Gender Equality, Disability and Social Inclusion Branch
Department of Foreign Affairs and Trade
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Dear Gender Equality, Disability and Social Inclusion Branch,

The International Planned Parenthood Federation (IPPF) welcomes the opportunity to provide input to the consultation on Australia's new International Disability Equity and Rights Strategy.

IPPF is a global service provider and leading advocate for sexual and reproductive health and rights. In 2022, IPPF reached over 71 million people around the world with more than 226 million sexual and reproductive health services, 86 percent of whom are categorised as marginalised and underserved[i].As a locally owned, globally connected civil society movement, IPPF works alongside national Member Associations and collaborative partners towards our vision for a world in which all people are free to make informed choices about their sexuality and well-being, without discrimination.

IPPF is grateful for Australia's contribution towards enabling this impact and ongoing support of our work as we embark on our next global strategy, *Come Together* (2023-2028)[ii], and dedicated Pacific Strategy, *Niu Vaka II* (2023 – 2028)[iii].

Drawing on our local experience and global expertise, we respectfully make the following recommendations to inform the development of Australia's new International Disability Equity and Rights Strategy.

1. Australia should take an intersectional, rights-based approach to strategy design, ensuring strong commitment to sexual and reproductive health and rights.

The realisation of Sexual and Reproductive Health and Rights (SRHR) is fundamental to achieving gains for gender equality, disability, and social inclusion. SRHR encompasses all matters related to gender, puberty, relationships, sexual health, fertility, and birth. It recognises the rights of all individuals to have their bodily autonomy respected, freely define their sexuality, exercise sexual and reproductive choice, decide whether, when and whom to marry and have access to information, resources, services, and support to realise their rights, free from discrimination, coercion, exploitation, and violence[iv].

The United Nations Convention on Rights of Persons with disabilities[v] (CRPD) affirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms – including education, access to healthcare, freedom from all manners of violence and exploitation, and the ability to decide whether, and when, to become parents. However, the ability for persons with disabilities to exercise bodily and reproductive autonomy is often hindered by harmful stereotypes and stigma that misrepresent them as asexual beings, without a 'legitimate' need for sexual and reproductive healthcare[vi]. Discriminatory attitudes regarding the 'reduced' capacity or desire of persons with disabilities to engage in romantic and sexual relationships, and to maintain families, contribute to the under-prioritisation of their SRHR needs by health systems. This is exemplified by the fact that decisions about their sexual and reproductive health (SRH) are often made by medical professionals, along with their guardians, and carers, contributing to a denial of their reproductive rights where medical procedures are performed without the informed consent of the individual in question[vii].

Restrictions on the reproductive autonomy of persons with disabilities have long been recognised as a violation of human rights, constituting an act of gender-based violence and discrimination[viii]. Despite this, women, girls, and gender-diverse people with disabilities often experience limited access to voluntary contraceptive options and are more likely than their non-disabled peers to be prescribed long-acting, injectable contraceptives or other forms of medical menstrual suppression to control fertility[ix-x]. Similarly, the forced sterilization of women, girls and gender diverse people with disabilities remains a prevalent issue in the Indo-Pacific region, often performed as a mode of population control, menstrual management, and pregnancy prevention[xixii]. For those that do become pregnant, health systems and legislative frameworks are often restrictive or burdensome to navigate leading to poorly managed pregnancy, and birth, or even involuntary or

coerced abortion – typically framed as being in the 'best interest' of the individual despite being widely considered an act of reproductive violence[xiii]. It is integral that any efforts toward disability equity and inclusion fully incorporate commitments to attaining the full range of sexual and reproductive rights for all people, promoting informed consent, respecting bodily autonomy, and encouraging greater access to services and systems to uphold these rights, regardless of identity or ability.

Australia has a strong global reputation in promoting SRHR, including supporting reproductive autonomy, advancing sexual rights, and combatting sexual and gender-based violence. Committing to a bold strategic framework, which recognises SRHR and bodily autonomy as foundational to achieving disability equity and inclusion presents a critical opportunity for Australia to show leadership in ensuring that no one is left behind in the progress towards the 2030 Agenda for Sustainable Development. It also aligns with DFAT's Good Practice Guidelines on disability inclusion in Australia's development program, which promotes participation on an equal basis for people with disabilities to realise their full potential[xiv]. As such, Australia should incorporate SRHR within the new Disability Equity and Rights Strategy, recognising the intersectional and cross-cutting nature of SRHR for gains for human rights, equity, and inclusion of all marginalised groups.

2. Australia should support the strengthening of disability inclusive sexual and reproductive health services, as central to achieving disability equity and rights.

According to the World Health Organization, 1 in 6 people worldwide is affected by disability[xv]. Persons with disabilities are not a homogenous group and they have varying, unique and at times greater SRH needs than the general population due to their increased vulnerability to abuse and exploitation, and to poorer health outcomes[xvi]. The persistence of ableism and other forms of oppression within health systems and policy circles means that persons with disabilities in particular, women, young people, trans, non-binary, and gender non-conforming persons with disabilities, often have limited access to SRH services**.** This is often due to compounding physical barriers to services, a lack of disability-inclusive clinical services, as well as stigma and discrimination by service providers, guardians and carers or communities more broadly.

The lack of SRH information and communication materials accessible for persons with disabilities, and limited knowledge among service providers on disability-inclusive care places them at additional risk of negative SRH outcomes[xvii-xviii]. For example, research shows that young people with disabilities generally show lower levels of knowledge concerning SRH, including HIV transmission and prevention, than their peers without disability and were less likely to seek out SRH services for fear of stigma from peers, guardians, or service providers[xix]. Available data also suggests that, on average, 29 per cent of births by mothers with disabilities are not attended by a skilled health worker in low-income countries[xx]. It is estimated that 22 per cent of married women with disabilities in low-income countries have an unmet need for family planning, with rates increasing significantly in rural areas[xxi]. Without access to SRH services, persons with disabilities are at higher risk of unintended pregnancies and sexually transmitted infections (STIs) including HIV/AIDS, along with birth-related complications and maternal and newborn mortality[xxii]. Furthermore, one in five women with disabilities will experience sexual and gender-based violence (SGBV) in her lifetime[xxiii]. Indeed, findings from UNFPA demonstrate that up to 68 percent of young women with disabilities experience SGBV before the age of 18[xxiv], with other research suggesting that women and girls with disabilities experience intimate partner sexual and physical violence at double the rate of those without disability[xxv].

To address these challenges, IPPF emphasises that Australia should promote disability-inclusive[xxvi] models for SRH services and systems, grounded in a rights-based approach that ensures fair, equal, and non-discriminatory treatment for all people. A disability-inclusive model for SRHR takes a holistic, multi-sectoral approach to disability inclusion and equity, not only considering disability in SRHR programming, but also implementing targeted actions for persons with disabilities in key activity areas such as the provision of appropriate and accessible comprehensive sexuality education (CSE) for young people and SGBV services for women, girls, and people with diverse SOGIESC. This means prioritising disability accessible clinical facilities, and informational resources and tools[1], as part of broader efforts to strengthen service delivery and build inclusive and sustainable health systems. Importantly, developing disability-inclusive services and systems also requires

[1] E.g., easy-read, braille and sign language formats.

building service provider knowledge and capacity of those working with persons with disabilities, and encouraging the involvement of people with disabilities in clinical and community-based service provision to ensure that their needs are understood and reflected in SRHR programming. In this regard, advancements for disability equity and inclusion in SRHR should be acknowledged as advancements towards Universal Health Coverage (UHC), enabling women, girls, and people of diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) with disabilities, in all their diversity, to enjoy good health, and to participate fully in all aspects of social, economic, and political life. By championing disability inclusive SRH care, Australia can more meaningfully address the links and intersections between different aspects of inequality such as poverty, gender, age, and disability, that may hinder people's access to SRH services and information as part of efforts towards the realisation of UHC within the Indo-Pacific region.

3. Strengthen DFAT's internal capacity to engage in disability equity and inclusion and bolster these efforts through the inclusion of indicators for disability equity in SRHR within Development Partnership Plans.

A strong evidence-base is essential for the design, implementation and monitoring of effective and efficient development and humanitarian programming, that is contextually appropriate and responsive to community needs. Despite this, a persistent and significant lack of data remains on critical SRHR indicators within the region, particularly that which is disaggregated by gender, disability, and other key factors. IPPF recommends that the collection of gender and disability disaggregated data should be advanced in data collection system and practices used within DFAT programming to ensure progress towards service and rights equity. As Australia implements a new performance delivery framework for the aid portfolio, including the development of regional and national Development Partnership Plans, it is essential that SRHR indicators be explicitly included to advance disability equity and inclusion.

As champions for SRHR on the global and regional stage, Australia should commit to the adoption of innovative and inclusive program design, implementation and monitoring and evaluation systems, to build a comprehensive evidence base for the SRHR of diverse groups. Prioritising the measurement of SRHR indicators, and disaggregated data, within Australia's aid portfolio and partnerships will enable national and local partners to better monitor and identify disability- and gender-responsive solutions to local development challenges. Additionally, this will better support Australian investments within the region, ensuring that priorities can be better identified and acted upon. To engage in this process fully, Australia should also consider strengthening internal capacity and expertise within DFAT by increasing disability representation within the department. Doing so would better position Australia and its partners to design and implement comprehensive disability-informed programming and policy.

4. Prioritise genuine partnerships with local civil society, including organisations for persons with disabilities, and sexual and reproductive health providers to implement disability inclusive programming.

IPPF welcomes Australia's commitment to investing in localisation, and the building of resilient, sustainable communities within the new International Development Policy. We recommend that this approach be grounded in engagement and inclusion of people with lived experience of marginalisation across all stages of the programmatic cycle.

Disability inclusion is often treated as an afterthought, or an 'add on' to program design, without adequate consultation of those who are 'experts by experience'. Despite this, local civil society, including organisations for persons with disabilities (OPDs), feminist and women's organisations and SRHR providers often hold strong links in the community as advocates and service providers, have established coordination mechanisms with others in the sector, including government, and have deep understanding of how best to navigate local and national systems to drive inclusion and equity efforts in the community. Similarly, when it comes to the provision of SRH and social services, the actors fulfil an important role as an extension to government health and social services. They are a critical component of broader health system strengthening, that recognises the preferences, needs, and priorities of their communities. Local SRHR providers, in particular, are often the touchpoint for women, young people, and LGBTQI+ people and other marginalised groups who may be otherwise reluctant to access government services due to institutional stigma.

To challenge deeply rooted patriarchal, Eurocentric and ableist power structures as a disability equity and inclusion priority, Australia should prioritise partnerships to leverage the capacity of local civil society, ODPs and SRHR actors, who are best placed to ensure community needs and preferences are prioritised and respected. It is essential that local actors not only participate in decision-making processes but can take meaningful ownership of development and humanitarian programming to foster knowledge exchange within the development sector and promote genuine partnership-building. By prioritising partnerships with local actors, Australia can better enable the advancement of sustainable development solutions, grounded in shared respect for the needs of those with diverse and intersecting identities.

5. Invest in long-term funding for disability inclusive SRHR programming to support cross-sectoral partnership building and the advancement of disability rights in global dialogues.

The SRHR sector has experienced major setbacks in recent years. The system is under enormous pressure. Globally, we have continued to see stagnant or declining investment in SRHR programming from national governments and donors alike. Within this context, the SRH needs of those 'doubly marginalised', including women and girls with disabilities, or young people with disabilities, are often sidelined or under-resourced. This is compounded by the prioritisation of short-term funding cycles, which often leave local partners and implementers ill-prepared to engage in long-term, strategic planning and broader system level change.

Feminist and disability activists have long pointed to the lack of attention and prioritisation given to disability equity and rights within funding for SRHR. As highlighted by the Guttmacher Institute[xxvii], the needs of persons with disabilities are often overlooked within SRHR programming, including young people with disabilities – representative of the broader health inequity encountered by these groups. Importantly, funding allocated to persons with disabilities globally is significantly smaller than for other populations, making up 3% of all human rights grant-making in 2019[xxviii]. Similarly, SRHR funding typically takes a generalised approach, focusing on women and girls, or broadscale approaches to addressing key issues such as SGBV – largely overlooking the differing challenges and barriers faced by some groups. Despite this, civil society providers including OPDs, and SRHR providers are often at the forefront of their movements, leveraging their knowledge, skills, and local networks to advocate for policy change and build and shape social movements to defend these critical rights. Although pivotal to the broader social and legislative change, their perspectives are often ill- represented within policy and programming, further contributing to a lack of cohesion within the disability, gender and SRHR movements.

Australia is in a prime position to support intersectional SRHR advocacy and programming that can give voice, decision-making power, and agency to persons with disabilities to shape the global SRHR agenda. Funding that bridges the nexus of SRHR and disability through cross-movement dialogue and coordination can help shape the broader human rights landscape, enabling actors to better understand, and engage, in disability rights as a matter of reproductive rights. This should be prioritised alongside the development of inclusive, well-informed policy and legislative frameworks by encouraging greater participation of OPDs and women's and feminist organisations, along with SRHR advocates within international and regional multilateral fora. Creating space for more diverse voices within international dialogue will better enable the global community to take proactive, coordinated action to promote and protect the sexual and reproductive rights of all people, particularly those often sidelined. As such, **Australia should commit to longer-term funding cycles to enable local actors engaging in intersectional and cross-cutting work to bring movements together to help enable more transformative change**.

6. Invest in disability equity and inclusion in SRHR as part of humanitarian preparedness and response efforts, and climate change adaptation strategies.

IPPF welcomes Australia's commitment to climate resilience and disaster preparedness within the new International Development Policy. As considered within our submission to the Australian International Gender Equality Strategy, and consultation on the Humanitarian strategy, we recognise that for these efforts to adequately respond to the needs of populations across the humanitarian-development cycle SRHR must be strongly integrated within these efforts. This should also place strong emphasis on meeting the acute needs of persons with disabilities within humanitarian settings, who are oftentimes at heightened risk of the range of

negative SRH outcomes, including contraction of STIs and HIV, maternal illness and death, unintended pregnancy, and unsafe abortion.

The climate crisis and SRHR are intrinsically linked, with changing climates, extreme weather events and climate-induced disasters contributing to worsening maternal and newborn health outcomes, increased rates of SGBV and forced or early marriage, and the neglecting of the health and rights of the most marginalised populations. In the Pacific region, rates of SGBV are twice the global average, increasing three-fold for women with disabilities[xxix]. At the same time, reduced access to clean water, drought and environmental hazards pose risk to pregnant people, newborns and young children and contribute to heightened rates of complications during childbirth along stunting, stillbirth, and maternal mortality[xxx]. During crises, the disruption of regular health services and systems in areas affected by climate change and disasters often results in lack of availability of lifesaving services such as those for SGBV frontline treatment, contraception, safe abortion care, and testing and treatment for STIs, posing severe threat to women and girls living in humanitarian settings, particularly those with disabilities[xxxi]. Indeed, in crisis situations, persons with disabilities remain among the most hidden, neglected and socially excluded populations, exposed to heightened vulnerability to SGBV, exploitation and abuse, whilst regular legal and health service, and systems become fractured or disrupted.

Despite this, it is often not adequately recognized in humanitarian response or climate adaptation strategies that people with disabilities are entitled to the same range, quality, and standard of free or affordable health care as those without disabilities. Failing to guarantee access to these basic rights leaves people with disabilities — especially people with intellectual disabilities — uninformed and unprotected. People with disability are largely excluded from climate adaptation, disaster risk reduction and emergency response decision-making processes due to discriminatory practices that fail to recognise their agency. At the same time, SRHR is often treated as peripheral to traditional crisis preparedness and response efforts. As environmental disasters and conflicts within the region become increasingly frequent, it is critical SRHR is fully integrated into preparedness and response planning.

To address these gaps, disability and gender should be treated as a cross-cutting and non-negotiable considerations in Australia's humanitarian programming for SRHR. This should include full integration of disability indicators and inclusion across the entire humanitarian-development cycle, from preparedness, to response, and recovery, back to stable times. IPPF urges that increased support for the participation of people with disabilities, including women, people of diverse SOGIESC, and youth in decision making processes should be prioritised, with a particular focus on advancing the SRH needs of marginalised groups in humanitarian efforts.

Thank you for the opportunity to provide input to the strategy.

Kind Regards,

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