**Response by the Asian-Pacific Resource and Research Centre for Women (ARROW)[[1]](#footnote-1)**

**To the request for input by the Special Rapporteur on​ the Rights of Persons with Disabilities, Ms. Catalina Devandas Aguilar, for her next report​ focused on the right to sexual and reproductive health rights of girls with disabilities**

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Submit by June 5, 2017 to sr.disability@ohchr.org.

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**QUESTIONNAIRE:**

**THE RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF GIRLS WITH DISABILITIES**

**1. Please provide any information and statistics (including surveys, censuses, administrative data, literature, legal and policy documents, reports, and studies) related to the exercise of sexual and reproductive health and rights of girls with disabilities, with particular focus in the following areas:**

* **Harmful stereotypes, norms, values, taboos, attitudes and behaviours related to the sexual and reproductive health and rights of girls with disabilities;**
* **Sex education (in formal and non-formal settings) and access to sexual and reproductive health information;**
* **Access to child and youth-friendly quality sexual and reproductive health services;**
* **Prevention, care and treatment of sexually transmitted infections;**
* **Violence against girls with disabilities impacting their enjoyment of sexual and reproductive health rights; and**
* **Harmful practices, such as forced sterilization and child, early, and forced marriage.**
* **Medicalization to control/suppress sexuality.**

Sexual and reproductive rights (SRR) are fundamental human rights, which are enshrined in national, regional,[[2]](#footnote-2) and international laws and agreements. Sexual and reproductive health and rights (SRHR) is critical for gender equality and sustainable development. Girls’ and women’s control over their bodies, fertility, and sexuality is a critical prerequisite for empowerment and rights, and for enabling full participation in all domains of society—economic, social, political, and cultural. Sexual and reproductive health and rights (SRHR) is an integral part of girls’ and women’s rights to be free from discrimination, coercion and violence, and enshrines the principles of bodily integrity, dignity, equality, and respect for diversity.

Despite this, SRHR and sexuality remain contentious issues, as seen in the negotiations for the UN Convention on the Rights of Persons with Disabilities (CRPD). A strong lobby between the Holy See, aligned NGOs, and several governmental delegations, combined with less effective responses from progressive governments and NGOs, resulted in the watering down of rights related to sexuality and to sexual and reproductive health in the convention. These became “far less explicit and affirmative,” SRHR becoming seen mainly in the context of family and marriage, as well as sexual violence.[[3]](#footnote-3)

The sexuality and SRHR of girls and women with disabilities are frequently omitted in public discourses, policymaking, programming, and services. This largely stems from the lack of recognition that they, like everyone else, are sexual and reproductive beings with desires, dreams, hopes, and needs for intimacy, pleasure, romance, touch, childbearing and childrearing, and/or relationships. The converse of this, is the control and monitoring of girls and women with disabilities’ reproductive capacities or ‘hypersexuality,’ mainly through medicalisation and pathologisation of their sexuality.

These result in the violation of the sexual and reproductive rights of girls and women with disabilities, including forced/coerced sterilisations and forced abortions, lack of access to sexual and reproductive health information and services, as well as physical, mental, and sexual violence.[[4]](#footnote-4) Specific information related to SRHR of girls and women with disabilities follow:

**Harmful stereotypes, norms, values, taboos, attitudes and behaviours related to the sexual and reproductive health and rights of girls with disabilities**

Girls and women with disabilities experience double stigma and discrimination, both for their disability, as well as for being a woman. Discrimination may vary from “public comments and insults to institutionalised violence, leading to women being unable to access education, jobs, or other forms of societal support.”[[5]](#footnote-5) Moreover, shame associated with disability can lead to families to ‘hide’ family members with disabilities. They act as gatekeepers to sexual and reproductive health information and services, thus impacting their health and well-being negatively.[[6]](#footnote-6) In the South Indian context, a study on violence against disabled, lesbian, and sex-working women in Bangladesh, India, and Nepal, found that families also arrange marriage to daughters with disabilities with whoever accepted them.[[7]](#footnote-7)

Biased and discriminatory attitudes towards girls and women with disabilities seeking sexual and reproductive health services were shown by some health service providers in the Philippines.[[8]](#footnote-8) Indicative of societal perceptions of women with disabilities as asexual, only one respondent of the Philippine study recognised that women with disability are as likely as women without disability to have sexual desires and experiences, and thus need SRH services. Further, girls and women with disabilities were seen by respondents as at fault for unwanted or unplanned pregnancies, despite their perceived low level of SRH knowledge and awareness, and even if the pregnancy is a result of sexual violence.

**Sex education (in formal and non-formal settings) and access to sexual and reproductive health information**

Comprehensive sexuality education and information on sexual and reproductive health information are critical elements of sexual and reproductive rights. PWDs themselves consider information on SRH not just as a need, but as their right, as in the case of study participants in Indonesia.[[9]](#footnote-9) Participants stressed that PWDs have sexual and reproductive rights, including the right to information on contraception and to make choices on what method to use, and the right to be free from sexual violence.

Despite being a right, young people with disabilities often do not have equal access to information and education related to SRH, sexuality, and relationships, thus hampering their ability to make informed decisions about these issues.[[10]](#footnote-10) Access to comprehensive sexuality education for young people in the Asia-Pacific region is hotly contested and limited by moral panics and societal mores that control young people’s sexuality outside marriage. Added to this, PWDs’ perceived asexuality results in comprehensive sexuality education and SRHR information not being considered essential for them.

A study of women, men, and adolescents with disabilities in refugee settings in Kenya, Nepal, and Uganda[[11]](#footnote-11) found that refugees with limited access to information, particularly those with intellectual impairments, had the least awareness about sexual and reproductive health. Overall, adolescent girls and boys with disabilities knew less than adults about sexual and reproductive health issues. Participants were not aware of emergency contraception despite being availability in camp. Nevertheless, PWDs across age, sex, language, and impairment group in all three countries were interested in learning more about SRH.

Ratnaboli Ray, Founder and Managing T[[12]](#footnote-12)rustee of the Anjali Mental Health Rights Organisation, in an interview by ARROW,[[13]](#footnote-13) noted the lack of adequate information on their bodies, on sexual and reproductive health, and sexuality of girls and women with psychosocial disabilities in India. There are no provisions for such education or information provision in mental health institutions, given that expression of love and desire of girls and women with psychosocial disabilities are regarded as forbidden and their sexuality is pathologised. She noted that the sex education should not just be about how babies are born, but about having positive body image, smashing stereotypes, and having a sex-positive and affirmative view of sexuality.

The lack of sexuality education for girls and women with disabilities in India, let alone comprehensive sexuality education, was also highlighted in the Pleasure, Politics, and *Pagalpan*: National Conference on Sexuality, Rights, and Psychosocial Disability, organised by ARROW and Anjali on 13-14 May 2017 (*see more on the conference in the response to the second question)*. Sexuality education is not available in the mainstream school curriculum India, having met heavy opposition when it was promoted in 2007 by the government.[[14]](#footnote-14) Moreover, for girls and young people with disabilities, access is even more difficult particularly if they are based out of the metropolis, and are not able to access libraries or the internet.[[15]](#footnote-15) Girls and young people with disabilities are thus dependent on their family or institutions, which is highly problematic due to the view that issues related to contraception, safer and pleasurable sex, relationships, and reproduction are irrelevant, or if not, needing controlling without their consent.

**Access to child and youth-friendly quality sexual and reproductive health services**

Girls and women with disabilities are often denied access to child and youth-friendly, disability-inclusive sexual and reproductive health services. These violations stem from deep-rooted “disability-based and gender-based stereotypes that view women with disabilities as undesirable, unworthy and incapable of love and sexual expression.”[[16]](#footnote-16)

Supply-side barriers to access to disability-inclusive and youth-friendly sexual and reproductive health services include insufficient understanding by health service providers on disability and of the rights of girls and women with disability, and inadequate awareness of their SRH needs, as in the case of Kiribati, the Philippines, the Solomon Islands, and Tonga.[[17]](#footnote-17),[[18]](#footnote-18) Marital status is a defining factor for provision of services, with a provider saying those who are married do not need family planning services, while another conversely said they do not need such services as they are unmarried. Health service providers in the Philippines are also uninformed about violence, abuse, and other factors undermining the health of girls and women with disabilities.[[19]](#footnote-19)

Furthermore, service providers lack capacity to provide disability-inclusive service provision, including how to communicate with PWDs, and have limited access to resources for disability-inclusive service provision (such as accessible facilities).[[20]](#footnote-20),[[21]](#footnote-21) In Indonesia, reproductive health services are available at different levels to support PWDs, but health care providers do not know how to communicate with people with hearing impairments.[[22]](#footnote-22)

Religious conservatism can also be a barrier to access to services to women, including those with disabilities. In the Philippines, for example, study participants pointed out that their capacity to provide sexual and reproductive services were affected in the past by the religious stance of their former head who was against family planning.[[23]](#footnote-23)

Demand-side barriers preventing access to SRH services are multi-faceted, including families acting as gatekeepers to health and SRH information and services, lack of mobility of girls and women with disabilities, and financial dependence which makes paying for health services and accessible transport required to get the services difficult.[[24]](#footnote-24),[[25]](#footnote-25),[[26]](#footnote-26)

**Violence against girls with disabilities impacting their enjoyment of sexual and reproductive health rights**

Studies indicate that the prevalence of violence amongst girls and women with disabilities are higher, but national-level disability-disaggregated statistics are unavailable in many countries in Asia and the Pacific region.[[27]](#footnote-27), [[28]](#footnote-28) Global estimates indicate that children and adolescents with disabilities are three to four times more likely to experience violence and neglect compared to those without disabilities, while women with disabilities are ten times more likely to experience sexual abuse than those without.[[29]](#footnote-29) Nevertheless smaller scale studies in the region support that women with disabilities experience high levels of violence from intimate partners and natal families, as in the cases of Bangladesh, India, and Nepal.[[30]](#footnote-30) In the Pacific, young women and women with disabilities experience the highest risk for gender-based violence, including family violence and sexual violence.[[31]](#footnote-31) Nearly half of the women with disabilities interviewed in the study in Kiribati, the Solomon Islands, and Tonga, shared their first sexual experience was coerced or forced.[[32]](#footnote-32)

A study of women with disabilities in Bangladesh revealed that more than 57.7% believed wife-battery (in general) is justified in cases of unfaithfulness, 47.5% if she disobeys him, 30.4% if she does not complete her household work to his satisfaction, and 19.4% if she refuses to have sex with him, indicating deep levels of gender inequality in society.[[33]](#footnote-33) While the percentages were much lower in Nepal for other reasons, 42.3% still believed that wife-battery is justified in cases of unfaithfulness.[[34]](#footnote-34)

Women with disabilities experience grave difficulties in accessing justice in cases of violence. In Bangladesh, courts seldom employ measures that would allow to present evidence.[[35]](#footnote-35)

Refugees with disabilities in Nepal, across age groups, did not know about the importance of health care after experiencing sexual violence.[[36]](#footnote-36) However, it should be noted that health services providers often do not know how to recognise and deal with sexual abuse. Even when they do, suggested strategies often focus on prevention of the pregnancy, rather than of the abuse.[[37]](#footnote-37) Moreover, institutionalisation can be seen as a protective solution, not realising that people with disability living in institutions worldwide experience high levels of abuse.[[38]](#footnote-38)

Women with psychosocial and intellectual disabilities encounter violence in the form of forced institutionalisation, as documented in India.[[39]](#footnote-39) Those institutionalised often experience various types of violence, “inhumane and degrading treatment” with little or no access to redress; they are also robbed of their ability to make decisions.[[40]](#footnote-40)

**Harmful practices, such as forced sterilization and child, early, and forced marriage**

Forced sterilisation and contraceptive use of girls and women with disabilities, especially those with intellectual and psychosocial disabilities, occurs in the Asia-Pacific region, as demonstrated by examples from India,[[41]](#footnote-41) Japan,[[42]](#footnote-42) Kiribati,[[43]](#footnote-43) the Philippines,[[44]](#footnote-44) the Solomon Islands,[[45]](#footnote-45) and Tonga.[[46]](#footnote-46) In the Philippines, a study of health providers revealed that families request for tubal ligation of young women with cognitive disability for pregnancy prevention without their consent, and that while this is a violation of their rights, they felt the practice was justifiable in some cases “to ease the burden on families and the strain on social services.”[[47]](#footnote-47) Likewise, in the Pacific study, forced contraception or sterilisation are initiated by either by families or medical professionals because women are repeatedly being raped and getting pregnant, and are perceived as not being capable of managing their fertility.[[48]](#footnote-48) In India, while there are Ministry of Health guidelines for the sterilisation of men and women, there are no explicit and clear provisions against forced sterilisation of girls and women with disabilities.[[49]](#footnote-49)

**Medicalization to control/suppress sexuality**

Human Rights Watch reports that forced medication is often used on girls and women with psychosocial disabilities in Indian mental institutions to ensure they keep within the bounds of ‘appropriate’ behaviour.[[50]](#footnote-50) Additionally, family members (such as husbands, wives, or parents in the case of adolescents) may also request over dosage of medication to control sexual urges of their relative who has psychosocial or intellectual disabilities.[[51]](#footnote-51)

**2. Please provide information in relation to any innovative initiatives that have been taken at the local, regional or national level to promote and ensure the exercise of sexual and reproductive health and rights of girls with disabilities, and identify lessons learned from these.**

Below are collaborations that the Asian-Pacific Resource and Research Centre for Women (ARROW) has done in relation to SRHR, sexuality, and disability.

**Capacity Development of Disability Rights Activists on Gender and SRHR.** CREA[[52]](#footnote-52) and ARROW, in collaboration with ADF, conducted a series of trainings to develop a group of disability rights activists, practitioners and leaders from Southeast Asia (Brunei, Cambodia, Indonesia, Malaysia, Thailand, Philippines, and Vietnam) to be able to take forward inclusive national, regional, and global advocacy for the sexual and reproductive health and rights of girls and women with disabilities. This stems from the recognition that SRHR of girls and women with disabilities is not prioritised in public agendas and discourse, but at the same time, disability organisations themselves may not have a good understanding of gender, sexuality, and sexual and reproductive health and rights issues, thereby hampering their ability to be strong advocates and to see these as priority issues.

A key outcome of the first workshop is the development of a response to the UN Summit Outcome Document to adopt the Post-2015 Agenda by members of ADF, partners, and allies, including ARROW and CREA.[[53]](#footnote-53) The statement emphasised the need for “more effective inclusion of people with disabilities not only within the outcome document but also in terms of implementation of programmes.” This statement is significant in being one of the few developed by/with DPOs from the Southeast Asian region.

The statement highlighted that Goal 3 is particularly of interest to girls and women with disabilities. In particular, “Issues of maternal mortality and morbidity are further exacerbated for PWDs who are often denied access and information on maternal health services; women with disabilities are also more vulnerable to HIV and AIDS and other diseases. Further, forced sterilization, institutionalization and forced medical interventions are forms of violence that women with disabilities (WWDs) are subjected to. WWDs must be included in these discourses. Further, universal access to Sexual and Reproductive Health (SRH) services including family planning and other RH services, along with sexuality education will be incomplete if these do not include WWDs.” The statement also noted with respect to Goal 7: “Lack of mobility also affects sexual and reproductive health and rights (SRHR) issues of WWD with less access to SRH services. We therefore recommend for assurance of existing energy for all services and buildings for transportation, better access to transportation and energy to operate devices, machines and to work with Disabled People’s Organisations (DPOs) to review the issues we have.”

The workshops helped build a better understanding of sexuality and sexual and reproductive health and rights, as well as strengthened advocacy and research capacities of activists and leaders from the disability rights movement from seven countries in the ASEAN region—Brunei, Cambodia, Indonesia, Malaysia, Thailand, Philippines, and Vietnam. It also increased participants’ knowledge of the links of the UNCRPD with gender, SRHR, and sexuality issues, as well as of the 2030 Agenda with disability and SRHR issues, thereby strengthening their capacity to use these for advocacy in advancing gender equality for girls and women with disabilities.

One of the strong points of this collaboration was that the need for the engagement with sexual and reproductive health and rights was recognized by ADF and the participants themselves. This reflects a bottom-up approach in which the communities recognize and articulate the need for engagement on a particular issue rather than it being addressed by external agents who may not have an adequate understanding of the grassroots realities. This approach truly recognizes and takes into consideration the needs of the participants, and thus is an important strategy to remember and follow in project development.

This initiative demonstrated the importance of cross-movement collaborations between the women’s movement, SRHR movement, and disability movement. These interactions highlighted more than anything else the need for open channels of communication, inter-sectoral movement building, and the need to learn and engage with issues and challenges across movements. A key learning as well is the need to ensure that DPOs themselves ensure inclusion of adolescent girls and young women, and that their SRHR is also highlighted.

**Intersections of Psychosocial Disability and SRHR.** ARROW is collaborating with Anjali, an organisation working in the field of mental health and human rights,[[54]](#footnote-54) in a cutting-edge initiative on sexuality, SRHR, and psychosocial disabilities. Psychosocial disability is one of the less discussed and most misunderstood areas within the disability discourse, and the sexual and reproductive rights of girls and women with psychosocial disabilities is even more hidden. We believe there’s a need to change prevailing mental health discourses and practices to recognise that persons with psychosocial disabilities are sexual beings with rights and citizenship. The historical view of sexuality of people with mental health issues has been one of pathology and dysfunction, and excludes rights, including to pleasure, while mental health issues have also been disregarded in the arena of SRHR.

As part of this collaboration, Anjali and ARROW convened the “Pleasure, Politics, and *Pagalpan:* National Conference on Sexuality, Rights, and Psychosocial Disabilities” on 13-14 May 2017 in Kolkata, India, which was attended by about 150 participants from diverse backgrounds.[[55]](#footnote-55) The conference addressed issues around language, body, and representation of persons with psychosocial disabilities, with particular focus on girls and women. Sessions explored current practice and frameworks in dealing with sexuality of persons living with psychosocial disabilities, notions, and lived realities of pleasure and danger, determinants to sexuality and psychosocial disabilities, and how to move forward to new paradigms.[[56]](#footnote-56),[[57]](#footnote-57) At the conference, sharing by participants included experiences of expressions of desire within adolescent girls’ homes, and yet carers did not know how to handle these; sex is pathologised and sexuality is repressed. Issues of consent vis-à-vis girls with psychosocial disability was raised as key concerns.

Other initiatives around these issues include:

* The Centre for Creative Innovation in Health and Population (CCIHP), as part of a regional partnership coordinated by ARROW, has advocated for **comprehensive sexuality education (CSE) in Vietnam, including for young people with disabilities**. ARROW and CCIHP believes that CSE curricula should be crafted and implemented based on the principles of equity and non-discrimination, and that it should be accessible by all adolescents and young people regardless of age, disability status, sexual orientation and gender identity, geographical location, religious beliefs, and health, marital, and socio-economic status. CCIHP also ensures young people’s involvement in programmes and events through the formation of network of youth volunteers, that have been active in conferences and events on sexuality and gender-based violence, as well as on young people with disabilities. [[58]](#footnote-58)
* WE DECIDE, by UNFPA, an initiative that aims to increase access to SRH information and services, ending gender-based violence, addressing discrimination, and strengthening young people with disabilities’ voices and participation on issues and policies.[[59]](#footnote-59)

**SOME KEY RECOMMENDATIONS**

* Recognise that people living with disabilities, including girls and women living with disabilities have human rights, and States should be accountable for respecting, protecting, and fulfilling their rights.
* Recognise that girls and women with disabilities have sexual and reproductive rights, and are sexual beings. Sexuality of girls and women with disabilities should not be pathologised; rather, policymaking and programming should rights-based, sex-positive/affirming, and disability inclusive.
* Ensure policy coherence amongst various international and regional commitments, including CRPD, the Incheon Strategy to “Make the Right Real” for Persons with Disabilities in Asia and the Pacific, and the 2030 Agenda for Sustainable Development, and national laws and policies, such that sexual and reproductive rights of girls and women with disabilities are respected, protected, and fulfilled.
* Provide equal opportunities for education, self-development, and work for girls and women with disabilities.
* Invest in more research on SRHR of girls and women with disabilities. Ensure data disaggregation by disability, sex, and age, amongst other characteristics. These are crucial for evidence-based legislation, investment, and programming.
* Ensure that laws, policies, programmes, and services are rights-based, disability-inclusive, gender-responsive, and youth-friendly. These should be cognisant that there are different types of disabilities, including intellectual, physical, sensory, and psychosocial.
* Address supply side barriers to health service provision, including physically inaccessible facilities, health provider bias, and lack of capacity to provide disability-inclusive and youth-friendly service.
* Ensure access to comprehensive sexuality education and sexual and reproductive health information and services for girls and women with disability, including that formats and language are accessible.
* Invest in measures to prevent and respond to violence and abused experienced by girls and women with all types of disabilities, in all settings, including home, work place, health setting, and institutions.
* Reduce stigma and discrimination, including by focusing on changing mind-sets and raising awareness on disability, sexuality, SRHR, and rights amongst the general public, policy makers, educators, and service providers, amongst other key stakeholders.
* Ensure active and meaningful participation of girls and women with disabilities in mainstream development, including in developing and evaluating policies and programmes. Policies should ensure integration, rather than segregation.

1. ARROW is a regional feminist organisation based in Kuala Lumpur championing women’s and young people’s sexual and reproductive health and rights. http://www.arrow.org.my [↑](#footnote-ref-1)
2. For example, the ASEAN Human Rights Declaration recognises that every person (including PWDs) has the right to the highest attainable standard of reproductive health. It is unfortunate that sexual health is not included. See: http://www.asean.org/storage/images/ASEAN\_RTK\_2014/6\_AHRD\_Booklet.pdf. [↑](#footnote-ref-2)
3. Schaaf, M., ‘Negotiating Sexuality in the Convention on the Rights of Persons with Disabilities,’ Sur 21, Vol 8 N 14 Jan 2011, <http://www.conectas.org/en/actions/sur-journal/issue/14/1000404-negociando-sexualidade-na-convencao-de-direitos-das-pessoas-com-deficiencia>, <http://www.conectas.org/Arquivos/edicao/publicacoes/publicacao-201425155217642-84551381.pdf>. [↑](#footnote-ref-3)
4. UNFPA, *A Situational Analysis of the Sexual and Reproductive Health of Women with Disabilities,* 2009, http://wwda.org.au/wp-content/uploads/2013/12/UNFPA\_Repro\_wwd1.pdf. [↑](#footnote-ref-4)
5. CREA, *Count me IN! Research Report on*

   *Violence Against Disabled, Lesbian, and Sex-working Women in Bangladesh, India, and Nepal* (New Delhi: CREA, n.d.), accessed June 1, 2017, http://www.creaworld.org/sites/default/files/The%20Count%20Me%20In!%20Research%20Report.pdf. [↑](#footnote-ref-5)
6. Kira Lee, Alexandra Devine, Ma. Jesusa Marco, Jerome Zayas, Liz Gill-Atkinso, and Cathy Vaughan, “Sexual and Reproductive Health Services for Women with Disability: A Qualitative Study with Service Providers in the Philippines,” *BMC Women’s Health*, 2015, DOI: 10.1186/s12905-015-0244-8, accessed June 1, 2017, https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0244-8. [↑](#footnote-ref-6)
7. CREA, *Count me IN!*  [↑](#footnote-ref-7)
8. Kira Lee, et al. [↑](#footnote-ref-8)
9. ASEAN Disability Forum (ADF), *Sexuality and Reproductive Health of Persons with Disabilities* (Jakarta: ADF, 2016). [↑](#footnote-ref-9)
10. Sexual and Reproductive Health and Rights Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific* (Fiji: Secretariat of the Pacific Community, 2015), accessed June 1, 2017,http://www.pacificwomen.org/wp-content/uploads/SRHR-in-the-Pacific-Manual.pdf. [↑](#footnote-ref-10)
11. Mihoko Tanabe, Yusrah Nagujjah, Nirmal Rimal, Florah Bukania, and Sandra Krause, “Intersecting Sexual and Reproductive Health and Disability in Humanitarian Settings: Risks, Needs, and Capacities of Refugees with Disabilities in Kenya, Nepal, and Uganda,” *Sexuality and Disability,* 13, no. 4, 411-427 (2015), accessed 1 June, 2017, https://link.springer.com/article/10.1007/s11195-015-9419-3. [↑](#footnote-ref-11)
12. http://www.tarshi.net/downloads/Sexuality\_and\_Disability\_in\_the\_Indian\_Context.pdf. [↑](#footnote-ref-12)
13. To be published in a forthcoming issue of *ARROW for Change* bulletin on Disability and Sexuality. [↑](#footnote-ref-13)
14. [↑](#footnote-ref-14)
15. [↑](#footnote-ref-15)
16. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-16)
17. Kira Lee, et al. [↑](#footnote-ref-17)
18. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-18)
19. Kira Lee, et al. [↑](#footnote-ref-19)
20. Kira Lee, et al. [↑](#footnote-ref-20)
21. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-21)
22. ASEAN Disability Forum (ADF), *Sexuality and Reproductive Health of Persons with Disabilities* (Jakarta: ADF, 2016). [↑](#footnote-ref-22)
23. Kira Lee, et al. [↑](#footnote-ref-23)
24. Kira Lee, et al. [↑](#footnote-ref-24)
25. Only 19.2% of Bangladeshi women, and 42.6% of Indian women who participated in a study said they could visit the health centre or hospital without permission from the husband or family members. CREA, *Count me IN!*  [↑](#footnote-ref-25)
26. CREA, *Count me IN!* [↑](#footnote-ref-26)
27. This is the case in the Philippines. See Kira Lee, et al. [↑](#footnote-ref-27)
28. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-28)
29. “Youth with Disabilities Face Staggering Loss of Rights,” June 17, 2016, http://www.unfpa.org/news/youth-disabilities-face-staggering-loss-rights. [↑](#footnote-ref-29)
30. CREA, *Count me IN!* [↑](#footnote-ref-30)
31. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-31)
32. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-32)
33. CREA, *Count me IN!* [↑](#footnote-ref-33)
34. CREA, *Count me IN!* [↑](#footnote-ref-34)
35. CREA, *Count me IN!* [↑](#footnote-ref-35)
36. Mihoko Tanabe, et al. [↑](#footnote-ref-36)
37. Kira Lee, et al. [↑](#footnote-ref-37)
38. Kira Lee, et al. [↑](#footnote-ref-38)
39. CREA, “Written Submissions for Indian Third Cycle on Behalf of Creating Resources for Empowerment in Action (CREA),” accessed July 1, 2017, http://www.sexualrightsinitiative.com/wp-content/uploads/Submission-for-Indias-3rd-cycle-on-behalf-of-CREA.pdf. [↑](#footnote-ref-39)
40. CREA, “Written Submissions for Indian Third Cycle.” [↑](#footnote-ref-40)
41. CREA, “Written Submissions for Indian Third Cycle.” [↑](#footnote-ref-41)
42. “Intellectually Disabled Woman Seeks Compensation for Forced Sterilization under Eugenics Law in 1960s,” accessed June 1, 2017, http://www.japantimes.co.jp/news/2015/06/21/national/social-issues/intellectually-disabled-woman-seeks-compensation-forced-sterilization-eugenics-law-1960s/#.WTA9XxOGOuU. [↑](#footnote-ref-42)
43. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-43)
44. Kira Lee, et al. [↑](#footnote-ref-44)
45. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-45)
46. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-46)
47. CREA, “Written Submissions for Indian Third Cycle.” [↑](#footnote-ref-47)
48. SRHR Working Group, *Awareness, Analysis, Action: Sexual and Reproductive Health and Rights in the Pacific.* [↑](#footnote-ref-48)
49. CREA, “Written Submissions for Indian Third Cycle.” [↑](#footnote-ref-49)
50. Human Rights Watch, *Treated Worse than Animals: Abuses against Women and Girls with Psychosocial or Intellectual Disabilities in Institutions in India* (USA: Human Rights Watch, 2014), accessed June 1, 2017, <https://www.hrw.org/sites/default/files/reports/india_forUpload.pdf>. Cited in Brindaalakshmi K, “Right to Life: Has the Sexual Right of Persons with Psychosocial Disabilities Been Forgotten?,” May 1, 2017, accessed June 1, 2017, http://www.hidden-pockets.com/right-to-life-has-the-sexual-right-of-persons-with-psychosocial-disabilities-been-forgotten/. [↑](#footnote-ref-50)
51. Brindaalakshmi K, “Right to Life: Has the Sexual Right of Persons with Psychosocial Disabilities Been Forgotten?,” May 1, 2017, accessed June 1, 2017, http://www.hidden-pockets.com/right-to-life-has-the-sexual-right-of-persons-with-psychosocial-disabilities-been-forgotten/. [↑](#footnote-ref-51)
52. CREA is a feminist human rights organisation based in New Delhi working with partners from a diverse range of human rights movements and networks to advance the rights of girls and women, and the sexual and reproductive freedoms of all people. See: http://www.creaworld.org. [↑](#footnote-ref-52)
53. “ASEAN Disability Forum (ADF), Partners and Allies Respond to the UN Summit Outcome Document,” accessed June 1, 2017, http://arrow.org.my/adf-statement/. [↑](#footnote-ref-53)
54. Anjali Mental Health Rights Organisation, http://www.anjalimentalhealth.org/ [↑](#footnote-ref-54)
55. These include activists who work in the filed of mental health, gender, disability, sexuality, SRHR, and human rights; mental health practitioners; social workers; lawyers; and students and professors from psychology, psychiatry and other disciplines. [↑](#footnote-ref-55)
56. For more info on the conference, read ARROW’s Facebook post at <https://www.facebook.com/ARROW.Women/posts/1385937151464485facebook> and visit: <http://bit.ly/sex-psychosocial-disability>. [↑](#footnote-ref-56)
57. A thematic paper exploring the intersections of sexuality, SRHR and psychosocial disability, as well as a film featuring stories of love and desire of women with psychosocial disabilities will also be developed for this project. [↑](#footnote-ref-57)
58. ARROW, *The Essence of an Innovative Programme for Young People in Southeast Asia: A Position Paper on Comprehensive Sexuality Education (including Youth Friendly Services), Meaningful Youth Participation and Rights-Based Approaches in Programming* (Kuala Lumpur: ARROW, 2012)*,* accessed June 1, 2017, http://arrow.org.my/wp-content/uploads/2015/04/Programme-for-Young-People\_Position-Paper\_2012.pdf. [↑](#footnote-ref-58)
59. “Youth with Disabilities Face Staggering Loss of Rights.” [↑](#footnote-ref-59)