexual and reproductive healthcare and their sexual and reproductive health needs have been neglected.[161,162] Women with disabilities, especially those living in low- and middle-income countries, face the most significant barriers to accessing sexual and reproductive healthcare and realizing their reproductive rights.[163,164]

**Figure 41. Percentage of women aged 15 to 49 with comprehensive knowledge about HIV/AIDS,[165] by disability status, in 9 countries, in 2021 or latest year available.**

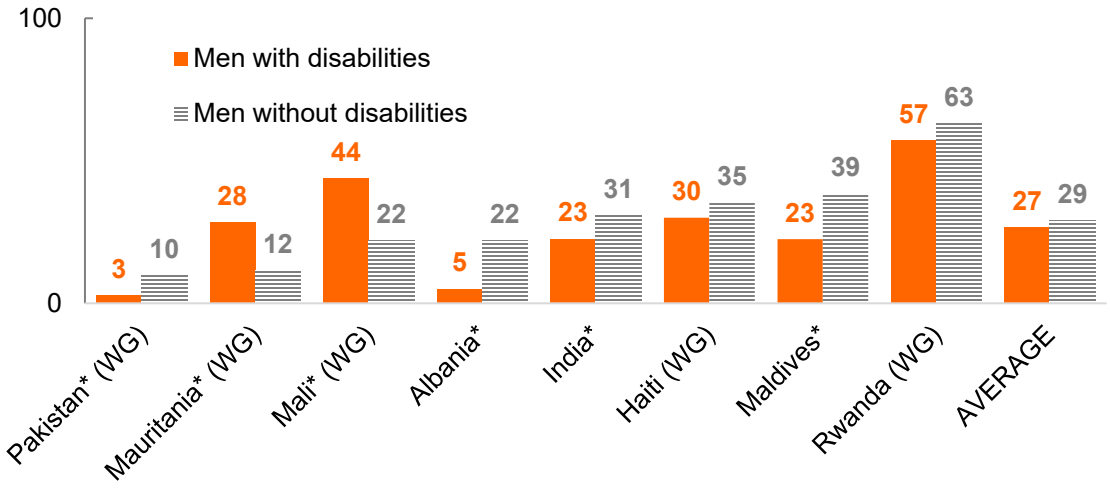



*Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.*
*Source: UNDESA and UNFPA (on the basis of microdata from DHS[6]).*

A persistent barrier for persons with disabilities is their lack of access to information about their reproductive rights as well as about sexual and reproductive health and related services. Due to this lack of access, persons with disabilities, especially individuals with intellectual disabilities, end up with low levels of sexuality education and sexual and reproductive health knowledge,[166] including low levels of knowledge on the prevention and transmission of sexually transmitted diseases. Among nine countries, 26 per cent of women with disabilities versus 30 per cent of women without disabilities have comprehensive HIV knowledge (Figure 41). The percentage of women with disabilities with this knowledge varies from 2 per cent in Pakistan to 61 per cent in Rwanda, with the largest gaps between women with and without disabilities observed in Albania and India. Among eight countries, 27 per cent of men with disabilities versus 29 per cent of men without disabilities have comprehensive HIV knowledge (Figure 42). The percentage of men with disabilities with this knowledge varies from 3 per cent in

Pakistan to 57 per cent in Rwanda. In Mali and Mauritania, the percentage of men with disabilities with comprehensive HIV knowledge is considerably higher than for men without disabilities; while in Albania and the Maldives, the opposite occurs. Lack of knowledge about HIV/AIDS can lead to risky sexual behaviours, such as low levels of condom and contraceptive use and HIV testing, even though persons with disabilities report being as sexually active as their peers without disabilities.[167] Compared to persons without disabilities, adults with disabilities are at equal or increased risk of sexually transmitted infections.[168,169,170] Likewise, children and youth with disabilities have a similar or increased risk of sexually transmitted infections compared with other youth, while girls with disabilities experience higher rates than boys with disabilities.[171] Persons with disabilities are at heightened risk of being subjected to sexual violence and abuse (see the chapter on Goal 16), which increases their risk of contracting sexually transmitted infections.

**Figure 42. Percentage of men aged 15 to 49 with comprehensive knowledge about HIV/AIDS, [172] by disability status, in 8 countries, in 2021 or latest year available.**




*Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between men with and without disabilities is statistically significant at the 5 per cent level.*
*Source: UNDESA (on the basis of microdata from DHS[6]).*

Several factors act as barriers for persons with disabilities to access information on sexual and reproductive health. Stigma and stereotypes significantly limit access to sexual and reproductive healthcare by persons with disabilities and the realization of their reproductive rights, from both community and healthcare providers.[173] The sexuality of persons with disabilities is generally considered a taboo subject.[174] Relatives, teachers and healthcare providers are often anxious, untrained and lack confidence about discussing sexuality with them.[175] There is a prevalent assumption that persons with

disabilities are either non-sexual or hypersexual.[176] Those stigmas and prejudices are particularly strong about persons with intellectual and psychosocial disabilities.[177] Stigma and stereotypes about sexuality can also lead to the exclusion of girls and young women with disabilities, as well as boys and young men, from existing sexuality education programmes by their parents, guardians and teachers.[178] There is a general lack of guidance for families and teachers about how to talk about sexuality and equality with children and youth with disabilities.[179]

Other stereotypes include the false beliefs that girls and young women with disabilities can be targeted for exploitation and abuse,[180] are unsuitable for marriage, and are unable to manage their fertility or raise children. These misplaced beliefs negatively impact women with disabilities and act as barriers to accessing education, information and services to enable them to enjoy safe and healthy sexual and reproductive lives free from violence.[181]

**Box 2. Key concepts related to autonomous decision-making in sexual and reproductive health and reproductive rights**

**Equal recognition before the law** is a right of all people, everywhere, under human rights law. Article 12 of the CRPD provides that States must realize this right for persons with disabilities. Understanding the right of persons with disabilities to equal recognition before the law[182] is necessary among sexual and reproductive health service providers to ensure that they do not violate this right.

**Legal capacity** is the capacity to be both a holder of rights and an actor under the law. Legal capacity entitles a person to the full protection of their rights by the legal system, with the power to engage in transactions and create, modify or end legal relationships; supported decision-making may be necessary to empower some persons with disabilities to exercise their legal rights.[183]

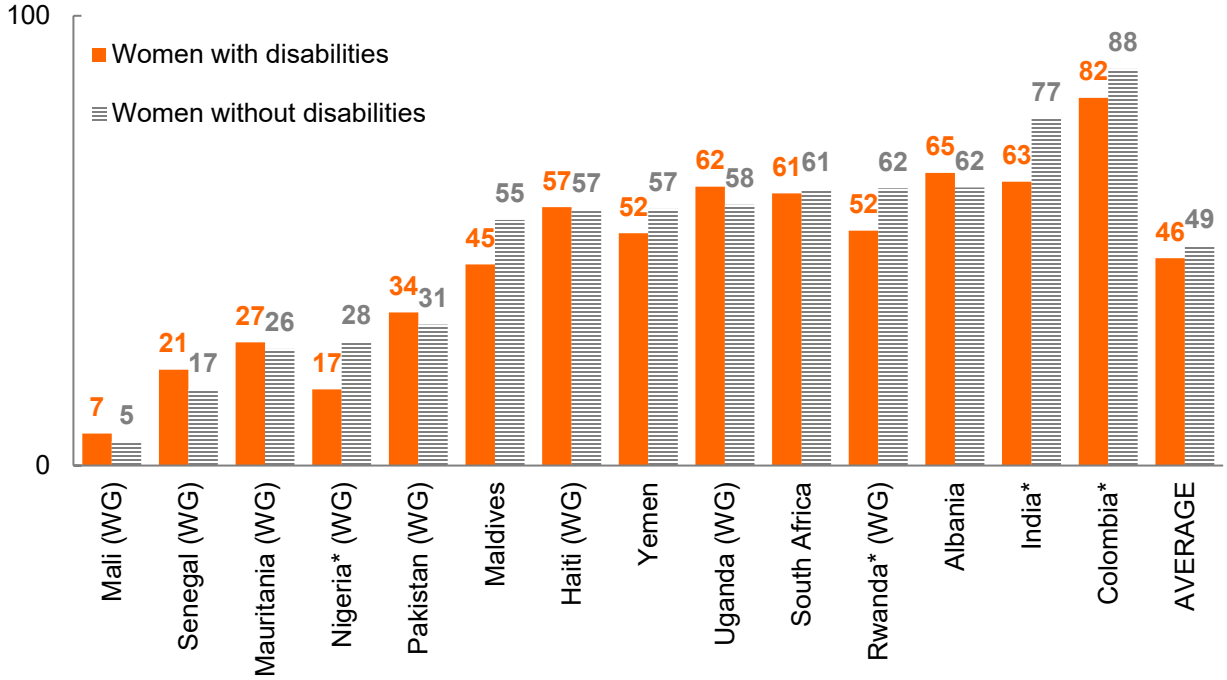
**Informed consent** is a communication process between a service provider and a service recipient that results in the service recipient giving, withdrawing or refusing permission for a procedure based on full knowledge of the procedure.[184]

**Supported decision-making** comprises various support options which give priority to a person's will and preferences and respects human rights norms. It should protect all rights, including those related to autonomy (for example, the right to legal capacity and the right to equal recognition before the law) and to freedom from abuse and ill-treatment (for example, the right to life and the right to physical integrity). Supported decision-making stands in contrast to substituted decision-making models, such as guardianship, which perpetuate power imbalances and can make persons with disabilities vulnerable to gender-based violence and other forms of abuse and ill-treatment.[185]

Moreover, sexuality education is not always delivered in accessible formats, sign languages and other alternative accessible modes of communication, and very often, it does not address disability-specific needs.[186] Furthermore, in many parts of the world, girls and boys with disabilities are often excluded from

the education system (see the chapter on Goal 2) or drop out of school too early to receive access to sexuality education. For girls and boys with disabilities who attend special education, sexual education programmes are also often unavailable in these education settings.

**Figure 43. Percentage of women aged 15 to 49 exercising autonomy in reproductive health decision-making and empowered to exercise their reproductive rights (also known as 'bodily autonomy'), by disability status, in 14 countries, in 2021 or latest year available.**



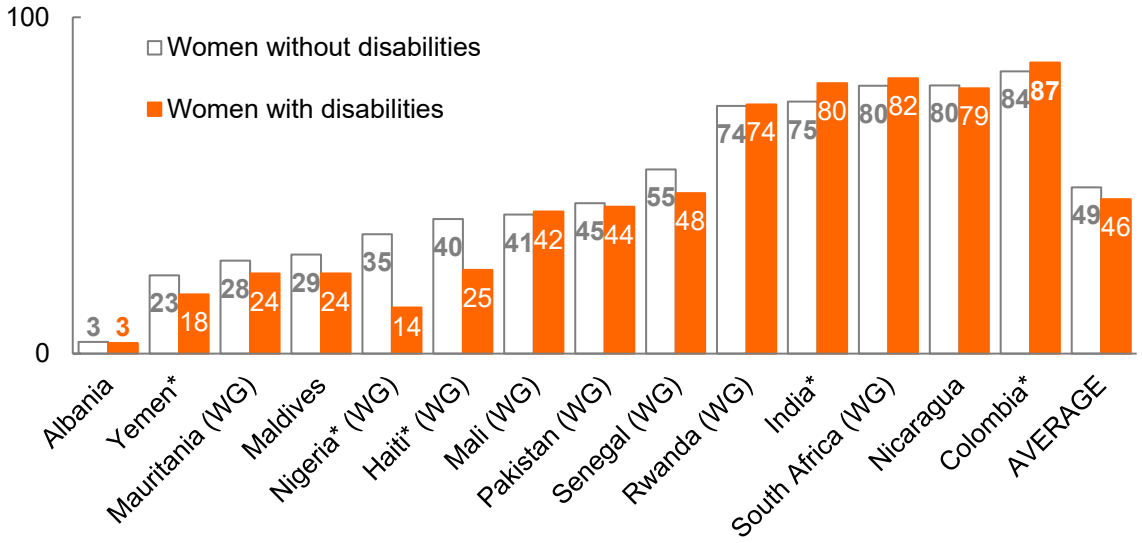

*Note: Women are considered to have autonomy in reproductive health decision-making and to be empowered to exercise their reproductive rights if they (i) decide on healthcare for themselves, either alone or jointly with their husbands or partners, (ii) decide on use or non-use of contraception, either alone or jointly with their husbands or partners and (iii) can say no to sex with their husband or partner if they do not want to. Data on (iii) were not collected in Colombia, India, Senegal and Yemen. (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.*
*Source: ESCWA, UNDESA and UNFPA (all based on data from DHS[6]).*

In addition to these barriers, for persons with disabilities, the right to make decisions about their bodies, health and sexuality is often not realized. Bodily autonomy encompasses an individual's power and agency to make choices about one's body, health, life and future, and having the information, services and means to do so free from discrimination, coercion and violence. It includes fundamental decisions such as whether to have sex, use contraception or seek healthcare. Key concepts related to autonomous decision-making regarding sexual and reproductive health and reproductive rights include equal

recognition before the law, legal capacity, informed consent and supported decision-making (see Box 2). In many societies, the decision-making power of persons with disabilities is subordinated to that of their families, guardians or the State. Social norms, sometimes enshrined in law, deem them incapable of making their own choices.

Women who have bodily autonomy – that is, they make decisions about their healthcare and their use of contraception, and they can say no to their husbands or partners if they do not want to have sexual intercourse – are empowered to realize their reproductive rights. Among 14 countries, the proportion of women with disabilities able to make these autonomous decisions ranges from 7 per cent in Mali to 82 per cent in Colombia (Figure 43). In four of these countries, women with disabilities have significantly less bodily autonomy than women without disabilities, with India and Nigeria showing the largest gaps between them. In the other countries, women with disabilities have similar bodily autonomy than women without disabilities.

**Figure 44. Percentage of women aged 15 to 49 years who have their needs for family planning satisfied with modern methods, in 14 countries, in 2021 or latest year available.**




*Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.*
*Source: UNDESA (on the basis of data from DHS[6]).*

Despite having the same sexual and reproductive needs and rights, and being as sexually active as their peers,[187,188] persons with disabilities face many barriers to accessing sexual and reproductive healthcare and services. In addition, the widespread false belief within the general population that persons with disabilities do not need as much sexual and reproductive health services as persons without disabilities,[189] deters many persons with disabilities from seeking sexual and reproductive healthcare and

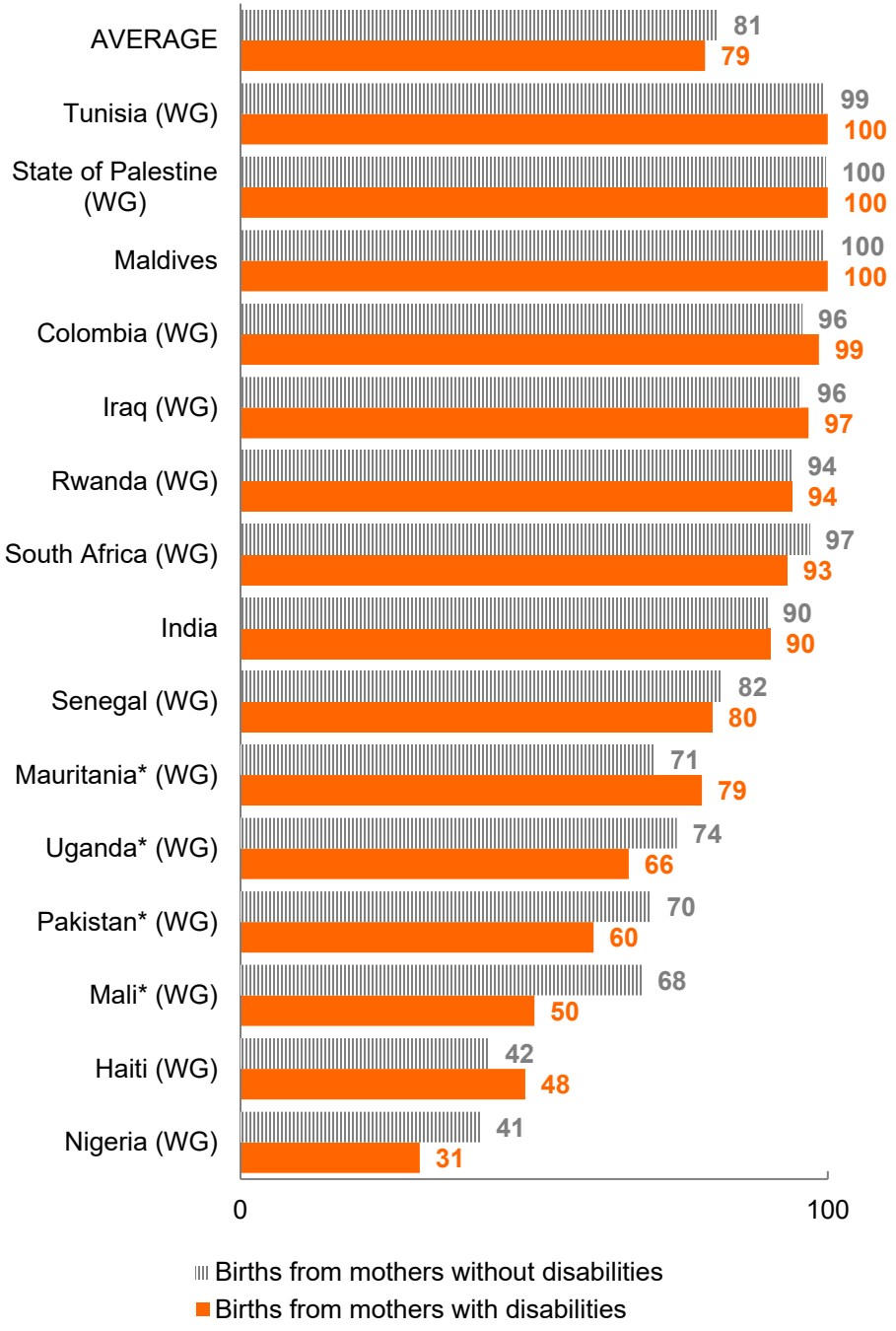
services.

For example, although family planning is a crucial component of sexual and reproductive health services, many women with disabilities who want to stop or delay childbearing do not have access to family planning. As a result, their needs to stop or delay childbearing remain unmet. Among 14 countries, on average, the percentage of women who have their need for family planning met with modern methods is 46 per cent for women with disabilities and 49 per cent for women without disabilities (Figure 44). The percentage of women with disabilities who have their needs for family planning met with modern methods ranges from 3 per cent in Albania to 87 per cent in Colombia. Particularly in countries with lower access to modern methods for family planning, such as Haiti, Maldives, Mauritania, Nigeria, Senegal and Yemen, fewer women with disabilities than women without disabilities have their family planning needs met with modern methods.

Maternal health is another key component of sexual and reproductive health services. It includes the health of women during pregnancy, childbirth and post-natal periods. Improved access to skilled health personnel for childbirth – such as a midwife, doctor or nurse – is crucial to improving maternal health and reducing maternal mortality for women with disabilities. Among 15 countries or areas, births from mothers with disabilities are slightly less attended by a skilled health worker (79 per cent) than births from mothers without disabilities (81 per cent), see Figure 45. In Maldives, State of Palestine and Tunisia, all births from mothers with disabilities are attended by a skilled health worker. In Colombia and Iraq, more than 95 per cent of births from mothers with disabilities are attended by a skilled health worker. In Mali, Nigeria, Pakistan and Uganda, mothers with disabilities are markedly less likely to be attended by a skilled health worker than mothers without disabilities, with a gap of 8 or more percentage points. The widest gap is found in Mali – 18 percentage points – where 50 per cent of births from mothers with disabilities compared to 68 per cent from mothers without disabilities are attended by a skilled health worker. The gap between births from mothers with and without disabilities could be due to several factors, including income disparities with more mothers with disabilities unable to afford medical care, negative attitudes among skilled health workers and a lack of accessible information on childbirth options for mothers with disabilities. Moreover, disrespect and abuse by service providers of women with disabilities during childbirth and obstetric procedures remains common.[190]

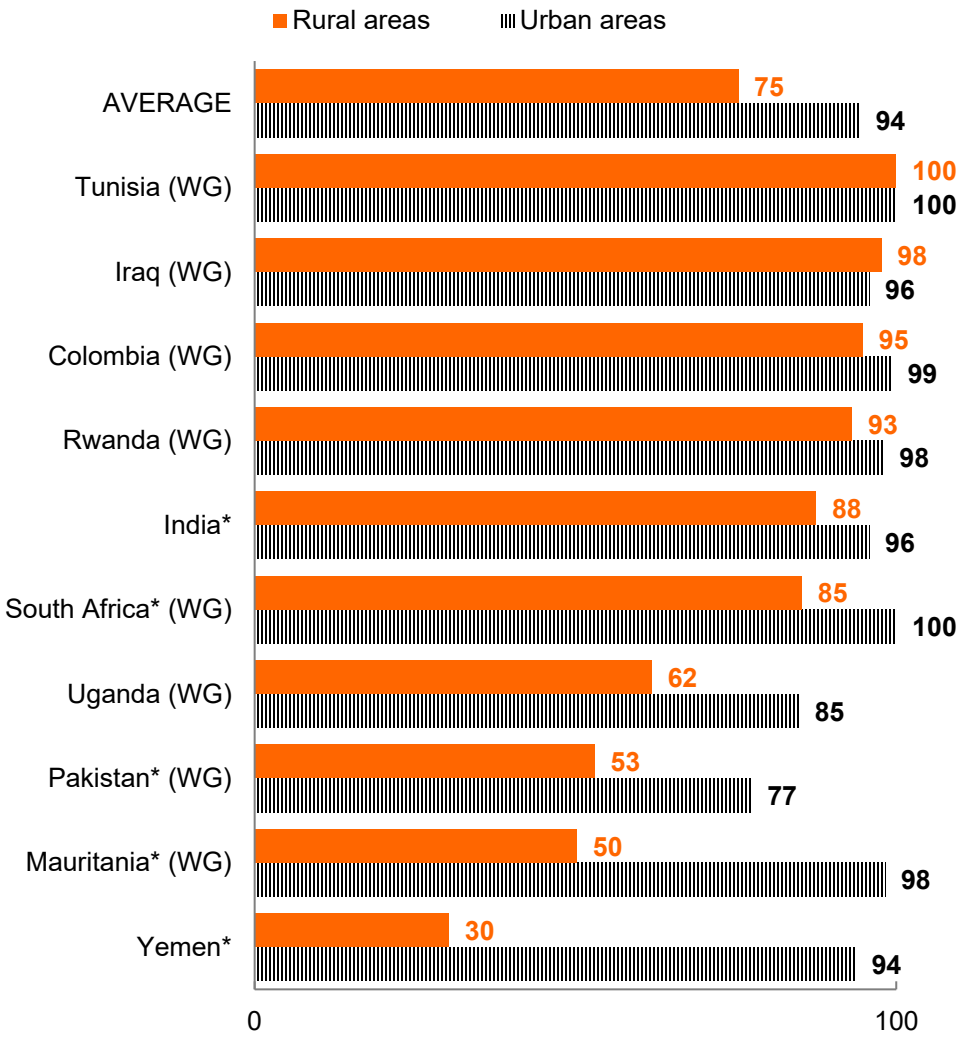
The country averages mask differences between urban and rural areas: 94 per cent of births from mothers with disabilities in urban areas were attended by a skilled health worker compared to 75 per cent of births from mothers with disabilities in rural areas, with several countries showing gaps larger than 20 percentage points between urban and rural areas (Figure 46).

**Figure 45. Percentage of births attended by skilled health personnel, by disability status of the mother, in 15 countries or areas, in 2021 or latest year available.**




*Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between the births of women with and without disabilities are statistically significant at the 5 per cent level.*
*Source: ESCWA (on the basis of data from MICS), UNDESA and UNFPA (on the basis of data from DHS[6]).*

**Figure 46. Percentage of live births attended by skilled health personnel, by area of residence of the mother with disabilities, in 10 countries, in 2021 or latest year available.**

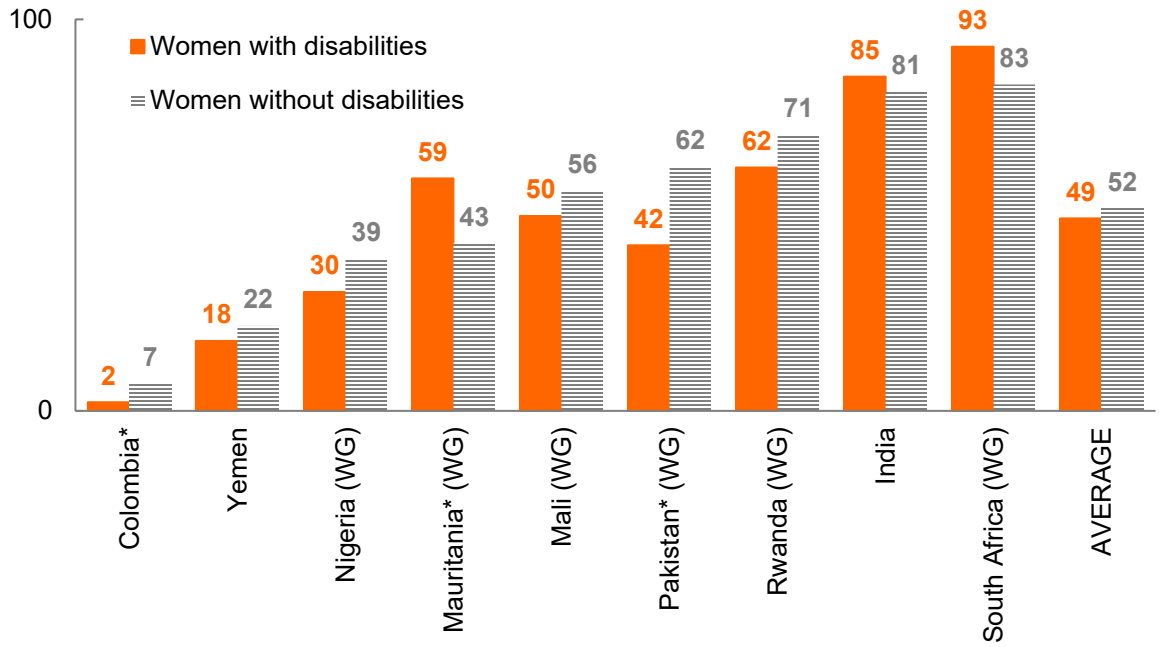



*Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between the births of women with disabilities in rural and urban areas are statistically significant at the 5 per cent level.*
*Source: ESCWA (on the basis of data from MICS) and UNDESA (on the basis of data from DHS[6]).*

Mothers with disabilities do not always receive a timely postnatal check after birth, that is, a check two days after giving birth (Figure 47). In nine countries, the percentage of women with disabilities who received a timely post-natal care visit for their last birth ranges from 2 per cent in Colombia to 93 per cent in South Africa. In Colombia and Pakistan, a significantly lower percentage of women with disabilities than women without disabilities received a timely post-natal care but in Mauritania, a significantly larger percentage of women with disabilities received such a visit. The lack of access to healthcare can be particularly impactful on women with disabilities because they are at greater risk than women without

disabilities for perinatal complications. For example, in Canada, significantly more women with physical (33 per cent), sensory (30 per cent), intellectual (49 per cent) and multiple (42 per cent) impairments have a postpartum emergency visit compared to those without these impairments (24 per cent).[191]

**Figure 47. Percentage of women aged 15 to 49 who received a timely postnatal check, by disability status, in 9 countries, in 2021 or latest year available.**




*Note: This indicator reflects the percentage of women with a live birth during the two years preceding the survey who received a postnatal check in the first two days after giving birth. The measure includes women who received a check from a doctor, midwife, nurse, community health worker or traditional birth attendant. Data from Colombia do not reflect the type of health provider performing the postnatal check. (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.*
*Source: UNDESA and UNFPA (on the basis of data from DHS[6]).*

Poorer access to sexual and reproductive healthcare among women with disabilities increases their risk of contracting additional disabilities related to sexual and reproductive health, including obstetric fistula and uterine prolapse. Obstetric fistula, a hole in the birth canal caused by prolonged labour without medical intervention, leaves a woman with chronic incontinence and, in most cases, a stillborn baby. If left untreated, fistula can also lead to ulcerations, kidney disease and nerve damage. Fistula occurs when obstetric care is unavailable which is why women with disabilities living in remote rural areas are most at risk. Surgery can normally repair the injury, but this procedure can be unaffordable for women with disabilities. Uterine prolapse occurs when the uterus sags or slips from its normal position into the vagina. Uterine prolapse can result from prolonged labour, too early or too closely spaced pregnancies, improper

delivery techniques and resuming work too soon after childbirth. This condition can also lead to additional disabilities unless there is a surgical intervention, a procedure which is not always available, particularly in remote areas, and is often unaffordable for women with disabilities.

Furthermore, sexual and reproductive health facilities in many low- and middle- income countries are physically inaccessible, lack adaptations such as ramps or moveable equipment,[192,193] and frequently have long waiting times.[194] Even when the facilities are physically accessible, the information in these services is often not available in accessible formats. For example, sexual and reproductive health and AIDS clinics rarely have access to sign language interpreters.[195] Distant healthcare facilities are also a barrier for many, especially when transportation is inaccessible, unreliable or expensive. The need for some persons with disabilities to have someone accompany them on the health visit not only increases costs, but also raises issues of confidentiality, especially when sexual and reproductive health issues are involved.

Moreover, healthcare professionals often share socially entrenched negative attitudes about disability and sexuality,[196,197,198 ,199] which can lead to distressing experiences for persons with disabilities when seeking care. Persons with disabilities are often denied sexual and reproductive health information and resources; and discouraged from becoming sexually active. Such barriers to sexual and reproductive health services arise because those working in public health and clinical services often have little knowledge or training on disability,[200,201] and the needs and perspectives of persons with disabilities are not considered when planning interventions, services and public information campaigns.

Compounding these barriers, persons with disabilities are frequently excluded in other domains of life, such as education, employment and socialization (see the chapters on Goals 4, 8 and 10). This means that persons with disabilities often lack the education, income and social support systems that would allow them to make informed decisions about their sexual and reproductive health options. Many persons with disabilities continue to live in institutions (see the chapter on Goal 10), where they are often not allowed to decide on their sexual and reproductive healthcare or access such services.

Child marriage can compromise sexual and reproductive health and affects girls with disabilities at similar rates as girls without disabilities (see the chapter on Goal 5). Child marriage subjects girls with disabilities to sexual violence, risky pregnancies, fistula and HIV. It is linked with early childbearing, leading to death and injury for many young mothers with disabilities. Girls with disabilities are likely to be married early in communities where child marriage occurs, as families see it as a way to ensure long-term security and protection for their children.

Little is known about access to sexual and reproductive health services for men with disabilities,[202,203] but given the existing barriers to access for persons with disabilities in general, it is anticipated that men with disabilities will also show lower levels of knowledge about and lower access to sexual and reproductive health services than their peers without disabilities.

Recent initiatives to improve the sexual and reproductive health of persons with disabilities include: the adoption of national policies on the sexual and reproductive health of persons with disabilities;[188,204] ensuring access by persons with disabilities to relevant information and services; engaging persons with disabilities in the planning, implementation, monitoring and evaluation of sexual and reproductive health programmes;[205] creating effective community support networks; and formulating evidence-based revisions of legislation, policies, strategies and guidelines concerning the sexual and reproductive health and reproductive rights of adolescents with disabilities.[206] In addition, increasing numbers of healthcare professionals have been trained on supported decision-making and the CRPD principles around legal capacity and reproductive autonomy, a key development for women with disabilities to make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare.

The sexual and reproductive health of persons with disabilities and their reproductive rights are negatively impacted by sexual and gender-based violence. Persons with disabilities, both men and women, are more likely to face sexual violence and abuse than persons without disabilities.[188] Girls and women with disabilities are disproportionately affected by this type of violence, including sexual violence and abuse (see the chapter on Goal 16); forced sterilizations and invasive and irreversible involuntary treatments; forced abortion; forced pregnancy; forced menstrual suppression; forced pregnancy prevention; criminalisation of abortion; denial or delay of safe abortion and post-abortion care; forced continuation of pregnancy; abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services; as well as trafficking and harmful practices such as child and forced marriage and female genital mutilation.

Many of those forms of sexual violence might happen while a person with disabilities performs daily tasks such as dressing, toileting or receiving health treatment. Sexual violence occurs at home, in institutions, schools, health centres and other public and private facilities. Perpetrators are frequently relatives, caregivers and professionals on whom the girl or woman with disabilities may depend. Women with intellectual and psychosocial disabilities are particularly vulnerable. For example, a study among women with intellectual disabilities revealed that 43 per cent had been sexually abused at the gynaecologist's office.[188]

The risk of sexual abuse tends to be higher during conflict, post-conflict and other humanitarian situations; among refugees, internally displaced persons, migrants or asylum seekers with disabilities; among persons with disabilities deprived of their liberty in hospitals, residential institutions, juvenile or correctional facilities; and among persons with disabilities who are homeless or live in poverty.

Persons with disabilities are less likely to have equal access to prevention and response services for sexual violence and abuse.[188] Higher rates of sexual violence among women with disabilities puts them at higher risk of unplanned pregnancies, and higher rates of sexual violence among both men and women with disabilities puts them at higher risk of sexually transmitted infections.[207]

Sterilization of women and girls with disabilities has been reported at three times higher rates than the general population.[208] While the sterilization of persons with disabilities constitutes discrimination,[209] many legal systems still allow judges, healthcare professionals, family members and guardians to consent to forced sterilization procedures on behalf of persons with disabilities as being in their best interest. Forced sterilization is an unacceptable practice with lifelong consequences on the physical and mental integrity of girls and women with disabilities. Many, particularly those with intellectual disabilities, have been subjected to involuntary sterilization in various countries.[210,211] For instance, a study among women with intellectual disabilities found that half had been recommended for sterilization by a family member and close to half of these had been sterilized. Moreover, 6 per cent had not been informed that the surgery was sterilization.[188]

Girls and women with disabilities are also frequently pressured to end pregnancies owing to negative stereotypes about their parenting skills and concerns about giving birth to a child with disabilities.[212,213] Moreover, there are reports about compulsory gynaecological checks and forced abortions in institutions as a way to contain the institution's population.[214] Forced contraception is also often used to control menstruation at the request of health professionals or parents.[215] Moreover, while the contraceptive needs of girls and young women with disabilities are the same as those without disabilities, they receive contraception more often through injection or intrauterine devices rather than orally, as it is less burdensome for families and service providers.[216] These forced interventions are still common in some healthcare settings. Often, mistreatment in sexual and reproductive health services and institutions is perpetuated by laws that discriminate against women's bodily integrity in general and that of women with disabilities in particular.

Female genital mutilation is also a concern for girls with disabilities. This practice can lead to additional disabilities, either at the time of the procedure or through complications at the time of childbirth.

## Impact of the COVID-19 pandemic

The COVID-19 pandemic has exacerbated existing barriers and created new challenges to the achievement of sexual and reproductive health and the realization of reproductive rights for persons with disabilities. There has been a lack of disability perspectives and inclusion in planning and developing the responses to the pandemic. The COVID-19 pandemic resulted in service disruptions that affected access to abortion, contraceptives and testing for HIV and sexually transmitted infections.[217] For persons with disabilities, these service disruptions and epidemic control measures such as school closures[218,219] and lockdowns, exacerbated existing barriers to access information and services.[220,221,222] Remote learning and school closures (see the chapter on Goal 4) led to the lack of access to sexuality education taught in schools. Strained healthcare resources during the pandemic resulted in policies and practices that failed to take disability into account, such as exclusion from remote learning platforms for comprehensive

sexuality education.[223,224] Remote-based information and services were not always made accessible to persons with disabilities.

**Box 3. Ensuring accessible sexual and reproductive health services and goods for women and girls with disabilities in Tajikistan, during the COVID-19 pandemic**

At the beginning of the COVID-19 pandemic, in May 2020, the Ministry of Health of Tajikistan in collaboration with the United Nations Population Fund (UNFPA) and organizations of persons with disabilities launched a project to provide access to information, free sexual and reproductive health services, sanitation and hygiene products and psychosocial support for persons with disabilities to ensure continuing sexual and reproductive health and to realize reproductive rights during the pandemic.

Since many of the centres providing sexual and reproductive health services were not accessible, particularly to persons with physical disabilities, five accessible rooms were built in local reproductive health centres or local non-governmental organizations. Staff were hired specifically to counsel, observe and refer persons with disabilities to services for issues related to sexual and reproductive health. Through these services, women with disabilities received ultrasounds to detect reproductive diseases or other issues, including cervical cancer; contraceptives; counselling on healthy lifestyles, family planning and sexually transmitted infections; psychosocial support for stress or violence; and referral for further testing and services. Women with disabilities learned about these rooms through social networks, the website of the National Association of Persons with Disabilities and leaflets distributed by organizations of persons with disabilities.

A working group was also established to develop standard operating procedures for providing sexual and reproductive health services for persons with disabilities. Following the adoption of these standard operating procedures, in December 2020, training sessions were conducted with a wide range of healthcare specialists on the rights of persons with disabilities and the need to ensure that persons with disabilities are treated with dignity.

*Source: UNFPA (2021).*[225]

Family planning clinics closed in local communities and lack of accessible and affordable transportation meant that women and girls with disabilities could not travel to other communities to receive sexual and reproductive health services. Even when they were able to access the services, women and girls with disabilities who required the assistance of sign language interpreters or other assistants to access these services were no longer allowed to bring those individuals with them due to social distancing rules. Additionally, as many women and girls with disabilities lost jobs and income during the pandemic, their ability to afford and fully exercise their sexual and reproductive health rights was impacted. This lack of access to sexual and reproductive health services has been detrimental to the health of women and girls with disabilities and, in extreme emergency cases, has put their lives at risk.

**Box 4. Addressing the sexual and reproductive health needs of women with disabilities in Kenya, during the COVID-19 pandemic**

The COVID-19 pandemic significantly impacted the lives of women with disabilities in Kenya. Sexual and reproductive health and reproductive rights among girls and women with disabilities were of particular concern, as an increase in sexual violence led to increases in unwanted pregnancies and caused families to consider sterilization as a misguided protection measure. To respond to these challenges, the organization This-Ability in collaboration with UNFPA, the Global Fund for Women and the African Women Development Fund gathered women with disabilities together in supportive networks and organized training programs and accessible e-learning platforms during the COVID-19 pandemic to learn about important topics, including sexual and reproductive health.

*Source: UNFPA (2021).*[225]

A number of initiatives were taken in various countries to improve the sexual and reproductive health of persons with disabilities during the COVID-19 pandemic (see Box 3 and Box 4), including establishing violence-related peer-to-peer support for women with disabilities, conducting public awareness campaigns during the pandemic about gender-based violence against women with intellectual or developmental disabilities, and allowing support persons to accompany persons with disabilities to sexual and reproductive health services.[225]

## Summary of findings and the way forward

Sexual and reproductive health is as important to persons with disabilities as it is for all members of society. Persons with disabilities are as sexually active as persons without disabilities and have similar sexual and reproductive health needs. Yet, persons with disabilities are regularly excluded from the provision of sexual and reproductive health services due to environmental and attitudinal barriers, such as lack of physical accessibility in healthcare facilities and public transport, low levels of awareness and misperceptions about the sexual and reproductive health needs of persons with disabilities. In various countries, more than 50 per cent of women with disabilities do not have comprehensive knowledge regarding HIV/AIDS, do not have their needs for family planning satisfied with modern methods, do not have the births of their babies attended by skilled health personnel, do not receive a timely postnatal check, do not have autonomy in making decisions about their reproductive health – with others making decisions for them – and are not empowered to exercise their reproductive rights. Similarly, in various countries, more than 50 per cent of men with disabilities do not have comprehensive knowledge regarding HIV/AIDS.

Without access to sexual and reproductive health services, persons with disabilities are at higher risk of unwanted pregnancies and sexually transmitted infections. The COVID-19 pandemic exacerbated the barriers to sexual and reproductive health and reproductive rights for women and girls with disabilities.

The collection and analysis of quantitative and qualitative data on persons with disabilities' access to sexual and reproductive health services and reproductive rights remain insufficient in many countries. This lack of data makes it impossible to assess global trends since 2015. The data available from a limited number of countries suggest that greater efforts are needed to speed up progress towards targets 3.1, 3.7 and 5.6 for persons with disabilities, namely regarding universal access to sexual and reproductive health services and ensuring their reproductive rights. In particular, the percentage of women with comprehensive knowledge of HIV/AIDS needs to increase at least 8 percentage points per year in order to make this knowledge available to all women with disabilities by 2030; the percentage of women with disabilities with their family planning needs met with modern methods needs to increase at least 6 percentage points per year to meet the needs of all women with disabilities by 2030; the percentage of births from mothers with disabilities attended by skilled health personnel needs to increase at least 2 percentage points per year to achieve 100 per cent coverage by 2030; the percentage of women with disabilities receiving a timely post-natal check needs to increase at least 6 percentage points per year to achieve 100 per cent coverage by 2030; and the percentage of women with disabilities empowered to exercise their reproductive rights, and with autonomy to make their own decisions about their reproductive health, needs to increase at least 6 percentage points per year in order to ensure that all women with disabilities can exercise these rights and autonomy by 2030.

A series of actions should be considered to support this progress, achieve targets 3.1, 3.7 and 5.6 for persons with disabilities and ensure that their sexual and reproductive health and reproductive rights are realized:

**1. Promote and protect the bodily autonomy of persons with disabilities.** Provide a national legal and policy framework that guarantees persons with disabilities the right to make decisions about their reproduction and sexuality, to better support reproductive self-determination for persons with disabilities. Ensure the participation of persons with disabilities in developing these laws.

**2. Develop national laws and policies that guarantee access to sexual and reproductive health services and reproductive rights for persons with disabilities.** Eliminate discriminatory laws that prevent persons with disabilities from exercising their reproductive rights and prevent discriminatory actions, including unconsented sterilization. Reproductive and obstetric violence should be defined, addressed and prohibited in local, national and regional gender and sexual and reproductive health strategies, policies and action plans. Ensure the participation of persons with disabilities in developing these laws and policies, as part of national programme planning and decision-making processes.

**3. Remove barriers to access of sexual and reproductive health services, including by making the services safe and affordable and the care facilities, communication and information accessible.** Healthcare facilities must be physically accessible and the information on sexual and reproductive health must be provided in accessible formats. Persons with disabilities must feel safe at the hands of healthcare providers and mechanisms to monitor, report and eliminate gender-based violence in healthcare settings must be in place. There is an urgency to promote access to maternal health, family

planning and contraception and safe abortion for persons with disabilities and to address barriers to the ability to seek, reach, afford and use such services to achieve sexual and reproductive health and to protect reproductive rights. Programmes working to eliminate female genital mutilation must consider and include girls with disabilities in all outreach efforts.

**4. Train sexual and reproductive healthcare workers on disability inclusion, focusing on eliminating discrimination and negative attitudinal barriers and improving service delivery for persons with disabilities.** To counter discriminatory practices, training programmes should be delivered on enhancing the understanding of the diverse needs of persons with disabilities, including autonomous and supported decision-making. Engage persons with disabilities in designing, implementing and evaluating such training programmes.

**5. Educate persons with disabilities, including adolescents, on sexual and reproductive health and reproductive rights.** Educate persons with disabilities, including by increasing the dissemination of high-quality, age-appropriate, accessible materials about sexual and reproductive health and reproductive rights. These materials should be accessible for persons with disabilities and developed in consultation with persons with disabilities and their organizations. These resources should be available to educators and advocates of sexual and reproductive health and reproductive rights. Reaching out to all children and youth with disabilities, including out-of-school children and youth with disabilities, is critical.

**6. Strengthen research and data to monitor, evaluate and guide the development of sexual and reproductive health services for persons with disabilities.** Conduct research and collect high-quality data disaggregated by disability on sexual and reproductive health and reproductive rights as well as on access to sexual and reproductive healthcare and services, emphasizing low- and middle-income countries and including more intersectional data, such as sexual and reproductive health among women from ethnic and minority communities. Produce data not only for women with disabilities but also for men with disabilities. Persons with disabilities must be engaged in such studies.

**7. Build on the lessons from the COVID-19 pandemic to plan better for future crises and emergencies with regard to the provision of disability-inclusive sexual and reproductive healthcare and services and the protection of reproductive rights of persons with disabilities.** Countries must better enforce existing international guidance on disability inclusion, sexual and reproductive health and reproductive rights, freedom from violence and related rights during crises and emergencies. Persons with disabilities must be included in preparing for, responding to and recovering from crises.