Women with Disabilities' Access to Sexual and Reproductive Health and Rights during the COVID-19 Pandemic

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ABSTRACT

The challenges of women with disabilities in accessing sexual and reproductive health and rights (SRHR) information and services were exacerbated during the COVID-19 pandemic. Increased barriers were due to the convergence of multiple factors including mobility restrictions, economic strains, and amplified health complications related with the virus. This research aims to highlight the experiences of women with disabilities in accessing SRHR programs during the pandemic. The research relies on key informant interviews (KII) with key women leaders representing organizations dedicated to the interests of women with disabilities. Additionally, the research incorporates a thorough review of secondary materials to enrich the contextual understanding of the challenges and experiences of women with disabilities. The analytical framework of the study draws from Naila Kabeer's Social Relations Framework, Kimberle Crenshaw's concept of Intersectionality, and Sara Hlupekile Longwe's Equality and Empowerment Framework. The findings of the study underscore the existence of systemic problems within the dynamics and exchanges of social institutions, where multiple inequalities intersect, reproducing more barriers that hinder women with disabilities from accessing SRHR information and services. The research then advocates for targeted interventions and program initiatives that are multi-sectoral, participatory, and intersectional in approach to dismantle the barriers and ensure equitable SRHR access for women with disabilities.

Introduction

Sexual and Reproductive Health and Rights (SRHR) are fundamental human rights. They are set down in national and international laws and agreements. The Beijing Platform for Action, for instance, states that "women's human rights include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" (BPfA, 1995). They are not only a crucial element of the right to health but are also indispensable for the realization of other human rights, encompassing the rights to life, freedom from discrimination, equal recognition before the law, privacy, and respect for family life, education, and work (UN Human Rights Council, 2008). As such, sexual and reproductive health rights are universal, i.e., they apply to all, without exception. But while women and their communities are starting to receive recognition and are gaining ground in this issue and in the larger domain of development, the perspectives and experiences of women with disabilities still remain on the sidelines.

According to UN Women (2015), an estimated one in five women live with disabilities, and the prevalence of disability is actually higher among women than men (19.2% vs. 12%). This "intersection" of gender and disability creates unique disadvantages for women with disabilities that are not suffered by other sectors of society. As the UN Economic and Social Council (2003) observes, "Women with disabilities may be particularly at risk due to stigmas associated with both disability and gender, and are more likely to suffer from discrimination than able-bodied women or men with disabilities" (para. 67). But such multiple experiences of marginalization are not recognized even within the mainstream disability community (United Nations, 2016) and are most likely subsumed under the generalized situation of women or people with disabilities. Thus, women with disabilities remain at the margins on both issues of gender equality and disability rights. They are particularly frequently left out in public discourses, policy-making, programming, and services regarding sexuality and SRHR. Across the globe, women with disabilities have been deprived of the right to establish intimate relationships and to decide whether, when, and with whom to have a family. Forced sterilization, abortions, and marriages are all manifestations of the abuse that women with disabilities throughout the course of history have experienced, disguised as "for their protection."

In the Philippines, of the 92.1 million household population recorded by the Philippine 2010 Census, over 1.4 million are persons with disabilities; and of this, females with disabilities comprised 49.1%, or over 707,000. Sexual and reproductive health has been a controversial issue, and is even more contested for women with disabilities if it is at all discussed. Furthermore, the COVID-19 pandemic greatly affected their access to their basic needs, including access to SRHR. This is within a national context where, in a little over a year into the various levels of community quarantine brought about by the pandemic and the government's misplaced priorities, the 1 million total number of COVID-19 cases was reached (Bueza, 2021).[2]

Given the restricted mobilizations in response to the pandemic, there was an abrupt discontinuation of public and private-led SRHR service providers or their transition from face-to-face to online modes. As a result, some SRHR clients discontinued their access to community-based services, while others missed their regular appointments for the following reasons: (1) some ervice providers had to close their clinics because of the pandemic; (2) reduced human resources, especially in local government health offices which focused more on the COVID-19 initiatives; and (3) delayed delivery of SRHR commodities and supplies. Online mechanisms may have provided options for women with disabilities; however, a digital divide or unequal access to stable internet and therefore these online platforms remained an issue as well (Fontamillas & Tamayo, 2021). Additionally, there were cases of women with disabilities who were forced to stay home with their abusers because of the pandemic.

This exploratory study aimed to describe the perspectives and experiences of women with disabilities, particularly those with active community engagement, in accessing SRHR especially at the height of the COVID-19 pandemic. Specifically, the study intended to:

1. Provide a platform for women with disabilities, particularly those with active roles in their community or organization, to share and describe their experiences in accessing their SRHR especially during the COVID-19 pandemic;

[1]On April 27, 2021, the Philippines reached one (1) million COVID-19 cases. (Article source: https://www.rappler.com/news-break/data-documents/charts-how-philippines-got-one-million-covid-19-cases)

2. highlight the intersectionality of being women and having disabilities in these experiences;
3. analyze how social institutions shape these experiences; and
4. recommend points of action that could improve the situation of women with disabilities and their access to SRHR.

Literature Review

Defining (the situation of) Persons with Disabilities

Disability is defined differently across countries and cultures (UNICEF, 2012). The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) defines persons with disabilities as persons "who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (United Nations, 2006). The UNCRPD recognizes that "disability is an evolving concept and that it results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on equal basis with others" (United Nations, 2006). Thus, in talking about persons with disabilities, we not only look at the health condition, i.e., being blind, deaf, mentally/physically challenged, and so on, but also how external and environmental factors—such as attitudes of others and accessibility of the community—contribute to the disability as well.

Persons with disabilities have limited access to services, such as health, work, education, government social welfare, rehabilitation, and disaster management, compared to persons without disabilities. Based on government estimates, 70% of persons with disabilities reside in rural areas, where access to services is limited (ADB, 2005). Limitations are also encountered in participating in social and religious activities and community meetings (Marella et al., 2016). Based on the report of the Department of Social Welfare and Development's (DSWD) Pantawid Pamilyang Pilipino Programme (4Ps), 5% of the total household beneficiaries have persons with disabilities (Taparan, 2018). Results of the 2016 National Disability Prevalence Survey (NDPS) show that persons with severe disabilities have less access to information (12%) than those with moderate (17%), mild (26%), and no disability (28%) (Philippine Statistics Authority; Department of Health, 2019).

Women with Disabilities in the Philippines

The Philippine Statistics Authority estimates that 3.1% of Filipinos over the age of five have a disability, and 49.1% of them are women (PSA, 2014 in Lee et al., 2015). Aside from ratifying the Universal Declaration of Human Rights (UDHR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of Persons with Disabilities (CRPD), the Philippines also has national legal frameworks that uphold the SRHR of women with disabilities. These include Republic Act (RA) 1970 or The *Magna Carta of Women,* RA 7277 or *The Magna Carta of Disabled Persons*, and RA 10354 or *The Responsible Parenthood and Reproductive Health Act of 2012* (RH Law). The RH Law holds the state accountable to take measures to ensure access to family planning, procurement and distribution of family planning supplies, quality healthcare facilities, and age- and development-appropriate reproductive health education. Specifically, Section 18 of the RH Law targets "Sexual and Reproductive Health Programs for Persons with Disabilities (PWDs)" and mandates cities and municipalities to remove barriers to SRHR services for PWDs by providing physical access, adapting health procedures to the needs and

conditions of PWDs, making use of accessible communication materials (braille, large print, simple language, sign language, etc.) to disseminate information, providing continuing education on the rights of PWDs among healthcare providers, and raising awareness and addressing stigma on the SRHR of PWDs (RA 10354, 2012, section 18). It can be said that, through this special mention, the State and policymakers in the Philippines recognize that persons with disabilities have sexual and reproductive health needs.

According to the study by Women with Disability taking action on Reproductive and Sexual Health (W-DARE) in 2015, however, Filipino women with disabilities continue to experience high rates of human rights violations, particularly violence and abuse. This was particularly true in the case of women with psychosocial disabilities, women with intellectual disabilities, and women who were deaf or hard of hearing. This reported violence is from perpetrators who are not just intimate partners but also family members, neighbors, strangers, teachers, transport providers, and health workers (Vaughan et al., 2016). These cases are examples of reproductive rights violations which are not the sole recognition of couples and/or individuals to decide freely and responsibly but also the right to make decisions concerning reproduction free of discrimination, coercion, and violence (UNFPA, 2014).

Relevant Legal Frameworks

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was adopted in the country in 2006. The UNCRPD reaffirmed the rights of persons with disabilities that are human rights to be promoted, protected, and ensured by State parties. The Preamble of the UNCRPD recognizes disability as an evolving concept resulting from the interaction between persons with impairment and attitudinal and environmental barriers that hinder their full effective participation in society on an equal basis with others. The Philippines was one of the earliest signatories of the UNCRPD, having ratified the Convention on April 15, 2008. Article 5 of the UNCRPD focuses on the right to equality and nondiscrimination. It guarantees equal protection and benefit of the law and prohibition against discrimination. Article 25 of the UNCRPD highlights the importance of persons with disabilities' right to quality, affordable, if not free, healthcare programs and services. The article indicates that State signatories of the Convention ensure access for persons with disabilities to health services, including sexual and reproductive health programs.

Republic Act (RA) 7277, also known as the Magna Carta for Disabled Persons, was approved on March 24, 1992. The Act provides the rights and privileges of persons with disabilities and their rights to participation in society. It emphasizes that every citizen should be involved in giving equal rights to persons with disabilities; like any other Filipino citizen, persons with disabilities should live as free and independent as possible without discrimination from the community. Chapter 3 of the Act focuses on Health that mandates State-funded service providers to adopt an integrated and comprehensive approach to persons with disabilities' health development. In April 2007, R.A. 9442 was enacted to amend R.A. 7277, adding the provisions of other privileges and incentives with the 20% entitlement of discount from all establishments for services, medicines, cinema, medical bills, fares, and such.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) provides measures and mechanisms for governments to eliminate all forms of discrimination against women. Article 1 defines "discrimination against women" as any distinction,

exclusion, or restriction made based on sex that has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, irrespective of their marital status, based on equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

The Magna Carta of Women (MCW) aims to eliminate discrimination through the recognition, protection, fulfillment, and promotion of the rights of Filipino women, especially the marginalized; it provides mechanisms for the Philippine Government in translating the CEDAW in the context of the country—defining gender, discrimination, obligations of the State, and special measures (Republic of the Philippines, 2009). Chapter V, Section 27 on Social Protection includes the provision that "the State shall support women with disabilities on a community-based social protection scheme" (Republic of the Philippines, 2009).

Medical versus Social Models of Disability

The medical model of disability focuses on the person with disability and defines the person as having a problem that must be treated or fixed. With this model, the focus is on treating the impairment through specialized provisions to make persons with disabilities adapt to what society defines as average or within the norm (Rieser, 2012). It limits the discussion around disability to the treatment and provisions that the person with disability can receive to be able to participate in society and lacks an emphasis on the societal barriers that contribute to the non-participation of the person in society (UNICEF, 2018).

Meanwhile, the social model is aligned with the rights-based approach outlined in the UNCRPD, which views disability as an evolving concept due to the interaction between an individual's impairment and the barriers that hinder their full and equitable participation in society (United Nations, 2006). The social model of disability states that disability is socially constructed (Inclusion London, 2015) and is, therefore, a societal problem—with eliminating the barriers to ensure the well-being of persons with disabilities being society's responsibility (Farkas, 2014). The social model of disability was developed by persons with disabilities about 40 years ago as a roadmap to identify barriers and solutions toward more inclusive ways of living in society (Inclusion London, 2015).

Analytical Framework

According to Kabeer (1994), social relations create and reproduce systemic differences in the social positioning of groups of people. This research will use Kabeer's institutional analysis as a general conceptual guide as it allows the research team to understand that the causes of unequal social relations are not solely confined to individual or family dynamics. Kabeer identifies four key institutions: the household which involves familial relationships and dynamics; the community which covers local communities, NGOs, and informal networks; the market which would include firms, corporations, and other economic enterprises; and the state which includes legal, military, and administrative organizations. These social institutions have the ability to sustain or (re)produce inequalities based on what rules are implemented, what activities or goals are achieved, how resources are used and distributed, who is included and excluded, and who holds the power and is served by it (March et al., 2005). This concept highlights how existing institutions could be unresponsive to and can reproduce, or even increase, the marginalization of women with disabilities. Looking

at gender inequality from an institutional perspective illustrates the interweaving relationships of organizational rules, cultural norms, and routinized practices. These altogether stem from institutional sites that produce and sustain inequality (Kabeer & Subrahmanian, 1996).

Secondly, intersectionality, according to Crenshaw, is "the idea that we experience life, sometimes discrimination, sometimes benefits, based on a number of identities." In an intersectional approach, the ways in which diverse socially and culturally constructed categories interact at different levels to produce different forms of power relations and inequalities are examined. This is a particularly useful frame of analysis for women with disabilities: girls and women with disabilities experience "intersectional discrimination," where two or more forms of inequalities combine to create a unique, distinct, and particular experience of disadvantage that is not suffered by others including women without disabilities or men with disabilities (ECOTEC, 2009; UN Economic and Social Council, 2003). Gender and disability, when combined in the same person, usually reinforce each other and compound prejudices (Ortoleva & Lewis, 2012). On top of the multiple discrimination that women with disabilities experience, they also suffer from "double invisibility" as women and as persons with disabilities (Ortoleva & Lewis, 2012). Their concerns remain underrepresented, and the intersecting discrimination and multiple rights violations they experience are insufficiently addressed through inclusive programs and policies (Handicap International, 2015).

People with disabilities are often personified without gender, yet "the image of disability may be intensified by gender—for women, a sense of intensified passivity and helplessness; for men, a corrupted masculinity generated by enforced dependence" (Chakravarti in UN Women, 2020). An intersectional approach recognizes the heterogeneity and diversity within groups. It challenges any conception of womanhood that is homogenized. It demands an end to the marginalization of the experiences of women whose oppression is shaped by intersecting structural social inequalities.

Finally, Longwe's Equality and Empowerment Framework identifies five levels of women's empowerment and gender equality. This framework is most helpful in assessing the level of impact that development interventions may have, and argues that all five levels must be achieved. These are: (a) *Welfare*, which refers to ensuring that women have basic needs such as food supply, income, and health; (b) *Access*, which pertains to enabling women's equal access to education, health, and social services and programs; (c) *Conscientisation*, which covers understanding the differences and complexities of sex and gender roles, and the systemic factors that disadvantage and discriminate women linked with the recognition that these barriers should be eliminated; (d) *Participation*, women having equal power and influence in the decision-making processes as men; and (e) *Control*, utilizing the participation of women to ensure equal control between men and women. It is emphasized as well that each of these levels are important and may be the entry point for intervention; it is in this context that "access" in this study is appreciated. Longwe further elucidates that access facilitates equality for women when all forms of discrimination are eliminated. This usually involves the law and administrative mechanisms (March et al., 2005).

Methodology

This study employed several research methods to capture the layers of realities experienced by women with disabilities. To draw primary data on the experience of women with disabilities in accessing SRHR services during the pandemic, the researchers invited key informants to participate in their research. The key informant interviews (KII) were conducted online via Zoom

in May 2021, more than a year after the peak of community quarantine. Secondary materials were also reviewed to expound on the legal underpinnings of the SRHR of women with disabilities and to contextualize the general situation in the country. Moreover, personal observations of the researchers were incorporated into the enrichment of the analysis.

The study interviewed three (3) women with disabilities who have been leaders and organizers working in the disability sector for 25 to 30 years through policymaking, disability-centered program implementations, and coalition-building at both the international and national level. Their sharing and insights represented their own experiences as well as that of other women with disabilities whom they led and worked with in their respective organizations. The approach to KII in this study was quite different from how it is traditionally used, where key informants shared their "expert knowledge" about the topic and the organizations they work with and lead. Lokot (2021) critiques that the KII hardly amplifies the voice of "ordinary women," as key informants are usually from a position of power and are usually males. It is contended that the women leaders who were invited for the interview have experienced the same marginalization that women with disabilities are confronted with, including within the disability, where women with disabilities' experiences are hardly given focus or priority. The interview questions were structured to surface the intersecting markers that affected the accessibility of SRHR services for women with disabilities during the COVID-19 pandemic.

The participants of this study were not categorized according to the specific type of disabilities they have but were identified as being part of the larger community of women with disabilities. Moreover, as an initial analysis, the study did not attempt to assess or evaluate specific SRHR services or programs. The emphasis was on understanding the perspectives and experiences of the participants regarding their access to SRHR services provided by the government.

Prior to the participants' involvement in the study, the researchers obtained informed consent by providing detailed information about the research objectives and procedures. The research team used accessible and clear communication methods, considering the diverse needs of the participants with disabilities. Given that the participants were asked to share their personal stories, the research team and participants decided to anonymize their names in the discussion of findings. After the data analysis, the research team presented the final output of the study to the participants, which they validated and approved. The steps that were taken by the research team aimed to practice inclusion and enhance the overall quality and ethical integrity of the research—promoting a respectful and inclusive environment for the women with disabilities who generously shared their insights and experiences as key informants.

Findings and Discussion

Background on the participants' organizations

Nationwide Organization of Visually Impaired Empowered Ladies, Inc. (NOVEL) Philippines is an organization of women with varying degrees of visual impairment. The organization aims to help women with sight disabilities to be empowered economically and intellectually. Similar to other organizations, the legal anchor of the organization is the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The organization focuses on advocating on the issues of gender and disability, particularly women with disabilities' right to health, education,

economic independence, and participation in policy development.

Women with Disabilities Leap to Social and Economic Progress, Inc. (WOW-LEAP) is a national organization of women with disabilities dedicated to promoting the rights and working with women with disabilities to become active participants in social and economic activities in their communities. WOW-LEAP has been working with the disability sector and other stakeholders for 21 years through livelihood programs supported by the Department of Labor and Employment (DOLE) and the Department of Social and Welfare Development (DSWD), among other institutions supporting the organization.

National Anti-Poverty Commission - Persons with Disabilities Sector (NAPC) is a government agency under the Office of the President responsible for coordinating poverty reduction programs and ensuring that marginalized sectors[3] including persons with disabilities are included in the decision-making processes of the government. NAPC works as an advisory and coordinating body that exercises oversight functions in implementing the social reform agenda of the sectors included in the institution.

Overview of the Pre-pandemic Access of Women with Disabilities to SRHR Services

The participants shed light on the general experiences faced by women with disabilities in accessing SRHR prior to the pandemic. Their responses thematically pointed to the issues of inaccessible physical structures and information and communications, attitudinal barriers, lack of education in SRHR, and economic inadequacy.

Inaccessible Physical Structures and Information and Communications. The Accessibility Law or Batas Pambansa Bilang 344 (BP 344) mandates the accessibility of educational institutions, airports, sports and recreation centers and complexes, shopping centers or establishments, public parking places, workplaces, and public utilities through the provision of architectural facilities or structural features to reasonably enhance the mobility of disabled persons such as sidewalks, ramps, railings and the like (Republic of the Philippines, 1982). Although the Department of Public Works and Highways issued Department Orders[4] to effect the implementation of BP 344, persons with disabilities' access to social and public services continues to be hindered by barriers in the physical environment and inaccessibility of information and communications. The W-DARE Research also reported that people with disabilities have poorer well-being compared to those without disability given the reduced access to health services, employment, social activities, and toilets (Vaughan et al., 2015); and the fact that access to these, in some instances, requires them to pay for services such as getting to the said facilities or paying a fee for personal assistance.

1. Transportation

   Section 18 of the RH Law encourages cities and municipalities to provide physical access to transportation for women with disabilities going to hospitals and service centers providing reproductive health services. Based on the experiences shared by the participants, they

[2] These sectors are (1) farmers and landless rural workers; (2) artisanal fisher folk; (3) urban poor; (4) indigenous peoples; (5) formal labor and migrant workers; (6) workers in the informal sector; (7) women; (8) children; (9) youth and students; (10) senior citizens; (11) victims of disasters and calamities; (12) non-government organizations; and (13) cooperatives.

[3] Department Order No. 34, s. 1988 (Requirement to include infrastructure funds for accessibility features and/or facilities); Departmert Order No. 21, s. 2009 (Policy guideline on implementing projects/activities/programmes for persons with disabilities); and Department Order No. 37, s. 2009 (Enforcement of Accessibility Law along National Roads)

cannot access such services because there is no transportation for those using wheelchairs, assistive devices, or personnel who can support them.

Persons with disabilities perceive accessibility as fully implementing accommodations, if not total access to facilities, in the journey cycle—from their point of origin or from their home to their destination. This means that they cannot access ramps, even when these are provided by establishments, without first having accessible public transportation services (such as tricycles, jeepneys, and buses) to get there. Most persons with disabilities cannot afford private vehicles because their cost of everyday living—such as personal assistance and assistive devices (due to the lack of free provision of devices), and their medical and/or maintenance expenses are more expensive than for those without disabilities. Because of this struggle with inaccessibility, women with disabilities, especially pregnant women, do not have a choice but to pay for a higher cost of transportation.

2. Infrastructure and Establishments

According to the participants, Barangay Health Offices, hospitals, and clinics can be inaccessible for persons with disabilities because these usually have no provisions for ramps, tactile flooring, audio and visual formats of information, or appropriate bathroom facilities. These observations are consistent with the finding in Vaughan et al., (2015) that, even when services are available, the facilities or spaces around the service centers or barangay health offices are physically inaccessible to women with disabilities. One of the participants shared her experience with the inaccessibility of the comfort room in the Senate of the Philippines building, as there was a step in the toilet room for persons with disabilities which made it impossible for her to use it because she was in a wheelchair and there was no provision of handrails. Thus, she had to force herself to hold her pee because she could not just go home, given that the transportation she paid for was already expensive and she could not afford additional trips.

3. Information and Communication

According to the W-DARE Research (2015), there exists a gap in the discourse surrounding Disability and SRHR, particularly in relation to the sexuality of women with disabilities. It highlights a prevailing issue where some women with disabilities demonstrate a limited understanding of how to access SRHR services. Furthermore, a concerning observation emerges as these women are often found to be uninformed about their fundamental sexual and reproductive rights. This was affirmed by the participants, who observed that government-initiated medical services are usually not equipped with assistance for deaf community members—there are no sign language interpreters, announcements in hospitals are always through audio, and the information provided on television screens does not have an inset for deaf community members. During the pandemic, the Philippine National Association for Sign Language Interpreters, in collaboration with the Philippine Federation of the Deaf, had to assert themselves to the Department of Health (DOH) to provide access to information by requesting the agency to ensure that informational commercials were accessible for the deaf community. Many deaf community members were not updated on the situation of the pandemic, especially those who were living alone and in rural areas

where information dissemination was done mostly via radio rather than television.

Moreover, the intricate challenges faced by women with disabilities in accessing Sexual and Reproductive Health and Rights (SRHR) are compounded by a range of factors. The participants mentioned that the miscommunication of crucial concepts, coupled with a pervasive lack of awareness within communities and among educators regarding the specific SRHR needs of women with disabilities, contributes significantly to this predicament. This also includes a prevalent hesitancy among parents, caregivers, teachers, and social workers to engage in open discussions about sex and sexuality with young women, thus further exacerbating the obstacles encountered by women with disabilities in their pursuit of comprehensive SRHR services.

Attitudinal Barriers. Attitudinal barriers are ways of thinking or feeling resulting in behavior that limits the potential of people with disabilities to be independent individuals. These may seem minute but are actually very powerful as they often contribute to other, more physical barriers. A participant shared that people with disabilities, especially women with disabilities, are often seen as asexual and/or as sexually inactive, and therefore there is no need for SRHR services for them. This coincides with data from various sources (UN Special Rapporteur, 2019; Leonard Cheshire Disability, 2014; Ortoleva & Lewis, 2012) which report that women with disabilities may be denied information on reproductive health or access to maternal/child health services, are less likely to receive information about HIV prevention and safer sex, and have limited access to condoms or other pregnancy prevention methods because they are assumed to be sexually inactive. Disability, especially when pertaining to women, is associated with asexuality and an inability and/or lack of desire to bear and parent (Gatrell et al., 2017).

When women with disabilities do decide to get pregnant and have a child, they hear different criticisms such as these mentioned by a participant:

> "Nagpabuntis ka?"
> (You let someone get you pregnant?)
>
> "Bakit ka pa mag-aanak e may kapansanan ka na?"
> (Why would you still get pregnant when you have disabilities?)
>
> "Pabigat lang kapag nagka-anak ka pa kasi di kaya alagaan ang sarili."
> (You will just be a burden if you get pregnant because you cannot take care of yourself.)
>
> "Mahihirapan ka, mahihirapan rin ang anak mo."
> (You will have a hard time, and so will your child.)

These are some subtle signs that people view women with disabilities as a burden to society. According to the National Council on Women and Development or NCWD (2016), the most pervasive negative attitude focuses on a person's disability rather than an individual's abilities. The view is that, since they have a disability and most often need extra care, they cannot care for others (as mothers and wives) and therefore have even less to contribute to society. Setting their SRHR

needs aside or not giving priority to them is thus deemed justified. This attitude further highlights the notion that women are "innate" caregivers, when in fact, it should be the family and community members working together to enable and empower children, and persons with disabilities through raising awareness, providing physical environment accessibility, and equal opportunities. Moreover, there is also the myth mentioned by one participant that, "*Kung ikaw ay may kapansanan at babae ka, automatically magkakaroon na ng kapansanan ang anak*" (If you have a disability and you happen to be a woman, your child will automatically have a disability). Where this myth is believed to be true, women with disabilities are discouraged from getting pregnant to avoid having a child with a disability, as having a disability is again seen as a burden.

Women with disabilities' access to SRHR is also affected by the stigma held by their communities, the health workers, and even their own families. One participant narrated how her family hid her inside the home because of shame, embarrassment, and fear of discrimination. This, in turn, affected her self-image, and she grew up feeling inferior and dependent. The same participant also shared that one of the doctors she went to commented, *"Bakit ka kasi nagpabuntis e nakita mo nang mahirap magpa-anak?"* (Why did you allow yourself to get pregnant when you know that childbirth is hard?). This supports the study conducted by Lee et al. (2015) in two research sites in the Philippines (Quezon City in Metro Manila and Ligao City in the province of Albay), where it was revealed that one of the primary obstacles faced by women with disabilities in accessing their SRHR is the perceptions on disability among (health) service providers. In describing persons with disabilities, there was a use of binary concepts: able-bodied men and women were referred to as "normal," while words like "deficient," "inadequate," and "broken" were used for persons with disabilities. However, these service providers also readily admit that they lack disability sensitization and are thus uncertain about what terms to use, recognizing that they must "study the language" (Lee et al., 2015). Their lack of understanding and knowledge of disability consequently impedes the provision of SRHR services as the providers themselves are unclear about the needs of persons with disabilities for such services.

Lack of Education in SRHR. Based on the participants' responses, they identified the lack of education of women with disabilities about SRHR services and the lack of training of medical and health professionals on how to provide SRHR services to the former. The personal stories and the narratives of other women with disabilities that our participants have worked with attest to this. As shared by the participants, women with disabilities have limited knowledge about the services they can access, which usually ends with contraceptives.

All the participants identified the lack of education in SRHR as an impediment to the access of women with disabilities to SRHR services. The primary question is how can a woman with disability know her rights if none of those were introduced to her. The participants recognize that comprehensive sex education is absent in the basic education curricula. Comprehensive education on SRHR is a vital component in accessing SRHR services. Education in SRHR, as identified by the participants, comes in two levels. The first level is education for women with disabilities and public information about SRHR services. The second level is education for medical and health professionals on providing these services.

1. Comprehensive Sexuality Education (CSE)

For the participants, education in SRHR for women with disabilities goes beyond being familiar with contraceptives. It should also encompass a comprehensive sexuality education interpolated in the basic education curricula. The Department of Education (DepEd) issued Order No. 31, series 2018, otherwise known as the "Policy Guidelines on the Implementation of Comprehensive Sexuality Education (CSE)." CSE intends to develop substantial life skills, attitudes, and behaviors in Filipino youth that will promote positive health outcomes, gender equality, and gender empowerment. CSE must cut across all basic education levels, including elementary, junior high school, and senior high school, including special education (SPED) learning centers (DepEd, 2018). Studies show that sex education interventions decrease early sex initiation. Prevention of HIV is also reinforced among youth with the introduction of CSE (Abrigo et al., 2016). Despite the passing of the RH Law in 2012, where provision for comprehensive sexuality education is stipulated, and the issuance of the directive of DepEd, the integrated inclusion of CSE in the K-12 curricula is still seemingly absent.

Drawing on the insights of the participants, it is deemed necessary for schools to offer basic lessons on proper hygiene, for instance, teaching young female teens with disabilities how to use sanitary napkins and teaching the importance of washing hands after touching their private parts. These are opportunities where SRHR can be made more relevant to youth with disabilities to start getting them on board for more mature reproductive responsibilities that await them.

2. Formal Training and Further Education of Medical and Health Professionals in SRHR

Women reported various negative experiences at health care facilities including negative attitudes, prejudice, discrimination, and abuse by health care providers (Vaughan et al., 2015)—which supports the responses of the research participants that it is common among medical and health professionals to not have comprehensive knowledge about the health conditions of women with disabilities. One of the participants shared a story about a woman with a spinal cord injury who was forced to have a normal delivery. As a result, the baby died because of the doctor's lack of knowledge on how to handle the case. Some health care providers are not knowledgeable about certain contraindications of treatments and medicines for women with disabilities. Sometimes, women with disabilities—especially those who are pregnant—would even receive derogatory remarks from these medical and health practitioners.

According to the World Health Organization (WHO), persons with disabilities suffer from the inadequate skills of medical and health professionals. It is more than twice more likely for persons with disabilities to report that their needs are unmet by medical and health professionals, four times more likely for them to be treated badly, and almost three times more likely that they are denied medical care (WHO, 2020). The lack of sensitivity and empathy of some medical and health professionals towards women with disabilities greatly affects the latter's willingness to consult them or even go to health facilities. This creates an even greater barrier for women with disabilities to express their needs and raise their queries about SRHR.

Studies show that women with mental disabilities have difficulty making informed decisions. Some medical and health professionals are inattentive to their need to be guided and given enough time to form their decisions regarding their healthcare preferences. In some instances, their preferences are ignored (Matin et al., 2021). Thus, receiving proper training will allow health professionals to communicate effectively regarding the medicines, treatments, and procedures to be performed. It could also establish a rapport between women with disabilities and medical and health professionals that will lead the former to have trust and confidence in the medical providers rather than feeling intimidated. Similarly, women with disabilities' decisions on their SRHR situations will not be clouded by ill-informed insinuations made by some medical practitioners because their own decision-making process is respected and encouraged from the outset. As emphasized in Vaughan et al. (2015), addressing these multifaceted challenges demands a concerted effort to foster awareness, enhance communication, and promote a more inclusive and informed approach to the SRHR needs of women with disabilities.

Economic Inadequacy. Poverty is a perennial social problem in the Philippines, but the poverty of women with disabilities is more pronounced because of their condition. Lack of financial resources for costs related to accessing SRHR services—such as transportation fare, fees for personal assistance, and costs of medication (Vaughan et al, 2015)—is among the common challenges factored in by the participants in fully accessing their SRHR services. Simply going to health facilities in itself already involves expenditures. Thus, the stories shared by the participants reveal a saddening scenario for women with disabilities: even if the women desire to go to hospitals, centers, and clinics to address their SRHR concerns, they forgo doing so because it will entail shelling out a large amount of money for transportation. Women with disabilities must hail a cab or book a vehicle via an online application. For women with disabilities who are employed in the informal economy, these services are already beyond their financial capacities.

The study of Albert et al. (2015) on persons with disabilities in Metro Manila shows a dramatic difference in income between women and men with disabilities. They discovered that women with disabilities receive a lower income than men with disabilities. One of our participants mentioned that many persons with disabilities, including women, are often stereotyped in the workforce, especially visually impaired people. They are usually employed as massage therapists. This social reality makes it difficult for women with disabilities to penetrate other industries to hone their skills. It limits them from utilizing the talents and skills that they already possess to generate income due to the scarcity of opportunities available to them.

The scarcity of employment opportunities for women with disabilities is rooted in their low educational attainment, according to one of the participants. Indeed, this is resonated by a study on the disparity between women and men with disabilities conducted by Tabuga and Mina (2011), which states that there is a wide gap between the educational attainment between women and men with disabilities. According to the study, more women than men did not complete any grade at all. This disparity is more evident for women in rural areas. This, of course, affects the economic opportunities of women with disabilities. The employability of men with disabilities is higher than for women with disabilities.

Access of Women with Disabilities to SRHR Services at the Height of the COVID-19 Pandemic

Inaccessible Physical Structures and Information and Communications. The COVID-19 pandemic worsened the access to services of persons with disabilities because of the lack of sign language interpreters in the municipality/local government unit, leading to the inaccessibility of information or announcements from the local government itself. Persons with disabilities were not able to give their feedback and complaints because it is difficult for them to communicate if there is no access to sign language interpreters in the LGU for feedback and mechanisms. Moreover, they were often unaware of any changes to the rules or ordinances concerning COVID-19 restrictions because of the inaccessible communication channels (Beyond Education, 2021).

The freedom of persons with disabilities has been limited, if not constrained, despite enacted laws due to a lack of program and project monitoring and explicit guidelines for persons with disabilities.Usually, programs and projects "include" persons with disabilities, leaving more room for neglect and the attitude, as observed by one participant: "If there are disability sector representatives available, there will be. If there is none, there is none." Most of the persons with disabilities who cannot afford to pay for private vehicle services such as Grab, and particularly for those who are mobility impaired, tend just to stay home discouraged.

Deaf women faced notable challenges during the pandemic, particularly in navigating essential administrative processes and staying informed about crucial health protocols and community services and assistance. According to the participants, many deaf women reported not knowing where to obtain barangay quarantine passes, encountering difficulties in availing the Social Amelioration Program (SAP), and struggling to stay updated with the Inter-Agency Task Force (IATF) guidelines (CHR, 2021). The absence of sign language interpreters in their barangays and local health centers compounded these difficulties, creating significant communication barriers and hindering their access to important health and quarantine-related information. The lack of accessible communication resources placed deaf women at a disadvantage, limiting their ability to effectively convey their requests and access essential information. This situation not only affected their capacity to comply with quarantine measures but also impacted their overall well-being and ability to access vital support systems.

Lack of accessibility, such as the examples above, resulted in restricted mobility worsened by the pandemic—putting persons, especially women, with disabilities one step behind in benefitting from basic health services.

Economic Inadequacy. Due to the recession brought about by the COVID-19 pandemic, the economic barrier experienced by women with disabilities was exacerbated. Many women with disabilities and even their intimate partners were retrenched from work, which resulted in financial deficits. Alongside unemployment, prices of basic commodities ballooned as the pandemic extended, which drained their finances. Hence, the SRHR needs of women with disabilities become the last priority in their households. In addition, transportation costs of vehicles booked online also increased due to the imposition of quarantine protocols. Given that transportation is a major expense to access SRHR services in health facilities, it became an even bigger hurdle for women with disabilities. The Commission on Human Rights (CHR) Peer Monitoring Project (2021) showed that 55.2% of their women with disabilities participants had health issues during the Enhanced Community Quarantine (ECQ) period and only 13.04% of them received medical attention due to

the lack of financial resources.

Moreover, there were also reports of women with disabilities, specifically the blind, losing their jobs during the pandemic. Even women with visual impairment who were working in massage services, lost their source of income because of the nature of their service which risked transmission of COVID-19 from close contact. As a result, their sexual and reproductive health-seeking behaviors also decreased because they had to prioritize other needs, particularly their basic survival needs.

Increased Sexual Abuse and Unplanned Pregnancies of Women with Disabilities during the Pandemic. Besides the mentioned barriers, the pandemic also resulted in the rise of sexual abuse and unplanned pregnancies experienced by women with disabilities. One of the participants shared that, being stuck at home, "wala silang magawa dahil mataas libido ni asawa" (they couldn't do anything because their husband's libido was high). They also observed that there was a higher incidence of violence against women with disabilities and/or gender-based violence (GBV), but these often remained unreported due to the inaccessible justice system. Women with hearing and intellectual impairment are the usual targets of GBV because their perpetrators know that they cannot report this, and the lack of trained personnel/sign language interpreters in police precincts does not help either.

Facilitating Factors to SRHR Access. While our participants identified several barriers that impede their access to their SRHR, they also reported a few facilitating factors that helped improve their access to these rights. First, research, such as was specifically done by W-DARE in 2015, paved the way for a better understanding of the access of women with disabilities to SRHR and the perceptions surrounding it. This was a significant feat as it asserted the right of women with disabilities to make informed decisions concerning their sexual and reproductive health. Second, the partnership established by women with disabilities with the Commission on Human Rights and UNFPA on the Reproductive Justice Project has provided a larger platform for their voices to be heard and has activated their collective power. Having allies in the government and women with disabilities working in government agencies has led to increased representation of women with disabilities, and the participation of women with disabilities in the Reproductive Health National Inquiry has allowed them to influence policy. Finally, the continuous advocacy of civil society groups and organizations for persons with disabilities has contributed to greater visibility for women with disabilities. It has helped them gain access to more spaces to discuss their SRHR needs.

Analysis and Discussion

The participants' experiences show that, prior to the pandemic, their access to SRHR services was already impeded by attitudinal barriers, the lack of access to physical structures and to information and communications, the lack of education in SRHR (of women with disabilities and of medical and health professionals), and economic inadequacies. These barriers were particularly heightened by the pandemic as the social markers of women with disabilities became more compounded, patriarchal forces entrenched further, and the pandemic worsened the delivery of SRHR services by social institutions.

While there have been some efforts and small gains when it comes to addressing and responding to the SRHR needs of women with disabilities, there remain multiple barriers in terms of accessing their SRHR. Access, according to Longwe, refers to "the right or means to obtain services, products or commodities" and is seen as essential for women's development. In this study, the participants narrated the difficulties and criticisms they encountered when accessing their SRHR and the multiple barriers contributing to this during the pandemic. In sum, they cannot fully access SRHR services like others (women without disabilities, men, and men with disabilities) do. Thus, looking at Longwe's levels of equality, there is a bottleneck occurring even at the level of access, which then affects the succeeding levels leading up to control. Access to SRHR for women with disabilities is critical to their empowerment as it gives them proper information that will enable them to make informed decisions and ultimately control their own bodies.

The findings also clearly show how women with disabilities' experiences of inequality are not confined to the household and family but are reproduced across various institutions. Following the Social Relations Framework, these observations are organized according to four key institutional locations: the household/family, community, market, and State.

1. Household

At the household level, the stigma regarding disability still exists even among family members, and the shame they feel is usually disguised as "protection" for women with a disability. Women with disabilities' sexuality is rarely discussed even within the household, as it is often seen as a taboo topic (Vaughan et al., 2015). Class is another intersecting layer at the level of the household that creates economic barriers that hinder access to SRHR. The overemphasis on women's reproductive role is also seen as a greater disadvantage to women with disabilities. According to the UNFPA Pandemic Impact Report (2021), more women with disabilities than those without disability reported increased anxiety, stress, and depression due to the additional care work, insufficient rest, and inability to provide adequate care for their family members. Disability affects the reproductive role of women—their ability to care for themselves and others. From an intersectionality perspective, it thus undermines their life chances considerably more than is the case even for men with disabilities. A woman or girl with a disability is perceived as unable to maintain a household and fulfill the roles of a "proper" woman. Therefore, she is less likely to marry compared to men with disability, which could increase her parent's financial burden.

During the pandemic, the decision-making of women with disabilities was not fully exercised. The participants mentioned that there was an increase in sexual abuse among women with disabilities, although many cases were unreported. They could not refuse their intimate partners' heightened sexual urges which resulted in unplanned pregnancies. Their freedom to make informed choices for their bodies was infringed upon by men's violence.

2. Community

At the community level, attitudinal barriers persist, specifically the view and treatment of women with disabilities as asexual beings. Again, looking at it from an intersectional lens, this "asexuality" attributed to persons with disabilities has greater consequences for women with disabilities than men with disabilities due to the dominant narratives surrounding

gender and sexuality. This also encompasses the bigger issue of control over women's bodies, and again women are seen as without agency and not capable of making autonomous decisions regarding their own bodies and their sexual and reproductive lives. At the height of the pandemic, physical barriers like inaccessible transportation and information were more present in the community, discouraging women with disabilities from seeking SRHR services.

3. Market

At the market level, stereotypes and other negative attitudes associated with women with disabilities clearly limit their employment opportunities. Furthermore, the pandemic caused some of them to lose their jobs, forcing them to set aside their SRHR needs to prioritize more basic survival needs. They also feared that they might get infected with the virus, so some did not continue accessing SRHR services. Their economic and financial difficulties became a more solid barrier as most health services are paid. Some women with disabilities also openly acknowledged a prioritization of basic necessities over contraceptives. Additionally, a number of them turned to the utilization of natural herbs as a substitute for conventional contraceptive pills, primarily driven by the unavailability of the latter at health centers, where, regrettably, women with disabilities are not given the priority attention they require (CHR, 2021). Moreover, to get to hospitals or health centers with public transportation being inaccessible, they would need to book a private vehicle service such as Grab, which was extremely expensive during the earlier part of the pandemic.

4. State

Finally, at the level of the State, there were compounding issues that affected women with disabilities' access to SRHR: the pandemic sidetracking efforts to improve SRHR services, the lack of clear policies specific to women with disabilities' SRHR which in turn also affected the implementation, the lack of comprehensive sexual education that is inclusive of persons with disabilities, limited capacities of health systems in dealing with the SRHR needs of women with disabilities, and gaps within the legal system that is unable to protect women with disabilities.

These institutions do not operate in a vacuum, and the interaction and combination of these institutions ultimately create the unique experience narrated by our participants regarding women with disabilities' access to SRHR before and during the pandemic. Moreover, social relations reinforce inequality and unequal access to resources, but people also rely on networks of social relations to survive. Again, this was proven by our participants with their identified facilitating factors. Notice how the facilitating factors are also a product of interactions between and among institutions. For example, the partnership between CSOs and government agencies is an interaction between the community and the State. In short, as demonstrated by the participants, improved social relations within and between institutions can also change their current situation.

Aside from looking at different institutions and existing social relations to understand a situation, multiple identities that interact, intersect, and compound each other to create a unique reality and experience of advantage/disadvantage should be considered. Disability rights cannot be guaranteed in a context that does not affirm the equality of all women and vice versa. Given that

women with disabilities are some of the most marginalized segments of a community, a recognition of the multiple identities of women with disabilities and how that can construct their experiences of multiple forms of discrimination will help shape better development programs and rights-based laws and policies. Women with disabilities often face multiple forms of discrimination based on gender and disability, both in the family and in public places. Laws, practices, programs, and policies rarely take into account this two-fold source of discrimination that women with disabilities are often subjected to, and women with disabilities are often masked behind each of the constituent parts rather than the whole. An intersectionality lens thus needs to be embedded in our analysis and understanding of the situation to ensure that we can account for the distinct experiences arising from intersecting identities of women with disabilities during the pandemic.

Conclusion

As stated in Philippine laws and international conventions and agreements, women with disabilities ought to be provided all forms of protection, provision, and assistance to attend to their holistic development, which includes their SRHR. However, this endeavor is yet to be fully realized as their SRHR needs are not yet completely addressed. The study shows that women with disabilities do not have complete access to SRHR services, and this only became worse during the pandemic.

Prior to the pandemic, women with disabilities already experienced multiple layers of barriers such as their lack of education in SRHR and that of medical practitioners, economic deficiency, lack of access to physical structures and information and communications, and attitudinal barriers. At the height of the pandemic, there was an apparent systemic problem in the dynamics and exchanges of social structures such as the State, household, market, and community that increased the inequalities and vulnerabilities experienced by women with disabilities, which obstructed, even increased the barriers from, their full access to SRHR services. The social relations among these institutions created a unique experience for women with disabilities in accessing their SRHR. Scrutinizing the interplay of these institutions, we recognized the poor flow of delivery of SRHR services to women with disabilities.

The institutional shortcomings aggravated the gender inequality experienced by women with disabilities. Adding the factor of the COVID-19 pandemic made the institutional landscape worse as it impacted women with disabilities' mobility, economic and health situation, reception of reliable information, and experience of increased abuse and violence from their male intimate partners. Moreover, the State showed non-prioritization of SRHR in its focus on resolving the COVID-19 pandemic. The worsened lack of accessibility of SRHR services during the pandemic hindered the fulfillment and enjoyment of women with disabilities of their physiological needs as women.

Understanding how each institution contributed to the situation of women with disabilities during the pandemic is critical. At the policy-making level, one-size-fits-all programs and policies hinder women with disabilities' access to SRHR services and commodities. An intersectional approach should be integrated into formulating policies and programs to cater to the unique SRHR needs of women with disabilities. Doing so will enable women with disabilities to increase their capacity for self-determination and self-actualization which is a real manifestation of empowerment.

Recommendations

This study grounds the accountability of the State, market, community and household, and all stakeholders to women with disabilities in accessing and enjoying their SRHR. These institutions must aim to lessen the gender inequality and forms of marginalization experienced by women with disabilities when it comes to their access to their SRHR needs. A thorough institutional and intersectional analysis must be employed to evaluate how the different barriers affected the access of women with disabilities. Considering the unprecedented effects of the pandemic on the lives and livelihoods of women with disabilities, which resulted in more limited access to SRHR services, immediate attention should be devoted to the matter.

Having gathered and analyzed pertinent, although preliminary, data on the perspectives and experiences of women with disabilities regarding their access to SRHR, we recommend the following to pave the way for an increased level of access for women with disabilities to SRHR services. Most of these were recommendations that the participants raised during our interview.

1. A renewed understanding of disability in connection with SRHR

   The attitudinal barriers posed by the community and family of women with disabilities are rooted in our cultural and societal understanding of disability—often associated with defects. This is internalized by women with disabilities, making them perceive that SRHR is not an essential part of their lives. Thus, it is recommended that families and friends of women with disabilities create a loving and supportive environment that does not see disabilities as defects. To facilitate this, organizations in the disability sector should continue to involve the family and the immediate circle of women with disabilities in their education programs toward a positive perception of disability.

   The vast majority of the population should also receive information about the disability sector in relation to the SRHR of women with disabilities. Organizations in the disability sector could use social media to their advantage. For instance, normalizing the public to see women with disabilities having children or a family of their own. Another would be normalizing in mainstream media to see women having romantic relationships.

2. Capacity building through education for women with disabilities, youth with disabilities, health workers, and government agencies

   There is a need for capacity building through education for women with disabilities regarding their awareness of CSE and SRHR services. Their increased knowledge about these will allow them to have informed SRHR choices that they freely choose and are not just a product of the dictates of their family and friends or medical practitioners. Moreover, there is a prevailing need for CSE to be integrated into the curricula of basic education through which youth with disabilities will benefit. DepEd should start providing foundational knowledge about sex education to youth with disabilities that will teach them how to care for their bodies and equip them with skills in recognizing threats of sexual abuse.

   Health workers and government agencies involved in this sector should be given proper training and education in delivering adequate, compassionate, and sensitive SRHR

services to create a more inviting environment for women with disabilities to go to health facilities.

3. Curation of more women with disabilities-friendly informational materials on SRHR

   As reported by the participants, most of the informational materials used in health facilities do not cater to the disabilities and impairments of women with disabilities. Thus, curating informational materials on SRHR both for physical and virtual spaces could make SRHR information more accessible for them. Information materials made available virtually were much needed during the pandemic since information dissemination heavily relies on social media. Virtual applications for women with disabilities could be further explored to offer them relevant information about SRHR while they are in the comfort of their homes.

4. Provision of more spaces and systems for feedback and mechanism

   The organizations of women with disabilities in this study actively make their voices heard by government agencies. This process would be more effective if the government would provide established systems and spaces for these organizations to express their experiences and sentiments regarding their SRHR needs. Furthermore, such consultation could assist the government in assessing if the current healthcare system addresses the SRHR needs of women with disabilities.

5. Economic alleviation for women with disabilities through a multi-sectoral approach

   The economic barrier of women with disabilities is deep-seated in their social fabric, affecting their access to SRHR services. This problem is connected to their disability, which impedes them from completing formal education, thus incapacitating them from employment in the formal economy. Different government agencies (DSWD, TESDA, etc.) should work together to come up with relevant livelihood training for women with disabilities for them to access more job opportunities and augment their economic situation.

6. Creation of intersectional approaches to the SRHR needs of women with disabilities

   The government-funded or supported programs and NGOs that cater to women with disabilities should understand the intersectional identities of women with disabilities. When organizations understand that they need to provide SRHR needs and transportation and reasonable accommodations such as hiring sign language interpreters and brochures translated into braille, it widens the room for more access of women with disabilities to services. There must be an emphasis on the other identities in pursuing social justice because there can be no social justice without justice for everyone. Every marginalized person needs to be explicitly included in every policy and program so they do not become neglected and forgotten in implementing such. Just like gender and class, disability should not be an additional indicator, but rather, it should be taken as a cross-cutting identity to promote more access and hopefully and eventually, social transformation through policies, programs, and welfare services.

7. Further research on government-provided SRHR services

For future research studies on women with disabilities' access to SRHR services, the voice of government agencies that provide SRHR services could be explored for a more comprehensive assessment. Likewise, knowledge of women with disabilities about SRHR may be assessed to determine particular topics to highlight when giving them SRHR education.

References

Abrigo, M. R., & Paqueo, V. B. (2016). *The irony of RH law critics' opposition to comprehensive sex education* (No. 2016-53). PIDS Discussion Paper Series.

ADB. (2005). *Disabled people and development: Philippines country report*. https://think-asia.org/bitstream/handle/11540/6142/Disabled%20people%20and%20development%20-%20Philippines%20country%20report%20Jun05.pdf?sequence=1: Asian Development Bank.

Aggarao, S., & Bernardino, B. (2020). *Access of Filipinos with disabilities to the Philippine Government Social Amelioration Program during the COVID-19 pandemic*. Philippine Coalition on the UNCRPD.

Albert, J. R., Reyes, C., Tabuga, A. D., Mori, S., & Yamagata, T. (n.d.). Income disparity among persons with disabilities, assessed by education and sex: Accentuated gender difference found in Metro Manila, the Philippines. *Developing Economies, 53*(4), 289–302. https://doi.org/10.1111/deve.12090

Beijing Declaration and Platform for Action. (1995). [online] United Nations. Accessed January 4, 2019, from http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf

BEST Program, Philippines-Australia. (2016). *Inclusive education for children with disabilities in the Philippines*. Cardno.

Beyond Education. (2021). *Initial analysis of disability-inclusive services in the Philippines*. Unpublished Manuscript. Social Development - The Asia Foundation Coalitions for Change Philippines Team.

Bueza, M. (April 27, 2021). How the Philippines reached 1 million COVID-19 cases. Rappler. https://www.rappler.com/newsbreak/data-documents/charts-how-philippines-got-one-million-covid-19-cases/

Commission on Human Rights of the Philippines. (2021). *Community based peer mentoring of access to services by women with disabilities during COVID-19 pandemic*. https://docs.google.com/document/d/1pqA1VeOHETXwr_oEHxs9bbMMc6FXeK1ZhQzDxyyc7dw/edit

Department of Education. (2018). *Comprehensive Sexuality Education: Developing responsible youth vs rising risks*. Department of Education. https://www.deped.gov.ph/2018/08/04/comprehensive-sexuality-education-developing-responsible-youth-vs-rising-risks/

Fontamillas, D., & Tamayo, A. (2021). *Beyond lockdowns: Narrative of sexual reproductive health and rights in the time of the COVID-19 pandemic.* Unpublished Manuscript. Sexual Health and Empowerment Project - University of the Philippines Center for Women's and Gender Studies.

Inclusion London. (2015). *Factsheet: The social model of disability*. https://www.inclusionlondon.org.uk/wp-content/uploads/2015/05/FactSheets_TheSocialModel.pdf

Kabeer, N. (1994). *Reversed realities gender hierarchies in development thought*. Verso.

Kabeer, N., & Subrahmanian, R. (1996). Institutions, relations and outcomes: Framework and tools for gender-aware planning. I*nstitute of Development Studies Discussion Paper 357*. https://www.ids.ac.uk/download.php?file=files/Dp357.pdf

Lee, K., Devine, A., Marco, M. J., Zayas, J., Gill-Atkinson, L., & Vaughan, C. (2015). Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines. *BMC Women's Health, 15*(87) DOI: 10.1186/s12905-015-0244-8

Lokot, M. (2021). Whose voices? Whose knowledge? A feminist analysis of the value of Key Informant Interviews. *International Journal of Qualitative Methods, 20*. https://doi.

org/10.1177/1609406920948775

March, C., Smyth, I., & Mukhopdhyay, M. (2005). *A guide to gender-analysis frameworks*. Oxfam.

Marella, M., Devine, A., Armecin, G., Zayas, J., Marco, M., & Vaughan, C. (2016). Rapid assessment of disability in the Philippines: Understanding prevalence, well-being, and access to the community for people with disabilities to inform the W-DARE project. *Population Health Metrics, 14*(26), 1–11.

Matin, B. K., Williamson, H. J., Karyani, A. K., Rezaei, S., Soofi, M., & Soltani, S. (2021). Barriers in access to healthcare for women with disabilities: A systematic review in qualitative studies. *BMC Women's Health 21*, 44. https://doi.org/10.1186/s12905-021-01189-5

Philippine Statistics Authority. (2013). *Persons with disability in the Philippines 2010 Census* [website]. https://psa.gov.ph/content/persons-disability-philippines-results-2010-census

Philippine Statistics Authority. (2019). *National Disability Prevalence Survey* [website]. https://psa.gov.ph/sites/default/files/2016%20NDPS.pdf

Philippine Statistics Authority; Department of Health. (2019). *National Disability Prevalence Survey (Model Functioning Survey) 2016*. Philippine Statistics Authority.

Philippine Statistics Authority. (2021). *Employment situation in January 2021* [website]. https://psa.gov.ph/content/employment-situation-january-2021

Rieser, R. (2012). *Implementing inclusive education: A commonwealth guide to implementing Article 24 of the UN Convention on the Rights of Persons with Disabilities.* Commonwealth Secretariat.

Republic of the Philippines. (1982). *National Council on Disability Affairs*. In Batas Pambansa Blg. 344 - An act to enhance the mobility of disabled persons by requiring certain buildings, institutions, establishments, and utilities to install facilities and other devices: https://www.ncda.gov.ph/disability-laws/batas-pambansa/batas-pambansa-blg-344

Tabuga, A. D., & Mina, C. D. (2011). *Disability and gender: The case of the Philippines.* Discussion Papers.

World Health Organization. (2011). *World Report on Disability* [website]. https://www.who.int/publications/i/item/9789241564182

World Health Organization (WHO). (2020 December 1). *Disability and health*. https://www.who.int/news-room/fact-sheets/detail/disability-and-health

United Nations (UN). (2015). *UN Global Status Report on Disability and Development* (Unedited Version). Accessed June 20, 2021, from http://www.un.org/esa/socdev/documents/disability/2016/GlobalStatusReportonDisabilityandDevelopment.pdf

UNICEF. (2018). *Children with disabilities in situations of armed conflict: Discussion paper*. UNICEF.

United Nations Population Fund (UNFPA) (2016). *Sexual & reproductive health*. [online] Unfpa.org. Accessed June 20, 2021, from https://www.unfpa.org/sexual-reproductive-health.

United Nations Population Fund Activities. (2018). *Women and young persons with disabilities: Guidelines for providing rights-based and gender-responsive services to address gender-based violence and sexual and reproductive health and rights* [website]. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0.pdf

UN Economic and Social Council. (2003). *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* Paul Hunt. Accessed February 8, 2024, from https://www.un.org/womenwatch/ods/E-CN.4-2003-58-E.pdf

UN Human Rights Council. (2008). *Report of the Special Rapporteur on the Right of Evryone to*

the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Paul Hunt. Accessed January 31, 2024, from https://www.refworld.org/reference/themreport/unhrc/2008/en/55558

UN Women (2020). *Sexual harassment against women with disabilities in the world of work and on campus.* Accessed June 11, 2021, from https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/discussion-paper-sexual-harassment-against-women-with-disabilities-en.pdf?la=en&vs=1256

Vaughan, C.; Marco, M. J.; Zayas, J.; Marella, M.; Devine, A.; Gill-Atkinson, L.; WOWLEAP; PARE; Likhaan Center for Women's Health; and UP Center for Women's Studies Foundation. (2015). *Women with Disability taking Action on REproductive and sexual health (W-DARE): A summary of initial findings and pilot interventions.* The University of Melbourne.