

**Submission to the Special Rapporteur on the right of everyone to the enjoyment of the
highest attainable standard of physical and mental health:
Questionnaire on Racism and the Right to Health**

The Right to Health for Women with Disabilities Who Experience Racism

June 2, 2022

I. Introduction

Women Enabled International (WEI), National Indigenous Disabled Women Association Nepal (NIDWAN), *Mujeres con Capacidad de Soñar a Colores* Collective (Women with the Ability to Dream in Color), and Minority Rights Group (MRG) appreciate the opportunity to provide the appreciate the opportunity to provide the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur) with information for her forthcoming report on racism and the right to health.

Women¹ with disabilities who experience racism face multiple and intersecting forms of discrimination on the basis of gender, disability, race, ethnic origin, and Indigenous identity. That discrimination imposes unique and pervasive barriers to the realization of their rights, including the right to health. Discrimination in healthcare settings leads to barriers to accessing health services, affects the quality of health services provided, and deepens exclusion.² This discrimination can take many forms, such as the denial of services, physical and/or verbal violence, forced treatment, denial of bodily autonomy, and lack of free and informed consent.³

Even though there is a lack of data on the intersection of race, gender, and disability, studies show that Black and Indigenous peoples experience higher rates of disability when compared to others.⁴ Nonetheless, the right to health of women with disabilities who experience racism has been considerably overlooked throughout history.

This submission provides a short summary of information gathered by our organizations, including country examples where appropriate and an international legal framework on the matter, in response to the questionnaire of the Special Rapporteur, to inform her forthcoming report on racism and the right to health. The submission concludes with brief recommendations for the Special Rapporteur for consideration in drafting a report on racism and the right to health.

II. Background on the Right to Health for Women with Disabilities Who Experience Racism

A. Available, Accessible, Acceptable, and Quality Healthcare

Many groups who experience racism have poorer health and less access to adequate healthcare in comparison to those who do not experience racism around the world,⁵ and persons with disabilities face barriers to accessing healthcare that non-disabled persons do not experience.⁶

For example, Black women with disabilities in **the United States** face systemic and structural barriers in healthcare due to a legacy of slavery, anti-Black racism, sexism, and ableism.⁷ Furthermore, in **Nepal**, over 80% of Indigenous people with disabilities report having inadequate or poor access to public services and facilities.⁸ There are many reasons for that,

such as the lack of accessibility; lack of free or affordable public transportation to access those services; lack of information about their own health; and lack of access to interpreters—both in sign and Indigenous languages—to communicate with healthcare staff. In **Guatemala**, Indigenous women with disabilities shared that both their disability and Indigenous status played a significant role in the negative treatment they received in healthcare settings.⁹

- “I think that because of my disability and because I am Indigenous, they [doctors] think that if they explained to me what I had or why they were doing what they were doing to me, I wouldn’t understand. They talk to my sister rather than me; they don’t give me a chance to talk. She tells them to talk to me.”¹⁰
- Another Indigenous woman with a disability in Guatemala described how stereotypes based on her disability, gender, and indigenous status intersect to create unique forms of discrimination in healthcare settings. “As an Indigenous, they [doctors] don’t take your opinion into account, and as a person with a disability, they don’t let you speak. Sometimes, for being Indigenous, they give us limited information. There is even more discrimination against women with disabilities because we are not allowed to give our opinion. They should let women with disabilities speak and let them be examined where they want to. Sometimes the doctors, because we are Indigenous and have another mother tongue, don’t listen to a person who has trouble speaking Spanish, the doctors don’t understand it well and do whatever they want with our bodies.”¹¹

Indigenous peoples with disabilities may also experience bureaucratic barriers to accessing healthcare. For instance, in **Rwanda**, historically marginalized people with disabilities, including ethnic minorities, face significant barriers to registering their children with disabilities at birth due to their extreme poverty and marginalization, lack of disability awareness and information, lack of documentation and lack of access to healthcare services that can verify disability status. Consequently, these children are left without access to healthcare, education, or social services and are hidden away at home.¹²

Likewise, in **Canada**, legislation establishes differences between persons with disabilities and Indigenous peoples in access to services, including healthcare. That is because Indigenous peoples’ services are regulated by national laws, whereas services for persons with disabilities are not. Consequently, Indigenous peoples with disabilities are placed in a legal limbo, which prevents them from accessing the same services as other persons with disabilities.¹³ In 2017, the Committee on the Rights of Persons with Disabilities (CRPD Committee) expressed concern to Canada about the intersecting nature of discrimination women with disabilities and Indigenous peoples with disabilities face, which leads to increased barriers to accessing mental health services. The Committee recommended ensuring that services for Indigenous persons with disabilities in First Nation communities are equitable and appropriate, including health services aimed at preventing suicide among Indigenous young persons with disabilities.¹⁴ The Committee also recommended that Canada adopt measures to ensure universal coverage of health services for Indigenous persons with disabilities, and that these services are accessible, affordable, and culturally sensitive, and prevent the denial of healthcare services, including abortion.¹⁵

Furthermore, in **the United States of America (United States)**, the absence of universal health insurance prevents those living in poverty from accessing healthcare. This situation disproportionately impacts Black and Hispanic women, including those with disabilities, because they are overrepresented among people living in poverty.¹⁶ In addition, households where one or more members has a disability are almost twice as likely to have medical debt (26.5 percent) as compared to United States households where no members are persons with

disabilities (14.4 percent).¹⁷ Furthermore, 27.9 percent of Black households have medical debt, compared with 17.9 percent of white households.¹⁸ Due to cost barriers, one-sixth of adults with disabilities who needed healthcare did not receive it.¹⁹ Black persons with disabilities in the United States were the most likely to face these cost barriers, whereas women, particularly Black women, were more likely to report not being able to afford care, even with insurance.²⁰

Similarly, the CRPD Committee has expressed concern about the lack of access to affordable universal healthcare for children with disabilities in **Ecuador**, particularly in the case of children with disabilities in Indigenous communities. The Committee recommended the State adopt measures to facilitate access to affordable universal healthcare services for Indigenous children with disabilities.²¹ To **Colombia**, the CRPD Committee called attention to the inadequate or non-existent health coverage in rural and remote areas, which disproportionately impacts Afro-Colombian and Indigenous peoples. The Committee suggested providing the financial and human resources necessary to extend healthcare to these groups.²²

There are frequently also significant accessibility barriers that women with disabilities who experience racism face in accessing healthcare. As the right to accessibility is both a fundamental right and a precondition to ensure other rights, it must be fulfilled in order to guarantee the right to health.²³ In spite of that, accessibility in healthcare is not widely ensured.

- Indigenous peoples with disabilities, including women, are often required to periodically reconfirm their disability status in a health center, but the lack or absence of accessible transportation in many countries converts such requirement into a burden, especially for those Indigenous women living in remote areas.²⁴
- Ethnic minorities in **Indonesia** who are part of the Deaf community lack access to interpreters proficient at using local ‘Malayu’ sign language at health facilities, which prevents them from communicating their health needs and wishes effectively to healthcare staff and, consequently, compromises the quality of medical treatment received.²⁵

Even when women with disabilities who experience racism overcome these barriers and access healthcare, they face intersectional discrimination when receiving medical attention. Indigenous women with disabilities may experience delays in recognition of disability status or even an over-diagnosis of intellectual disability due to cultural biases in testing.²⁶ In addition, when an indigenous person with a disability is ill and does access healthcare, doctors often say that the illness is due to their disability, instead of examining the patient further.²⁷ The lack of accessibility measures to overcome language and disability-related barriers between Indigenous peoples and healthcare professionals increases the chances of diseases being undiagnosed.²⁸

- A Black woman with a disability from Palestine living in **the United States** reported that at a young age, she noticed that healthcare providers treated her differently, particularly when her mother was with her compared with when she was alone. Her mother has darker skin, and the interviewee believed that her mother was not afforded the same level of respect and politeness because of her race. She also noted that the lack of respect and civility can be compounded when English is not the patient’s first language.²⁹
- In interviews and focus groups conducted in 2021, Black women with disabilities in **the United States** reported the times when they did not seek treatment because they knew they would not be believed or be treated. They said they were very mindful of their behavior—even when in pain—to avoid being perceived as angry, dangerous, or threatening. They also shared frustrations about needing to take extra steps to inform

themselves of possible treatments to be ensured care and of being labeled as difficult patients when advocating for their needs.³⁰

- Other Black women with disabilities in **the United States** mentioned having to “credential” themselves to get treatment.³¹ One woman said that during a hospital stay, she had to consistently mention her age and Ph.D. to receive help with a bedpan.³² Another woman had to constantly remind staff that they are a disability advocate and could file a complaint.³³

When planning healthcare laws and policies, it is crucial to take traditional healthcare systems into consideration. Indigenous concepts of health are broad and holistic, incorporating spiritual, environmental, cultural, and social dimensions in addition to physical health.³⁴ Many Indigenous women, including those with disabilities, use traditional health systems—which is based on this approach—and, when accessing mainstream healthcare, face a risk of cultural assimilation.³⁵ This concern is especially strong for those Indigenous women living in urban areas, as health services often do not respond to their traditional ways of addressing health and illness.

Although many Indigenous women with disabilities prefer using their traditional healthcare systems, they are often required to use mainstream medical services to be eligible for disability pensions,³⁶ another instance where disability, gender, and racism may intersect. In addition, they are sometimes denied access to traditional healthcare systems due to discrimination on the grounds of disability. For instance, in **Guatemala**, one virtual consultation participant reported that “many Indigenous women with disabilities don’t receive the ancestral knowledge about the use of plants, specifically medicinal plants. In many cases, the mothers know how to do it and share it with their other daughters, but not with their daughters with disabilities.”³⁷ All of these aspects combined lead to a lack of control over individual and collective health and undermine the realization of Indigenous women with disabilities’ health rights.³⁸

B. Racism, Ableism, and Gender Discrimination in Sexual and Reproductive Healthcare

Besides facing barriers to broadly exercising their right to health, women with disabilities who experience racism encounter many obstacles to exercising their sexual and reproductive health and rights (SRHR) in particular. Due to misconceptions related to the importance of ensuring the SRHR of both Indigenous women and women with disabilities,³⁹ those living at this intersection face misinformation and a lack of sexuality education.

For some Indigenous women with disabilities in **Guatemala**, this discrimination is rooted in family traditions.⁴⁰

- One Indigenous woman with a disability who participated in the virtual consultation in Guatemala shared, “Families do not want to talk about any issue related to the body. Women are ashamed. Also, information is not given because they think they [Indigenous women with disabilities] are ‘not old enough.’”⁴¹
- Another Indigenous woman with a disability in Guatemala shared, “In school, they kind of talked to me about it [SRHR]. They [school] think we won’t understand, they also think in our beliefs or our family’s beliefs that [sexuality] is a sin, so it’s not good for you to know about it.”⁴²

For Black women with disabilities in **the United States**, the intersectional discrimination they face in healthcare settings is often linked to wrongful assumptions about Black women and/or

women with disabilities, such as their ability to become a parent⁴³ and that they experience less pain.⁴⁴ In this regard:

- A Black woman with a disability in the United States shared that when she gave birth to her daughter, the doctors asked her: “Are you really sure you can do this?”. By then, she assumed the doctors asked that question because she looked young, but now, she wonders if they would have asked if she didn’t identify as a person with a disability.⁴⁵
- Another Black woman with a disability in the United States reported a visit to the emergency room when she became unable to walk due to illness and pain. She said the hospital discharged her with a heating pad, lifted her into a cab, and sent her on her way.⁴⁶

Research by Minority Rights Group in 2020 in **Myanmar** indicated that there are disparities in access to SRH care between Indigenous women with and without disabilities. The study found that Indigenous women with disabilities in the country were less likely to have received at least four prenatal visits (55% and 89% respectively), less likely to have access to and use contraception (55% and 72% respectively), and less likely to report that they were satisfied with the service they received and been treated with respect (33% and 72% respectively) when compared to other women.⁴⁷

In **Nepal**, SRHR of women with disabilities is often violated in many forms, such as sexual violence, forced contraception, sexual and reproductive stigma, early marriage, and pregnancy.⁴⁸ For instance, indigenous women with disabilities die at an early age more frequently than other women, due to factors such as early pregnancy and childbirth.⁴⁹ In addition, many indigenous women with disabilities have no awareness of SRHR and are at risk of involuntary sterilization, decided by family members and health professionals without the free, prior, and informed consent of the women or girls with disabilities themselves.⁵⁰

This is a common reality in other countries, as Indigenous women with disabilities are also particularly at risk of forced sterilization globally.⁵¹ This is in large part because, in many countries, forced or involuntary sterilization is legal when performed on those whose legal capacity is restrained or denied on the grounds of disability,⁵² and Indigenous peoples, regardless of their disability status, are particularly vulnerable to acts of violence, including coercive sterilization,⁵³ due to population control policies that target Indigenous women in some countries, resulting in thousands of Indigenous women, including those with disabilities, being sterilized without consent.⁵⁴ They also experience higher maternal mortality.⁵⁵

C. Racism, Ableism, and Gender Discrimination during the COVID-19 Pandemic

Barriers to ensuring the right to health for women with disabilities who experience racism have increased during the COVID-19 pandemic, as this health crisis has disproportionately affected minority groups, including Black⁵⁶ and Indigenous women⁵⁷ and women with disabilities.⁵⁸ There is anecdotal evidence that Indigenous women with disabilities have been overlooked during the COVID-19 response, as the lack of coordination between local governments and organizations of Indigenous communities and of persons with disabilities and bureaucratic and attitudinal barriers have prevented Indigenous women with disabilities from participating in the crisis response.⁵⁹

According to a January 2021 study by Center for American Progress, counties in **the United States** with disproportionately high populations of people with intellectual or developmental disabilities also had higher rates of COVID-19. More specifically, these individuals were largely from racial or ethnic minority groups or Indigenous populations and were young,

female, and living below the poverty level. As the study highlights, an intellectual disability was the strongest indicator of a COVID-19 diagnosis and, other than age, intellectual disability was the strongest independent factor for COVID-19 mortality.⁶⁰

As Minority Rights Group has affirmed, there has been limited access to quality and culturally respectful information for persons with disabilities from Indigenous communities about the COVID-19 pandemic, leaving this group without knowledge or awareness about the virus and how to protect themselves. Indigenous communities in **Nepal, India, and Papua New Guinea** have reported that there is a lack of COVID-19 information in accessible and culturally appropriate formats available in mother-tongue languages, especially in local and minority languages, avoids jargon and provides an explanation of terminology.⁶¹

Misinformation and lack of accessible and culturally appropriate information about COVID-19 also led to confusion and fear among Indigenous women with disabilities in some cases. For instance, Pratima, an Indigenous woman with a physical disability in **Nepal**, shared, “When I went to the rural part, they said that the word COVID is so similar to the food they get in the forest, so many people were confused on whether the COVID is related to the food that they receive from the forest.”⁶² Furthermore, national laws and policies in Nepal related to accessing social benefits throughout the COVID-19 pandemic required official accreditation of disability, which led to the exclusion of many Indigenous persons with disabilities from these programs. Pratima further shared that: “One of the requirements that the Government had provided [to receive food assistance during the COVID-19 pandemic] was you need to either have a citizenry or a disability card to receive those requirements. So when it comes to many, many Indigenous women with disabilities they do not have [either] of them.”⁶³

Throughout 2020, demands on health systems and restrictions on mobility during lockdowns and quarantines had a disproportionate effect on persons with disabilities from Indigenous communities. The lack of personal protective equipment and restrictions on mobility affected access to professional care and personal assistants and increased the risk of infection. In **Indonesia**, persons with disabilities from the Batubassi and Karaeng Bulu Indigenous Communities have been unable to access personal protective equipment and other basic necessities, a situation exacerbated for those living more remotely. Others have lost access to essential medical equipment and healthcare due to the quarantine measures and the resulting unsafe, physically inaccessible, gender inappropriate, and culturally inappropriate environments.⁶⁴

The COVID-19 crisis has also created further barriers for women with disabilities—including those who experience racism—to SRHR. Information, goods, and services on SRH and the exercise of bodily autonomy have been restrained or hindered during the pandemic. Some of these barriers have resulted from COVID-19 restrictions, such as lockdowns, while others have stemmed from fear and stigma, including fear of catching the virus and cultural barriers to accessing information, goods, and services.⁶⁵ Many of these barriers impact all women but are exacerbated for women with disabilities due to the pre-existing barriers to their exercise of SRHR⁶⁶—such as lack of accessible information, lack of access to healthcare, and poverty—as well as the creation of new protocols in healthcare settings that have not always considered a disability perspective.

Women with disabilities who face racism have also experienced barriers to accessing COVID-19 vaccines. Those living in rural areas, where most of the Indigenous peoples live,⁶⁷ were

often far from vaccination sites, and qualitative evidence shows that finding accessible transportation during the COVID-19 pandemic was very difficult.⁶⁸

- A Black woman with a disability in the United States mentioned that “there was no place for me to find information about the accessibility of a vaccine location, and nobody has answers when you ask about accessibility.”⁶⁹
- Another Black woman with a disability reported that when the vaccine rollout began in the United States, there were few sites accessible to residents in her city. And the few sites available were located in the suburbs—which are mostly white and wealthy neighbourhoods— areas where everyone needed a car to access.⁷⁰

III. International Human Rights and the Right to Health at the Intersection of Race, Gender, and Disability

There is a critical gap in human rights standards around the right to health, in that many human rights bodies have failed to fully integrate the intersection of race, gender, and disability into their analyses on these issues and apply those principles in their recommendations to States. Human rights analyses and standards rarely address the intersection of race, gender, and disability and the lived experiences of women, girls, and gender minorities with disabilities who experience racism, particularly on health issues that specifically impact this group such as described above.

Of the U.N. human rights treaty monitoring bodies, the CRPD Committee may have the clearest articulation of intersectionality and its imperative application in the context of the CRPD. Article 5 of the CRPD articulates that “States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.”⁷¹ In its General Comment No. 6 on equality and non-discrimination, the CRPD Committee articulates that “States parties must address multiple and intersectional discrimination against persons with disabilities,”⁷² and that the obligation to ensure effective legal protection against discrimination on all grounds as articulated in Article 5 “means that all possible grounds of discrimination and their intersections must be taken into account.”⁷³

The CRPD Committee then further articulates States’ obligations in relation to intersectional discrimination against persons with disabilities. For instance:

- States must both identify and take specific measures to accelerate the achievement of inclusive equality for groups subjected to intersectional discrimination.⁷⁴
- States must also train and build the capacity of “duty-bearers” (which include, for instance, healthcare providers and policymakers) on “[t]he complexities of intersectionality and the fact that persons should not be identified purely on the basis of impairment. Awareness-raising on intersectionality issues should be relevant to particular forms of discrimination and oppression.”⁷⁵
- States must further ensure that their data collection and analysis are “disaggregated on the basis of disability and of intersectional categories.”⁷⁶

The Special Rapporteur has previously placed the right to health within an intersectionality framework, highlighting that “the specific health needs and barriers faced by individuals or groups, women, girls, adolescents, lesbian, gay, bisexual, transgender and intersex persons, and persons with disabilities, and in particular those that experience multiple and intersectional forms of discrimination, must be addressed and differential treatment provided.”⁷⁷ Indeed, an intersectional human rights framework for the right to health inclusive of gender, disability,

and race should recognize both the systemic and legal barriers to fully exercising the right to health, including exercising bodily autonomy in the context of healthcare. For instance, in the context of reproduction and reproductive rights in particular, the Special Rapporteur on the Right to Health has described that different groups are encouraged or coerced to reproduce, while others are discouraged or forced not to do so, and “[h]ow women experience these parameters of sexual and reproductive health depends on which intersections of privilege and oppression they live at...”⁷⁸

While the Special Rapporteur recognizes that gender and race can play a role in this stratified system of reproduction, she does not specifically address how disability is included within in this stratification, nor how the disability intersection with gender and/or race further stratifies reproduction and jeopardizes the right to bodily autonomy and the right to health more broadly. In particular, there are at least two concepts from disability rights that should be included in any intersectional analysis of the right to health based on race, gender, and disability.

- **Accessibility:** Any analysis of the right to health should include an analysis of whether information, services, and goods are fully disability accessible. Indeed, as the CRPD Committee outlines in its General Comment No. 2 on accessibility, the right to be free from discrimination includes an obligation to ensure that persons with disabilities have equal access to all goods, products, and services that are open to the public, including when provided by private entities.⁷⁹ The Committee notes that the exercise of the right to health is not possible without accessible premises where healthcare services are provided, accessible transportation to access those locations, and accessible information and communication about health, including through sign language, Braille, accessible electronic formats, alternative script, and alternative means of communication.⁸⁰ In particular, the Committee notes that States should take the “gender dimension” into account when ensuring that reproductive health services are accessible to women and girls with disabilities.⁸¹
- **Legal Capacity:** Furthermore, any analysis of the right to health must also include an analysis of the degree to which different groups can fully exercise bodily autonomy. For persons with disabilities, bodily autonomy is often jeopardized when they are deprived of legal capacity, in violation of Article 12 of the CRPD, and third parties such as caregivers, parents, doctors, or judges are allowed to make healthcare decisions on their behalves.⁸² This deprivation of legal capacity can occur formally (through legal systems such as guardianship or conservatorship) or informally (for instance, through individual interactions that are colored by stereotypes healthcare providers or others may hold about the decision-making ability or value of individuals). Within this context, the CRPD Committee has repeatedly recognized how intersectional discrimination based on gender and disability can lead to forced or coerced reproductive health interventions and has called on States to directly prohibit and prevent this widespread and systemic rights violation.⁸³

IV. Recommendations

Women with disabilities who experience racism face increased and specific barriers to fulfilling their right to health. To tackle this issue and implement effective solutions to the problem, States must incorporate gender, race, Indigenous identity, and disability perspectives in the design and implementation of policies to ensure the right to health, including sexual and reproductive health and rights.

With this in mind, we hope that the Special Rapporteur will consider including the following recommendations in the preparation of a report on racism and the right to health:

- Ensure that all laws developed to guarantee the right to health include a gender, race, ethnicity, Indigenous identity, and disability perspective. This means that these laws should guarantee accessibility and reasonable accommodations in healthcare settings, provide safeguards for the full exercise of bodily autonomy in those settings, ensure respect for intercultural perspectives, and incorporate concepts of racial, disability, and gender justice.
- Abolish guardianship, conservatorship, or other formal systems that deprive individuals of the ability to make their own healthcare decisions and replace them with systems that provide consent-based and respectful support for healthcare decision-making. Further adopt laws and policies that prohibit reproductive health interventions performed without the free, prior, and informed consent of the person, including forced sterilization, which disproportionately impacts women with disabilities who experience racism.
- Include women with all types of disabilities who experience racism, as well as their representative organizations, in the development and implementation of laws and policies on any issue that directly or indirectly affects their lives. Further ensure that their needs and rights are reflected in these laws and policies, with corresponding budget allocation and government representation.
- Increase the availability of accessible healthcare services, including SRHR, in rural and remote areas. Such services must respect the traditional indigenous health practices and medicines and promote collective rights.
- Increase the availability of accessible information on healthcare services, including in indigenous local languages and sign languages, as well as the availability of free or affordable accessible transportation to reach these services.
- Ensure that quality accessible health services are affordable or free to women with disabilities who experience racism, and that staff members are trained to work with and provide respectful care to women with disabilities who experience racism.
- Guarantee enough funding and resources for sexual and reproductive health and rights, including accessible services, within the budget allocated for healthcare to ensure that SRH is not overlooked.
- Ensure universal health coverage or insurance for women with disabilities who experience racism, who are disproportionately impacted by health costs.
- Adopt policies and programs that address the indigenous, racial, gendered, and disability impacts of the pandemic, and develop a legal framework, in line with international human rights standards, to provide legal mechanisms to monitor and respond to the inequitable health impacts of COVID-19 based on disability, gender, race, and indigenous identity.
- Disaggregate data by sex, gender, age, race, indigenous identity, language, religion, and type of disability and increase the research available on Black and Indigenous women with disabilities from an intersectional perspective, analyzing data and its impact accordingly.

Thank you for your consideration of this submission. If you have any questions, please contact Alana Carvalho, a.carvalho@womenenabled.org and Amanda McRae, a.mcrae@womenenabled.org.

¹ This submission generally uses the term “women” to refer to all women, girls, and, where applicable, gender minorities throughout the lifecycle, unless otherwise noted.

² World Health Organization, *Joint United Nations statement on ending discrimination in healthcare settings* (2017), <https://www.who.int/news/item/27-06-2017-joint-united-nations-statement-on-ending-discrimination-in-health-care-settings>.

³ *Id.*

⁴ U.N. Human Rights Council, *Right to health and Indigenous peoples with a focus on children and youth - Study by the Expert Mechanism on the Rights of Indigenous Peoples* ¶ 67, U.N. Doc. A/HRC/33/57 (2016). [hereinafter Human Rights Council, *Right to health and indigenous peoples*]. In the United States, disability impacts one in four Black people, which is higher than the ratio for Whites, Hispanics, Native Hawaiians / Pacific islanders, and Asians. Only American Indian / Native Alaskans have a higher ratio of disability (three in ten) in their communities. See Courtney-Long, E.A., Romano, S.D., Carroll, D.D. *et al.* *Socioeconomic Factors at the Intersection of Race and Ethnicity Influencing Health Risks for People with Disabilities*. J. RACIAL AND ETHNIC HEALTH DISPARITIES 1 (2017), <https://link.springer.com/article/10.1007/s40615-016-0220-5>.

⁵ United Nations Inter-Agency Support Group, *Thematic Paper on the Rights of Indigenous Peoples/Persons with Disabilities* 3 (2014),

https://www.un.org/en/ga/69/meetings/Indigenous/pdf/IASG%20Thematic%20Paper_Disabilities.pdf;

According to a study published in 2000, in the United States, Black, and Native women tended to report poorer physical health and more disability than white women. More recent data on that topic was not found, highlighting the need for updated research on the matter.

⁶ World Health Organization, *Disability and health* (2021), <https://www.who.int/news-room/fact-sheets/detail/disability-and-health>.

⁷ Center for American Progress, *Improving Health Outcomes for Black Women and Girls With Disabilities* (2022), <https://www.americanprogress.org/article/improving-health-outcomes-for-black-women-and-girls-with-disabilities/>.

⁸ Austin Lord & Bandita Sijapati *et al.*, *Disaster, Disability, & Difference - A Study of the Challenges Faced by Persons with Disabilities in Post-Earthquake Nepal*, UNPD, SOCIAL SCIENCE BAHA AND NFDN NEPAL 17, (2016), https://www.un.org/disabilities/documents/2016/Disaster-Disability-and-Difference_May2016_For-Accessible-PDF.pdf.

⁹ Virtual consultation participants on the rights of indigenous women with disabilities in Guatemala, June 14, 2021.

¹⁰ Virtual consultation participant on the rights of indigenous women with disabilities in Guatemala, June 14, 2021.

¹¹ Virtual consultation participant on the rights of indigenous women with disabilities in Guatemala, June 14, 2021.

¹² Minority Rights Groups, African Initiative for Mankind Progress Organisation (AIMPO) and First People’s Disability Organization (FPDO). Unpublished study (2020). The study identified 26 Historically Marginalised children with disabilities in 4 districts who were without birth or disability registration nor access to any health or education services.

¹³ The United Nations, *Expert Group Meeting on Indigenous Persons with Disabilities* 11 (2016), <https://www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/IPDisabilities.aspx>.

¹⁴ CRPD Committee, *Concluding Observations: Canada* ¶¶ 13-14, U.N. Doc. CRPD/C/CAN/CO/1 (2017). In many countries, suicide rates of Indigenous peoples are higher than among the average population. (Human Rights Council, *Right to health and Indigenous peoples*, *supra* note 4, Annex ¶ 3.).

¹⁵ CRPD Committee, *Concluding Observations: Canada* ¶ 46, U.N. Doc. CRPD/C/CAN/CO/1 (2017).

¹⁶ Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, ¶ 61, U.N. Doc. A/HRC/32/44/Add.2 (2016).

¹⁷ Center for American Progress, *Improving Health Outcomes for Black Women and Girls With Disabilities* (2022), <https://www.americanprogress.org/article/improving-health-outcomes-for-black-women-and-girls-with-disabilities/>.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ CRPD Committee, *Concluding Observations: Ecuador*, ¶¶ 17-18, U.N. Doc. CRPD/C/ECU/CO/2-3 (2019).

²² CRPD Committee, *Concluding Observations: Colombia*, ¶¶ 56-57, U.N. Doc. CRPD/C/COL/CO/1 (2016).

²³ CRPD Committee, *General Comment No. 2 on accessibility*, ¶ 40, U.N. Doc. CRPD/C/GC/2 (2014).

²⁴ Human Rights Council, *Right to health and Indigenous peoples*, *supra* note 4, ¶ 69.

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- ²⁵ Unpublished study conducted by Institute of Peace Studies, Prince of Songkhla University (IPS) and Southern Association of Disabilities on behalf of Minority Rights Group International, July 2021.
- ²⁶ Human Rights Council, *Right to health and Indigenous peoples*, *supra* note 4, ¶ 69.
- ²⁷ *Id.*
- ²⁸ *Id.*
- ²⁹ Center for American Progress, *Improving Health Outcomes for Black Women and Girls With Disabilities* (2022), <https://www.americanprogress.org/article/improving-health-outcomes-for-black-women-and-girls-with-disabilities/>
- ³⁰ *Id.* The report draws from interviews and three roundtable conversations that the Center for American Progress hosted with Black disabled women and girls in 2021.
- ³¹ *Id.*
- ³² *Id.*
- ³³ *Id.*
- ³⁴ Human Rights Council, *Right to health and Indigenous peoples*, *supra* note 4, Annex ¶ 2.
- ³⁵ The United Nations, *Expert Group Meeting on Indigenous Persons with Disabilities* 10 (2016), <https://www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/IPDisabilities.aspx>
- ³⁶ *Id.*
- ³⁷ Virtual consultation participant on the rights of indigenous women with disabilities in Guatemala, June 14, 2021.
- ³⁸ Human Rights Council, *Right to health and Indigenous peoples*, *supra* note 4, Annex ¶ 2.
- ³⁹ World Health Organization and United Nations Population Fund (UNFPA), *Promoting Sexual and Reproductive Health for Persons with Disabilities: WHO/UNFPA Guidance Note 3* (2009), <https://apps.who.int/iris/handle/10665/44207>
- ⁴⁰ *See, e.g.*, Indigenous women with disabilities in Guatemala: “As we are Indigenous, there is less information in our family, our parents and ancestors have brought this information, and there is less information available to our parents because of that [belonging to the Indigenous community].” And “That’s how they raised our parents, and they want to raise us the same way. We must do what they think is best.” (Virtual consultation participants on the rights of indigenous women with disabilities in Guatemala, June 14, 2021).
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- ⁴² Virtual consultation participant on the rights of indigenous women with disabilities in Guatemala, June 14, 2021.
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- ⁴⁵ Center for American Progress, *Improving Health Outcomes for Black Women and Girls With Disabilities* (2022), <https://www.americanprogress.org/article/improving-health-outcomes-for-black-women-and-girls-with-disabilities/>
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- ⁴⁷ Unpublished research from Minority Rights Group’s ‘Enhancing quality and universal access to Indigenous peoples’ reproductive healthcare (EQUIP) project 2020-2023. Survey conducted with 173 respondents who were Kachin, Burman or other Indigenous women.
- ⁴⁸ National Indigenous Disabled Women Association Nepal, *Indigenous Women and Girls with Disabilities in Nepal: A brief Overview* 11 (2021) https://nidwan.org.np/development-research/indigenous-women-and-girls-in-nepal-a-brief-overview/?doing_wp_cron=1654086004.2101979255676269531250.
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- ⁵⁰ *Id.*
- ⁵¹ U.N. Economic and Social Council, *Study on the situation of Indigenous persons with disabilities, with a particular focus on challenges faced with regard to the full enjoyment of human rights and inclusion in development*, ¶ 51, U.N. Doc. E/C.19/2013/6 (2013).
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- ⁵³ U.N. Inter-Agency Support Group, *Thematic Paper on the Rights of Indigenous Peoples/Persons with Disabilities* 3 (2014), https://www.un.org/en/ga/69/meetings/Indigenous/pdf/IASG%20Thematic%20Paper_Reproductive%20Health%20-%20rev1.pdf.
- ⁵⁴ *Id.*

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- ⁵⁶ Rasheeta Chandler, *et al.*, *The impact of COVID-19 among Black women: evaluating perspectives and sources of information 2* (2020), <https://www.tandfonline.com/doi/full/10.1080/13557858.2020.1841120>.
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- ⁵⁸ UNFPA & WOMEN ENABLED INTERNATIONAL, *THE IMPACT OF COVID-19 ON WOMEN AND GIRLS WITH DISABILITIES: A GLOBAL ASSESSMENT AND CASE STUDIES ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS, GENDER-BASED VIOLENCE, AND RELATED RIGHTS 5* (2021), <https://womenenabled.org/blog/covid-19/>.
- ⁵⁹ Minority Rights Group, *Statement on the Impact of the Global COVID-19 Pandemic on Persons with Disabilities from Minority, Indigenous and other Marginalised Communities* (2020), <https://minorityrights.org/2020/04/27/statement-covid-19-pandemic-on-persons-with-disabilities-from-minority-Indigenous-communities/>.
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- ⁷² CRPD Committee, *General Comment No. 6 on equality and non-discrimination*, ¶ 19, U.N. Doc. CRPD/C/GC/6 (2018).
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- ⁷⁴ *Id.*, ¶ 32.
- ⁷⁵ *Id.*, ¶ 55(a).
- ⁷⁶ *Id.*, ¶ 71.
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⁸¹ *Id.*

⁸² *See, e.g.*, CRPD Committee, *General Comment No. 1: Article 12: Equal recognition before the law*, ¶ 41, U.N. Doc. CRPD/C/GC/1 (2014).

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