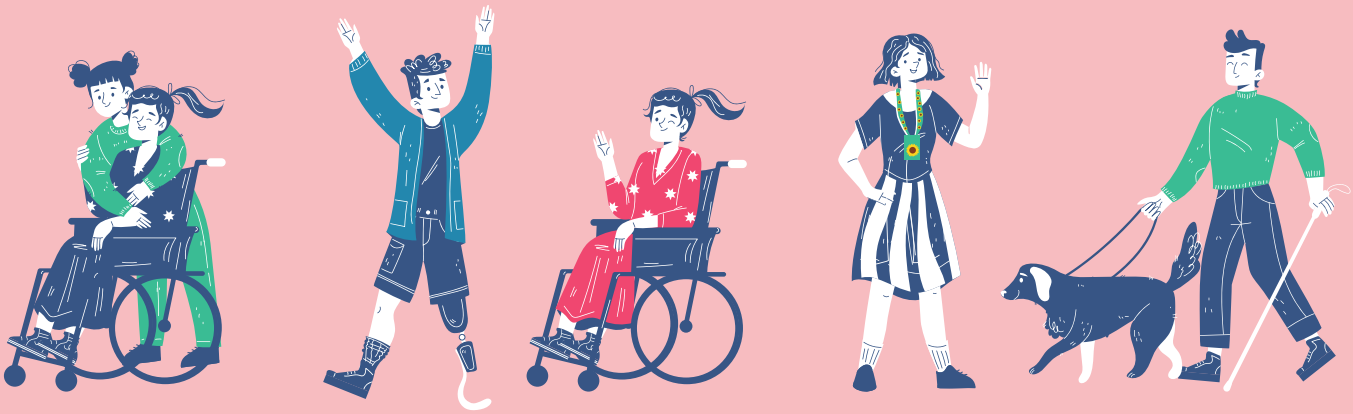

ANNUAL REPORT ON THE INDEPENDENT LIVING PILLARS: Sexual and Reproductive Health and Rights

EUROPEAN NETWORK ON INDEPENDENT LIVING

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ANNUAL REPORT ON THE INDEPENDENT LIVING PILLARS:

Sexual and Reproductive Health and Rights

EUROPEAN NETWORK ON INDEPENDENT LIVING

Contents

1

Introduction

This report marks the launch of the Independent Living Pillars Reports, part of the broader series of Annual Reports on Independent Living Pillars. This series aims to assess the implementation of the key pillars of independent living, improve access to information, and raise awareness of critical issues, while monitoring progress across these areas. The Independent Living Pillars refer to the essential conditions, supports, and rights required for disabled people to live independently and participate fully in society.

Building on ENIL's previous work on sexual and reproductive health and rights, this report explores the sexual and reproductive health and rights (SRHR) of disabled people across Europe.[1] It brings together insights and evidence collected from ENIL members and partners, academics, disabled activists, and Disabled People's Organisations (DPOs). The report highlights existing barriers and identifies good practices. Its aim is to contribute to improved access for disabled people to sexual and reproductive health and rights, including healthcare, education, bodily autonomy, and pleasure.

1 This report draws on ENIL's previous work on SRHR, including the Family Planning Project, which explored barriers faced by marginalised communities, including women and girls with disabilities, in accessing comprehensive family planning services and commodities in the UNFPA Eastern Europe and Central Asia region. To read more: https://enil.eu/project/family-planning-project/.

2

Methodology

Between March and April 2026, ENIL launched a survey on the sexual and reproductive rights of disabled people. Input was collected from Disabled People's Organisations (DPOs) and disabled individuals across Europe to better understand barriers, gaps, and best practices. Geographical diversity was prioritised to ensure the survey was representative and included perspectives from countries that are often underrepresented in research, including several countries in Eastern and Southeastern Europe. While the majority of responses came from European DPOs, outreach also targeted organisations and participants beyond Europe to broaden the range of experiences and viewpoints captured.

Respondents were asked to:

- Assess the overall level of access to sexual and reproductive rights for disabled people in their country
- Identify the main barriers and forms of discrimination
- Highlight additional challenges faced by disabled people with intersecting identities (such as those from racialised or minority backgrounds, LGBTIQ+ community, neurodivergent individuals, people with chronic illnesses, people with psychosocial or intellectual disabilities, migrants, women, etc.)
- Share examples of good practices supporting sexual and reproductive rights

In line with ENIL's commitment to centring lived experience, respondents were also invited to share direct testimonies of accessing sexual and reproductive health and rights.

An intersectional approach was adopted throughout both the data collection and research processes. This included actively seeking and reflecting the experiences of people with different types of impairments, diverse forms of self-identification, and individuals belonging to marginalised or underrepresented groups, including LGBTIQ+ communities and others facing multiple and overlapping forms of oppression and discrimination.

The collected responses were analysed and complemented with additional research, as well as ENIL's past and ongoing advocacy work in this area.

3

Independent Living Pillars

The Independent Living Pillars are the key supports and conditions necessary to make Independent Living a reality. They were originally developed by Disabled People's Organisations (DPOs), before Independent Living was formally recognised as a human right through the adoption of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

The concept has evolved over time. In 1981, Centres for Independent Living (CILs) in the UK identified seven core needs of Independent Living, building on the five core services developed at the first CIL in Berkeley: information, peer support, housing, equipment, personal assistance, transport, and access. These needs guided the establishment of CILs and continue to serve as a valuable reference.

In 2010, the Hampshire Centre for Independent Living expanded these into the 'twelve pillars of Independent Living', also known as the 'twelve pillars of full citizenship'. These pillars represent the fundamental rights required for disabled people to live independently and be fully included in society.[2]

In addition to the CRPD, its General Comments, and the Guidelines on deinstitutionalisation, the Independent Living Pillars remain a strategically important framework for the Independent Living movement. They also serve a key monitoring function, supporting the assessment of disability policies and acting as a watchdog mechanism.

In 2024, ENIL further expanded the framework by adding new pillars to the original twelve, reflecting emerging needs in rapidly changing societies and addressing persistent barriers to Independent Living.

2 ENIL, *Independent Living:* https://enil.eu/independent-living/.

ENIL agreed on the following eighteen pillars:

1. Appropriate and accessible information
2. An adequate income
3. Appropriate and accessible health and social care provision
4. A fully accessible transport system
5. Full access to the environment
6. Adequate provision of technical aids and equipment
7. Availability of accessible and adapted housing
8. Adequate provision of personal assistance
9. Availability of inclusive education and training
10. Equal opportunities for employment
11. Availability of independent advocacy and self-advocacy
12. Availability of peer support
13. Availability of supported decision-making
14. Awareness about the Independent Living history and philosophy
15. Full access to sexual and reproductive rights
16. Availability of legal aid
17. Full access to digital technology
18. Adequate support for life transitions (childhood to adolescence, adolescence to adulthood, adulthood to old age)

The Independent Living Pillars are underpinned by three cross-cutting priorities. These principles also informed the recent update of the pillars.

- Intersectional perspective: adopting an intersectional perspective in advocating for Independent Living accommodations and supports.
- Independent Living and emergencies: ensuring Independent Living support and accommodations in emergency situations (armed conflicts, natural disasters, pandemics)
- Globalisation of Independent Living: 'decolonising' Independent Living, by engaging with local knowledge and practices regarding self-determination. Developing culturally sensitive, locally appropriate Independent Living ideas and practices.

4

Sexual and Reproductive Health and Rights as an Independent Living Pillar: **Definition and Scope**

Article 25 of the UN CRPD[3] provides for the right to the highest attainable standard of health, without discrimination. This includes having access to sexual and reproductive health services, and the ability to exercise sexual and reproductive autonomy and decision-making, including through supported decision-making.

As stated by the Office of the United Nations High Commissioner for Human Rights (OHCHR):

> **Sexual and reproductive health and rights (SRHR)** comprise a set of interrelated freedoms and entitlements that are essential to women's human rights and gender equality. At their core, these rights guarantee individuals the freedom to make autonomous and informed decisions about their bodies and their sexual and reproductive lives, free from violence, coercion and discrimination.[3] They also encompass entitlements to timely and unrestricted access to a comprehensive range of health services, information and goods necessary to the realisation of those choices.

In this sense, access to sexual and reproductive healthcare lies at the heart of fundamental rights such as equality, privacy and bodily integrity, and is closely linked to the enjoyment of other rights, including health, education, work, an adequate standard of living, and participation in public and political life.

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3 UN, United Nations Convention on the Rights of Persons with Disabilities (CRPD), Article 25 (health), 2006.
4 OHCHR, *Sexual and Reproductive Health and Rights*.

SRHR cover a wide and interconnected range of services and areas, including maternal and perinatal health, family planning and access to contraception, comprehensive sexuality education, prevention and treatment of sexually transmitted infections (STIs), including HIV, as well as reproductive cancers, safe and legal abortion care, fertility and infertility services, and menstrual health. As emphasised by the World Health Organization (WHO), sexual and reproductive health extends beyond service provision to reflect a state of physical, mental and social well-being in all matters relating to the reproductive system and its functions.[5] In practice, this implies the ability to have safe and satisfying sexual lives, to experience healthy pregnancies and childbirth, and to make informed and autonomous decisions about if, when, and how many children to have.

Human rights standards further clarify that SRHR-related services, goods and facilities must be available in sufficient quantity, accessible both physically and economically, provided without discrimination or barriers, and of good quality. Access to these services throughout the life course is a recognised human right and a key component of universal health coverage, contributing not only to improved health outcomes but also to gender equality and broader social and economic development.

For disabled people, the realisation of SRHR is intrinsically linked to the principle of Independent Living. Control over one's body, relationships and reproductive choices is a precondition for autonomy and self-determination. Persistent barriers, ranging from inaccessible services and information to discriminatory attitudes and practices such as forced sterilisation, undermine this autonomy and restrict full participation in society. Ensuring equal access to SRHR is therefore not only a health or gender equality issue, but a fundamental requirement for enabling Independent Living and the full inclusion of disabled people in all aspects of life, as enshrined in Article 19 of the CRPD (right to Independent Living)[6]

Before turning to the following sections, it is useful to clarify **key concepts** used throughout this report. For ease of reference, the definitions below draw on *All the (Tricky) Words: A Glossary of Terms on Sex, Gender and Violence* **by Talia Meer,**[7] and are intended to support a shared understanding of sexual and reproductive health, rights and related terminology.

5 WHO, *Sexual and Reproductive Health and Rights.*

6 CRPD, Article 19 (Living independently and being included in the community).

7 Meer, T. (2014). *All the (Tricky) Words: A Glossary of Terms on Sex, Gender and Violence.* Cape Town: GHJRU, University of Cape Town

Reproductive Health:

A state of complete physical, mental and social well-being in all matters relating to the reproductive system (sex organs) and to its functioning. This implies that people are able to have a responsible, satisfying and safe sex life and that they may have children, and the freedom to decide if, when and how to do so.[8]

Reproductive Rights:

The basic right of all people to decide freely if they will have children, when they will have children and how many children they will have, as well as to have access to the information that helps them to make these decisions and to have access to sexual and reproductive health care. For example, access to family planning clinics and contraception is an important reproductive right. Reproductive rights also include the right to make decisions concerning reproduction free of discrimination, coercion and violence.[9]

Sexual Health:

Physical, emotional, mental and social well-being related to sexuality that includes positive feelings about sexuality, respect for your body and that of your partner/s, feeling comfortable about having pleasurable sexual experiences and understanding and practicing safe sex, free of coercion, discrimination and violence. For sexual health, the sexual and reproductive rights of all persons must be respected, protected and fulfilled.[10]

Sexual Rights:

These are the rights of all people to sexual health, access to sexual and reproductive health care services, information and education about sexuality, and to choose how, when and with whom to be sexually active. That means to have consensual sex and consensual marriage, to decide if and when to have children, to decide one's sexual orientation and sexual preferences, and to have an enjoyable, safe and pleasurable sexual life, free of coercion, discrimination and violence.[11]

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8 Ibidem.
9 Ibidem.
10 Ibidem.
11 Meer, T. (2014). *All the (Tricky) Words: A Glossary of Terms on Sex, Gender and Violence.* Cape Town: GHJRU, University of Cape Town

5

Legal framework

The legal framework underpinning sexual and reproductive health and rights (SRHR) for disabled people is grounded in several key international and regional instruments.

The **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**[12] establishes the foundation for women's reproductive rights, further elaborated in CEDAW General Recommendation No. 24,[13] which clarifies states' obligations under Article 12 on women's health, including access to appropriate and non-discriminatory health services.[14]

The **Convention on the Rights of Persons with Disabilities (CRPD)** reinforces these principles by explicitly recognizing the rights of persons with disabilities to access SRHR on an equal basis with others, including the right to bodily autonomy and informed consent.[15]

Broader commitments are reflected in the **Beijing Declaration and Platform for Action**[16] and the **Programme of Action of the International Conference on Population and Development**,[17] both of which affirm the universality of SRHR and the need to address intersecting forms of discrimination.[18]

At the regional level, the **Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (the "Istanbul Convention")**[19] explicitly identifies forced abortion and forced sterilisation as forms of violence, reinforcing the obligation of states to protect women with disabilities from such practices.[20]

Together, these frameworks establish a comprehensive legal basis for promoting, protecting, and fulfilling SRHR for disabled people.

12 OHCHR, Convention on the Elimination of All Forms of Discrimination against Women New York, 1979.
13 CEDAW General Recommendation No. 24: Article 12 of the Convention.
14 CEDAW, Article 12.
15 CRPD, Articles 12 (equal recognition before the law), 23 (respect for home and family), and 25 (health).
16 Beijing Declaration and Platform for Action, 1995.
17 International Conference on Population and Development ('ICPD') Programme of Action, 1994.
18 Beijing Declaration and Platform for Action, 1995, paras. 89-106; ICPD Programme of Action, 1994, Chapters VII-VIII.
19 Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, 2011.
20 Council of Europe, Istanbul Convention, 2011, Article 39 (forced abortion and forced sterilisation).

6

General and Intersectional Barriers to Sexual and Reproductive Health and Rights

Access to sexual and reproductive health and rights services continues to be affected by many obstacles across Europe. Disabled people face multiple forms of discrimination and stigma when trying to access these rights and services. This directly impacts Independent Living, undermining the principles of self-determination and autonomy. In exploring this topic, the report also aims to highlight how the SRHR pillar – enshrined in Article 25 of the CRPD – is closely linked to the other Independent Living pillars, listed in *section 3* of the report.

Some of the main barriers identified include the lack of accessible information, inaccessible services, lack of trained professionals, stigma and stereotypes, denial of legal capacity, lack of privacy and personal assistance, institutionalisation, lack of inclusive sexuality education, and financial barriers.

Beyond the above-mentioned general obstacles, some disabled people face additional and specific forms of discrimination linked to the intersection of different identities. Disabled women, people from migrant or racialised communities, and LGBTIQ+ people often experience multiple and overlapping forms of discrimination. These experiences are unique and therefore require targeted and intersectional responses.

Below, we analyse some of the main concerns and obstacles that emerged from direct consultations with DPOs and individuals, previous work, and recent research conducted by ENIL on the topic.

The issues identified in this report are interconnected and often experienced simultaneously. The table provides an overview of the main topics and areas of concern explored in the following sections.

6.1. Infantilisation, desexualisation and hypersexualisation

Disabled people are still frequently denied recognition as sexual and autonomous individuals. Harmful stereotypes continue to portray disabled people either as asexual, childlike and incapable of intimate relationships, or, conversely, as hypersexualised and lacking self-control. Some disabled people also experience fetishisation, where their disability becomes the object of sexual fascination, exoticisation or objectification rather than being recognised within respectful and equal relationships. These narratives affect how disabled people are treated by families, caregivers, healthcare professionals, institutions and society more broadly.

Infantilisation often results in disabled adults being treated as incapable of making decisions about their own bodies, relationships or sexuality. This can lead to excessive control over personal choices, denial of privacy, restrictions on relationships and limited access to sexual and reproductive healthcare. Hence, many disabled people, particularly persons with intellectual and psychosocial disabilities, report not being taken seriously when expressing emotional or sexual needs.

At the same time, some disabled people – particularly disabled women, LGBTIQ+ people, and those living in institutional settings – are exposed to hypersexualisation, fetishisation, objectification and sexual abuse. In these cases, disability is not erased but instead sexualised in a distorted way, where disabled bodies are reduced to objects of curiosity, fetish or exploitation rather than recognised as autonomous individuals with equal rights to sexuality and bodily integrity. Participants highlighted that disabled women in institutional settings are particularly affected by this dynamic and are disproportionately exposed to violence and coercion, including forced abortions, forced sterilisation and invasive medical interventions carried out without free and informed consent.

Stigma around sexuality is often intensified by gender, culture, religion, sexual orientation or ru-

ral isolation. For example, some participants noted that unmarried women in rural areas may face strong social pressure and shame when attempting to access gynaecological care or sexual health services. In some cases, women have never visited a gynaecologist due to fear of stigma, family control or lack of accessible services.

These stereotypes and discriminatory attitudes reinforce social exclusion and undermine disabled people's rights to bodily autonomy, intimacy, relationships, pleasure and family life.

6.2. Lack of accessibility in SRHR services

Accessibility is not only one of the core pillars of Independent Living, but is also explicitly recognised under Article 9 of the CRPD. The Convention requires States Parties to ensure that disabled people can access the physical environment, transport, information and communications, technologies, facilities and public services on an equal basis with others. This includes identifying and removing barriers in healthcare settings, information systems and public services, and ensuring accessible communication, interpretation, guidance and support.

Physical accessibility barriers remain one of the main obstacles to accessing SRHR. Many disabled people still face difficulties accessing healthcare facilities such as gynaecological clinics, sexual health centres and other SRHR services because buildings, equipment and transportation remain inaccessible. For instance, the lack of ramps, paved pathways, accessible toilets and adjustable examination beds can prevent persons with mobility impairments from accessing healthcare facilities and receiving appropriate care. Inaccessible transportation and medical equipment further limit access to gynaecological clinics, sexual health centres and other SRHR services.

When discussing the lack of accessibility in relation to SRHR, this report refers not only to physical barriers, but also to barriers in procedures, communication and access to information. Accessibility barriers include the lack of information in accessible formats, such as Easy-to-Read, Braille, large print, sign language, captioning and accessible digital formats, as well as the lack of clear, inclusive and understandable information about available services and rights. These barriers particularly affect persons with intellectual and cognitive disabilities, neurodivergent people, persons with visual impairments and others who require information to be provided in formats that meet their individual accessibility needs.

Procedural barriers also play a significant role. Complicated booking systems, unclear instructions, online-only appointment platforms, rigid administrative procedures or healthcare processes that are not designed in an intuitive and accessible way can create significant obstacles to accessing care on an equal basis with others. These barriers can disproportionately affect neurodivergent people, as well as persons with intellectual and cognitive disabilities, who may require more flexible, predictable and accessible procedures to navigate healthcare services effectively. In some cases, accessible services may exist, but disabled people are not aware of them because information is not properly disseminated or provided in accessible formats. Participants also highlighted a broader lack of knowledge and accessible information regarding sexual and reproductive rights, administrative procedures and available financial support.

In addition, the absence of trained staff, interpreters or support services often prevents disabled people from fully understanding their options and making informed choices about their bodies, relationships and healthcare. These barriers undermine autonomy, self-determination and equal participation in society, and therefore directly impact the right to Independent Living.

6.3. Safe sex, contraception and access to sexual healthcare

Disabled people continue to face significant barriers in accessing safe sex information, contraception and sexual healthcare services. Many participants reported that healthcare systems often fail to recognise disabled people as sexually active individuals, leading to inadequate information, dismissive attitudes and exclusion from sexual health programmes.

Accessible and inclusive information about sexually transmitted infections (STIs), HIV prevention, contraception and reproductive healthcare remains limited. Information is often unavailable in accessible formats, including Easy Read, plain language, Braille, sign language or alternative communication formats. This particularly affects persons with intellectual disabilities as well as deaf, blind, and neurodivergent people.

Stigma and desexualisation further contribute to exclusion from sexual health education and services. Disabled people are often perceived either as "asexual" or solely as vulnerable victims of violence, rather than as individuals with the right to sexual expression, pleasure and informed choices. Many participants in the consultation reported how shame and discrimination discourage disabled people from seeking healthcare, discussing contraception or reporting abuse.

Women and LGBTIQ+ disabled people often face additional barriers. Participants also highlighted that abortion care, gynaecological services and contraception are frequently physically inaccessible, financially unaffordable or delivered in discriminatory ways. In some cases, healthcare professionals bring stigma and discourage disabled people from being sexually active, entering relationships or becoming parents.

Furthermore, disabled people with chronic illnesses, psychosocial disabilities and trans disabled people frequently experience dismissal of their sexual and reproductive healthcare needs. Some reported a lack of information regarding the sexual and reproductive side effects of medication, including psychiatric medication, hormone treatment and long-term medication related to chronic illnesses, particularly regarding impacts on libido, menstruation, fertility and emotional well-being. Others described experiences of transphobia and ableism, lack of recognition of gender identity, and dismissal of gynaecological or reproductive health concerns, including conditions such as Premenstrual Dysphoric Disorder (PMDD), endometriosis and chronic pain.

Participants highlighted significant barriers in accessing abortion care. Beyond legal and financial restrictions existing in some countries, disabled people may face additional obstacles linked to stigma, dependency and lack of support. Some disabled people, particularly those who rely on family members or informal caregivers for transportation, communication or personal assistance, may be unable to access abortion services privately and independently. In situations where relatives or caregivers oppose abortion on moral, religious or personal grounds, disabled people may experience pressure, refusal of support or practical impossibility in reaching healthcare facilities. This dependency can undermine confidentiality, bodily autonomy and the ability to make free reproductive choices.

All these barriers increase the risk of exclusion, inadequate healthcare, violence and lack of bodily autonomy.

6.4. Legal capacity and denial of supported decision-making

Legal capacity remains one of the most significant barriers affecting disabled people's autonomy and control over their sexual and reproductive lives. Despite the obligations established under Article 12 of the CRPD,[21] many disabled people across Europe continue to be subjected to guardianship and substituted decision-making systems, which allow others to make decisions on their behalf.

Supported decision-making is a process through which disabled people receive the assistance they may need to understand information, consider options, communicate choices and make their own decisions, while keeping full control over their lives and legal capacity.

In practice, many persons with intellectual disabilities and psychosocial disabilities are still denied the right to make decisions about their own bodies, relationships, finances, contraception, parenthood or healthcare. Guardians, family members, institutions or medical professionals may exercise control over highly personal decisions, often without respecting the person's will and preferences.

The denial of legal capacity is closely connected to institutionalisation and segregation. Individuals placed under guardianship are at greater risk of being institutionalised and excluded from community-based support systems. Participants stressed that without legal capacity and supported decision-making, disabled people cannot fully exercise their rights to independent living, bodily autonomy and family life.

Although some countries have introduced reforms towards supported decision-making systems, implementation remains inconsistent and many disabled people still lack access to information, peer support and self-advocacy – all needed to make autonomous and informed choices.

6.5. Relationships, privacy and gaps in personal assistance provision

The right to establish and maintain relationships is closely linked to independent living, autonomy and participation in the community. However, many disabled people continue to face barriers that limit their ability to form intimate relationships, explore their sexuality and experience emotional and sexual fulfilment on an equal basis with others.

Lack of accessible transportation, inaccessible housing and social isolation can significantly reduce opportunities to meet people, socialise and maintain relationships. Disabled people living in institutions or other segregating settings are particularly affected by restrictions on privacy, autonomy and freedom of movement.

The lack of adequate personal assistance[22] also creates significant barriers. Without appropriate support, disabled people may face difficulties attending medical appointments, accessing community spaces, maintaining personal hygiene or exploring intimate relationships safely and independently. In many cases, family members act as primary caregivers, which can create additional challenges around privacy, dependency and personal boundaries. Some disabled

21 CRPD, Article 12.

22 ENIL, Personal Assistance

people report feeling uncomfortable discussing sexuality, relationships or reproductive health when support is provided exclusively by parents or relatives. Insufficient or inflexible personal assistance schemes can limit disabled people's ability to participate spontaneously in social life, attend cultural or community activities, go on dates or maintain intimate relationships independently. Some disabled people may require support to access sexual and reproductive healthcare, communicate privately with partners, engage in intimate relationships, have sex, or participate safely in LGBTIQ+ spaces and peer networks. Where assistance is unavailable, overly restrictive or shaped by paternalistic attitudes, disabled people may experience social isolation, reduced autonomy and limited opportunities to explore relationships, intimacy and sexuality on their own terms.

In rural or remote areas, there are additional barriers linked to social isolation, lack of accessible transportation and limited access to community-based support services. In small or conservative communities, fear of stigma, lack of anonymity and cultural taboos surrounding disability and sexuality may further restrict opportunities to explore relationships and intimacy safely and freely.

Participants also highlighted that societal stigma around disability and sexuality continues to affect disabled people's ability to express their identities freely, including sexual orientation and gender identity. Thus, LGBTIQ+ disabled people may face multiple and intersecting forms of discrimination, both within disability-related services and within broader society.

Another key issue concerns the narrow framing of sexuality in public discourse and SRHR services: discussions around sexuality often focus exclusively on protection, risk or abuse prevention, and overlook disabled people's rights to intimacy, pleasure, consent and fulfilling sexual experiences. This contributes to the continued desexualisation of disabled people and limits access to information and services that support healthy and autonomous relationships.

6.6. Gender-based and sexual violence

Disabled women and girls are disproportionately exposed to gender-based and sexual violence across all settings, including within families, institutions, healthcare systems and intimate relationships. Women with disabilities are estimated to be two to five times more likely to experience violence compared to non-disabled women.[23] In the European Union, available data shows that 34% of women with a health problem or disability have experienced physical or sexual violence by a partner in their lifetime, compared to 19% of women without disabilities. In addition, 61% of women with a health problem or disability have experienced sexual harassment since the age of 15, compared to 54% of women without disabilities.[24]

Despite these findings, violence against women and girls with disabilities remains significantly underreported and under-documented due to major gaps in data collection, particularly the absence of systematic disability-disaggregated data. Existing data often fail to capture violence occurring in closed settings, such as institutions, asylum centres and psychiatric hospitals, disability-specific forms of violence, including forced sterilisation, the relationship between victims and perpetrators, and the barriers to reporting that keep women and girls with disabilities

23 European Parliament, Women with Disabilities, 2025

24 European Disability Forum, Position Paper on Violence against Women and Girls with Disabilities in the European Union, 2021.

silenced and invisible. There is also limited data and research on the experiences of disabled women in relation to emerging forms of violence, such as cyber gender-based violence, as well as violence occurring in educational and workplace settings.

Multiple barriers continue to prevent survivors of violence from accessing justice, protection and support services. Dependence on family caregivers, lack of accessible reporting mechanisms, communication barriers and fear of institutionalisation can make it extremely difficult for disabled people to report violence or seek support. Women living in institutions or under guardianship are at particularly high risk of abuse and exploitation.

During the consultation, participants stressed that disabled people with intersecting identities face additional barriers when seeking protection and justice. Migrant disabled women, asylum seekers, LGBTIQ+ disabled people and persons with psychosocial disabilities may encounter language barriers, fear of authorities or institutionalisation, inaccessible reporting systems and discriminatory assumptions regarding credibility, consent and capacity. In rural areas, lack of accessible shelters and specialised support services can further increase isolation, dependency and vulnerability.

Participants also highlighted that violence against disabled people is often minimised, disbelieved or ignored by authorities and healthcare professionals. Harmful stereotypes portraying disabled people as unreliable, incapable or lacking credibility continue to undermine access to justice. At the same time, the absence of accessible shelters, crisis centres, hotlines and support services leaves many survivors without adequate protection or assistance.

6.7. Forced sterilisation, forced contraception and reproductive coercion

Forced sterilisation remains a serious human rights violation affecting disabled people, particularly women and those with intellectual disabilities.

Sterilisation refers to a procedure resulting in the permanent loss of natural reproductive capacity. It is considered forced when it is carried out without a person's knowledge or free and informed consent, against their explicit refusal, or in situations where there is no serious and immediate threat to the person's health or life justifying the intervention. Sterilisation may also be coerced when individuals are pressured into agreeing to the procedure by family members, guardians, institutions or medical professionals, or when sterilisation is imposed as a condition for accessing services, institutional care or legal recognition.[25]

Despite growing international condemnation, forced sterilisation is still legally permitted or insufficiently prohibited in several European countries. According to a report by the European Disability Forum, forced sterilisation is authorised in 13 out of the 27 EU Member States, including: Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Hungary, Latvia, Lithuania, Malta, Portugal and Slovakia.[26]

Participants highlighted that sterilisation procedures are often carried out without free and informed consent, or under pressure from family members, guardians, institutions or medical professionals. In some cases, sterilisation or contraception may be presented as a condition

25 EDF, Forced sterilisation of persons with disabilities in the EU, 2022.
26 *ibidem*.

for entering institutions or accessing certain forms of support. Moreover, many disabled women reported discovering only later in life that sterilisation procedures had been performed without their full understanding or informed consent, particularly when they attempted to become parents.[27] This often causes trauma, feelings of violation, long-term psychological harm, mistrust in healthcare systems and grief linked to the denial of reproductive choice and the possibility of having children.

Concerns raised include forced contraception, coerced abortion and forms of reproductive control rooted in discriminatory assumptions about disability and parenthood. As highlighted during the consultation, this includes forms of so-called "new" or liberal eugenics, where reproductive decisions are shaped by medicalised risk discourse, selective information and social pressure and negative assumptions about disabled people's capacity to parent, rather than genuinely free and informed choice.

While these practices may appear formally voluntary, they often occur in contexts of unequal power relations, dependency and limited alternatives, where disability is portrayed as undesirable and where disabled people's reproductive choices are systematically questioned or discouraged. These dynamics particularly affect women, persons with intellectual and psychosocial disabilities, people under guardianship, and LGBTIQ+ disabled people. Participants also highlighted that coercive practices may disproportionately affect disabled people living in institutions, migrant women, persons living in poverty and individuals whose access to healthcare, housing or social support depends on family members, guardians or institutional systems.

6.8. Access to parenthood, motherhood and care roles

Disabled people continue to face widespread discrimination in relation to parenthood and family life. Negative stereotypes often portray disabled people – especially women, LGBTIQ+ people, and persons with intellectual disabilities – as incapable of being parents or caring for children.

Many disabled people reported facing pressure not to have children, discriminatory attitudes from healthcare professionals and social services, and assumptions that disability is incompatible with parenting. In this context, disabled mothers are particularly scrutinised and may face disproportionate interventions from child protection systems.

Participants also highlighted that migrant disabled women, women from ethnic minority backgrounds and women with psychosocial or intellectual disabilities may face heightened surveillance, discriminatory assumptions and additional barriers linked to language, documentation, poverty and lack of appropriate support.

Contradictions in reproductive healthcare and family planning practices affecting disabled people also emerged. While access to safe and legal abortion remains restricted or difficult to access in some contexts, abortion may nevertheless be encouraged or implicitly promoted in cases involving foetal impairment or when disabled people become pregnant, regardless of their actual health situation, support networks or capacity to parent. Some participants described

27 EDF, Silenced Truth – stories of forced sterilisation in the EU, 2025.

experiencing pressure from healthcare professionals, family members or social services to terminate pregnancies based on assumptions that disability is incompatible with parenting or that disabled people would be unable to raise children adequately. These attitudes reflect persistent ableist stereotypes that devalue disabled people's reproductive choices, family life and right to parenthood on an equal basis with others.

At the same time, traditional gender expectations often place additional care responsibilities on women while failing to provide adequate support. Lack of accessible housing, community-based services, personal assistance and financial support can create significant barriers for disabled parents and families.

Participants stressed that the right to parenthood should be supported through community-based services, accessible healthcare, peer support and measures that respect disabled people's autonomy and family life.

6.9. Menstrual health and menstrual poverty

Menstrual health remains a neglected issue for many disabled people. Participants highlighted barriers in accessing menstrual products, information, healthcare and appropriate support.

Disabled people living in rural areas, poverty or institutions may have limited control over menstrual products, privacy and hygiene. Inaccessible toilets, lack of adapted products and limited access to information can further affect dignity, health and participation in daily life. Women and girls with disabilities are disproportionately deprived of access to the facilities and resources necessary for proper menstrual hygiene management, with additional barriers faced by transgender and gender-diverse persons, who often experience compounded exclusion and invisibility in both gendered and disability-related services.

Disabled girls are also frequently excluded from comprehensive education on menstrual health due to stigma, assumptions of incapacity, or lack of accessible formats, reinforcing a double layer of discrimination and taboo around both disability and menstruation.

For persons with intellectual disabilities, the absence of accessible and inclusive information about menstruation may lead to confusion, fear or dependence on others. Persons with physical, sensory or psychosocial disabilities may also face significant barriers to managing menstruation independently where personal assistance or other forms of support are unavailable or inadequate. Even when menstrual products are physically accessible, some individuals may require assistance to use them safely and hygienically, making access to appropriate support services an essential component of menstrual health. In addition, stigma surrounding menstruation and disability often increases silence and exclusion around these experiences. In some contexts, menstrual suppression through hormonal treatments or other medical interventions may be offered or encouraged for disabled persons, particularly those with high support needs. While such treatments may be appropriate when based on the informed choice and health needs of the individual, concerns have been raised where they are used primarily for the convenience of caregivers or institutions, without adequate informed consent or consideration of potential health implications.

Menstruation is also closely linked to physical pain, fatigue and chronic health conditions, which can be significantly exacerbated for persons with disabilities. The interaction between disability and menstrual-related symptoms can intensify existing impairments, affect daily function-

ing, and limit participation in education, employment and social life. These barriers are often compounded by difficulties in requesting or obtaining reasonable accommodation in both educational and workplace settings, where menstrual and disability-related needs are rarely recognised or supported.

Participants also reported that menstrual and gynaecological health concerns affecting disabled women, trans people and people with chronic illnesses are frequently dismissed or inadequately addressed within healthcare systems. Conditions such as PMDD, endometriosis, chronic pain and hormonal side effects may remain undiagnosed or untreated due to stigma, lack of specialist knowledge and gender bias in healthcare.

6.10. Comprehensive and inclusive sexuality education

Comprehensive sexuality education remains insufficient across many European countries, and where it exists, it is often not inclusive. Disabled children and young people are frequently excluded from discussions around intimacy, consent, relationships, sexual orientation, body image and reproductive health.

In many schools, sexuality education is either not mandatory, limited in scope or heavily focused on risk prevention. Disability is rarely included in discussions about sexuality and relationships, reinforcing the misconception that disabled people do not have intimate lives or sexual identities, desires, and needs.

The absence of inclusive sexuality education leaves many disabled young people without the knowledge necessary to understand consent, establish healthy relationships, identify abuse or make informed decisions about their bodies and health. This lack of information can increase vulnerability to violence, dependency, exploitation and misinformation.

Sexuality education should reflect diverse cultural, linguistic, gender and disability experiences. This includes accessible and culturally appropriate information for migrants, ethnic minorities and persons living in rural areas, as well as disability-inclusive and LGBTIQ+-inclusive discussions on relationships, gender identity, consent, pleasure and bodily autonomy.

Respondents to the consultation also stressed the importance of accessible and age-appropriate sexuality education that reflects diverse bodies, identities and experiences, including LGBTIQ+ perspectives and disability-inclusive discussions on intimacy, pleasure, parenting and self-determination.

6.11. Equal access to intimacy, pleasure and body representation

Discussions around disability and sexuality are often centred exclusively on protection, prevention or medical needs, while neglecting disabled people's rights to intimacy, desire, pleasure and positive sexual experiences. The testimonies collected illustrate that disabled people are rarely recognised as individuals with the same emotional, relational and sexual needs as others.

The lack of positive representation of disabled bodies and relationships in media, education, healthcare and public discourse contributes to exclusion and invisibility. Disabled people are often absent from discussions around beauty, attraction, dating, intimacy and parenthood, reinforcing harmful assumptions that disability is incompatible with sexuality, pleasure or desirability.

For many disabled people, this lack of representation can negatively affect self-esteem, body image and mental well-being. Participants highlighted that growing up without inclusive discussions about disability and sexuality may lead to shame, insecurity or difficulties in developing confidence and healthy relationships. Disabled people with intersecting identities, including LGBTIQ+ disabled people, migrants, persons from ethnic minority backgrounds and people living in rural areas, are particularly underrepresented within media, public discourse and sexuality education. This invisibility can reinforce isolation and limit access to inclusive spaces, information and community support.

At the same time, inaccessible social spaces, stigma and discrimination can limit opportunities to explore relationships and intimacy freely and safely. LGBTIQ+ disabled people, disabled women and persons with intellectual disabilities may experience additional exclusion from spaces and conversations related to sexuality and self-expression.

A crucial point is that equal access to sexual and reproductive health and rights must also include the right to pleasure, intimacy, bodily autonomy and positive representation. Promoting inclusive narratives around disability, sexuality and relationships is therefore essential to challenge stigma and support disabled people's full participation in society and community life.

6.12. Sexual assistance, intimacy and sexual citizenship

Sexual assistance has become an increasingly visible topic in discussions on disability and sexuality and is recognised by some as an important aspect of supporting disabled people's autonomy, intimacy and quality of life. At the same time, discussions on disability and sexuality should not be limited to sexual assistance alone. Broader issues such as access to healthcare, relationships, consent, bodily autonomy, inclusive sexuality education, parenthood and protection from violence are equally essential to ensuring the full enjoyment of sexual and reproductive health and rights. A comprehensive rights-based approach should therefore recognise sexual assistance as one element within a wider framework of sexual citizenship and Independent Living, rather than treating it as the sole or defining issue affecting disabled people's sexual and reproductive rights.

The lack of support related to intimacy, sexuality and sexual expression can constitute a significant barrier to independent living and quality of life. Access to personal assistance and other appropriate forms of support may directly affect the ability to establish relationships, experience intimacy, explore sexuality and exercise bodily autonomy on an equal basis with others.

Testimonies consistently show that disabled people are frequently denied recognition as sexual beings and often face assumptions that they are either asexual or incapable of experiencing sexual pleasure, intimacy or fulfilling relationships. This can be particularly harmful for disabled people who rely on personal assistance services or support in daily life, as sexuality remains a highly stigmatised and taboo topic within many support systems and healthcare services. Discussions around sexuality are often limited to risk prevention, abuse or medical dysfunction, while issues such as pleasure, intimacy, emotional well-being and sexual fulfilment remain largely ignored.

Some participants reported that the lack of adequate support, accessible information and open discussions around sexuality can lead to isolation, loneliness and the avoidance of intimate relationships or sexual experiences altogether. This is particularly relevant for disabled people

who rely on support from personal assistants or caregivers for daily activities, mobility or communication. The testimonies highlighted that inaccessible environments, lack of privacy, fear of stigma and uncertainty around professional boundaries can create significant barriers to exercising what some researchers describe as "sexual citizenship", the right to express one's sexuality, form relationships and make autonomous decisions about one's intimate life.[28] Participants also noted that cultural stigma, religious taboos, rural isolation and lack of disability-inclusive and LGBTIQ+-inclusive support services may further restrict opportunities to discuss sexuality and intimacy openly. Migrants, persons from ethnic minority backgrounds and LGBTIQ+ disabled people may experience additional exclusion due to lack of culturally appropriate and intersectional support.

Although the importance of discussing sexual assistance within a rights-based framework, the topic raises complex legal, ethical and practical considerations. Some emphasise the importance of recognising sexual assistance and intimacy-related support as part of the broader right to Independent Living, bodily autonomy and participation in society. Others highlight the need to ensure that any approach is firmly grounded in free and informed consent, respect for professional boundaries, labour rights and appropriate safeguards against exploitation or abuse.

Research conducted in Norway highlighted that many disabled people receiving personal assistance services reported lacking guidance, information or safe spaces to discuss sexuality and intimacy. Some participants indicated that they would rather avoid sexual activity than request assistance related to intimacy or sexual facilitation because of fear of making personal assistants uncomfortable, fear of losing support staff, or uncertainty regarding acceptable boundaries and professional roles. The study also found that conversations around sexuality within support services are often absent, leaving disabled people without adequate support or information to navigate these issues safely and autonomously.[29]

Participants stressed that support systems, service providers and policymakers should acknowledge that sexuality, intimacy and emotional relationships are part of human life and closely linked to dignity, autonomy, well-being and quality of life. This requires moving beyond paternalistic or purely risk-based approaches and ensuring access to rights-based, consent-based and person-centred support, while fully respecting the autonomy, boundaries and rights of both disabled people and support workers.

6.13. Lack of training and disability-inclusive and intersectional competence among professionals

Lack of training and awareness among healthcare professionals, social workers, educators, institutional staff, support workers and personal assistants continues to create major barriers to sexual and reproductive health and rights for disabled people. Testimonies collected repeatedly highlighted that many professionals lack both disability-inclusive and gender- and sexuality-inclusive training, resulting in discriminatory attitudes, misinformation, paternalistic practices and inadequate support.

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28 Thunem et al., *Personal Assistance Services and Sexual Health in Norway — a Cross-Sectional Study of Disabled People's Experiences and Attitudes regarding Sexuality and Personal Assistants,* 2024.

29 *Ibidem*

Disabled people's choices and autonomy are frequently questioned or restricted by healthcare providers, family members and institutional staff. In general, sexuality is still frequently approached through a purely medical, risk-based or protective framework rather than a rights-based approach centred on autonomy, consent, relationships, pleasure and self-determination. Specifically, healthcare professionals often receive little or no training on disability, gender and sexuality, and many participants reported experiences in which professionals assumed that disabled people are not sexually active, are incapable of making informed decisions or should not become parents.

Participants also pointed to a significant lack of training on intersectionality and the diversity of disabled people's identities, experiences and access needs. Disabled LGBTIQ+ people reported that services are often neither disability-inclusive nor LGBTIQ+-inclusive, leading to exclusion, invisibility and discrimination within both sexual and reproductive healthcare and disability-related support systems. Queer and trans disabled people also reported experiences of transphobia, lack of recognition of their identities and limited access to appropriate sexual health, gender-affirming and mental health support.

Another key point highlighted by the consultation is that migrants, asylum seekers and persons from ethnic minority backgrounds face additional barriers linked to language obstacles, lack of accessible and culturally appropriate information, discrimination and the absence of reasonable accommodation within migration and healthcare systems. Disability is often overlooked within asylum and migration procedures, leaving many people excluded from both healthcare and broader rights protection mechanisms.

Participants also stressed that professionals often fail to recognise or adequately address issues such as Premenstrual Dysphoric Disorder (PMDD), chronic pain, endometriosis, gender dysphoria, trauma, reproductive coercion and the specific healthcare needs of disabled women and disabled trans people. Disabled women, particularly women with intellectual or psychosocial disabilities, continue to face paternalistic attitudes, dismissal of gynaecological health concerns and restrictions on bodily autonomy and decision-making.

Furthermore, in rural and remote areas, the lack of trained professionals and specialised services creates additional exclusion. Disabled people living in rural regions often reported very limited access to accessible sexual and reproductive healthcare, including gynaecological care, LGBTIQ+-inclusive services, mental health support and specialised counselling.

Improving access to sexual and reproductive health and rights requires mandatory disability-inclusive and intersectional training for healthcare professionals, educators, social workers and personal assistants. Such training should include consent, communication, supported decision-making, trauma-informed approaches, gender and sexual diversity, disability rights, anti-racism and the social model of disability, while fully recognising disabled people as autonomous individuals with the right to relationships, intimacy, parenthood and bodily autonomy.

6.14. Financial barriers

Financial barriers continue to significantly limit access to sexual and reproductive healthcare and rights. Disabled people are disproportionately exposed to poverty and social exclusion, while many SRHR-related services and products remain expensive or insufficiently covered by public healthcare systems.

Participants highlighted the high costs associated with contraception, gynaecological care, pregnancy-related healthcare, fertility services, abortion care and transportation to medical appointments. Lack of financial support may force disabled people to delay or avoid essential healthcare. Someone reported being forced to seek private healthcare due to the absence of accessible public pathways or specialised services, particularly regarding chronic illness, reproductive health, gender-affirming care and mental health support. Access to private care often depends on financial privilege and may deepen existing socio-economic inequalities.

Broader concerns regarding the financing of sexual and reproductive health and rights services emerged. While public investments contribute to the availability and affordability of care, overall funding remains limited. In 2024, European donors, including EU institutions and European Member State governments, allocated approximately €2.62 billion to SRHR-related activities, including sexual and reproductive health services, HIV programmes, and gender-based violence prevention. This funding refers to official development assistance (ODA) and is primarily directed towards programmes outside the European Union, rather than domestic healthcare systems within Member States. However, SRHR funding continues to represent only a small share of official development assistance, ranging between approximately 0.6% and 5.8% of donors' ODA depending on the country.[30] Within this overall picture, there is limited disaggregated data on funding allocated specifically to accessible and disability-inclusive SRHR services. This lack of targeted data makes it difficult to assess whether existing investments adequately address disability-related barriers, including accessibility adaptations, reasonable accommodation, accessible information, and specialised support services. As a result, gaps in financing that affect disabled people's access to SRHR may remain insufficiently visible and addressed.

Inaccessible transportation, additional disability-related expenses and the lack of nearby accessible healthcare services can further increase costs. Financial barriers are often compounded by unemployment, lower income and dependence on social protection systems.

Equal access to SRHR requires not only legal protections, but also affordable and accessible healthcare systems that address the socio-economic inequalities faced by disabled people.

30 Countdown 2030 Europe, Tracking What Counts – A Trends Analysis of European Donor Support to Sexual & Reproductive Health and Rights & Family Planning, 2025.

7

Good Practices Advancing Sexual and Reproductive Health and Rights

Several countries, organisations, researchers, and activists have developed initiatives and good practices aimed at strengthening the sexual and reproductive health and rights (SRHR) of disabled people. Many of them particularly target women and girls with disabilities. The initiatives mentioned below focus on empowerment, access to information, professional training, advocacy, peer support, and challenging societal stigma around disability and sexuality.

These good practices were collected through research, surveys, and an open call inviting organisations and initiatives to submit their work.

It is acknowledged that good practices play a crucial role in promoting empowerment, freedom, and independent living, and that they can serve as examples for countries and local contexts seeking to develop similar approaches. Some focus on workshops and peer support, others on awareness-raising or research – each responds to the specific challenges of its own context. For this reason, we have included several examples. We also recognise that many other relevant initiatives exist across the world.[31]

31 We welcome contributions from organisations, activists, researchers and other stakeholders who would like to share additional examples of good practices in this area. Please send relevant information, initiatives or resources to antonella.candiago@enil.eu or secretariat@enil.eu, so that we can continue to expand and share knowledge on inclusive approaches to SRHR.

Index of Good Practices

7.1. Improving disability-inclusive SRHR through accessible services, professional training and peer education in the Republic of Moldova

Background

This good practice originates from the collaborative efforts of the Ministry of Health of the Republic of Moldova, UNFPA Moldova, UN Women Moldova, the Swiss Agency for Development and Cooperation (SDC), organisations of persons with disabilities, including the Association Motivație of Moldova and the Centre for Information and Documentation on Sexuality (CIDSR), and other national and international partners. The initiative aims to improve the sexual and reproductive health and rights (SRHR) of women and girls with disabilities by addressing physical, attitudinal, and informational barriers that limit access to quality reproductive healthcare services.

The initiative was developed in response to evidence demonstrating significant inequalities in access to SRHR services. Research conducted in Moldova showed that only around half of women with locomotor disabilities accessed gynaecological services, while many reported experiencing inaccessible facilities, stigmatizing attitudes, and discrimination when seeking reproductive healthcare. Recognising these barriers, the partners adopted a comprehensive approach combining improvements in healthcare infrastructure, professional capacity-building, community empowerment, and awareness-raising.

Description

A central component of the initiative was the modernization of Youth-Friendly Health Centres and medical institutions through the provision of accessible gynaecological equipment. Beginning in 2017, thirty Youth-Friendly Health Centres across the country were equipped with adapted gynaecological examination chairs designed to accommodate women with reduced mobility. The programme was subsequently expanded through additional investments in accessible equipment for healthcare facilities in Chișinău, Cahul, Edineț, Hîncești, Ungheni, and other districts. In 2026 alone, twenty-two gynaecological cabinets across eleven medical institutions received electronically adjustable examination chairs, enabling women with locomotor disabilities, older women, and women with obesity to undergo examinations in safer, more comfortable, and dignified conditions.

The initiative also invested in strengthening the capacity of healthcare professionals to provide disability-inclusive SRHR services. Gynaecologists, family doctors, and other healthcare providers participated in training programmes addressing disability rights, non-discrimination, respectful communication, informed consent, and the delivery of accessible sexual and reproductive healthcare. These activities sought to improve both the quality of care and the confidence of healthcare professionals in responding appropriately to the needs of women and girls with disabilities.

Impact

Alongside improvements within the healthcare system, the initiative promoted community empowerment through awareness-raising and peer education. Between 2020 and 2024, the Association Motivație of Moldova, CIDSR, UNFPA, and other partners organised training sessions for adolescents, women with disabilities, caregivers, and young people on topics including bodily autonomy, contraception, healthy relationships, prevention of sexual violence, and access to

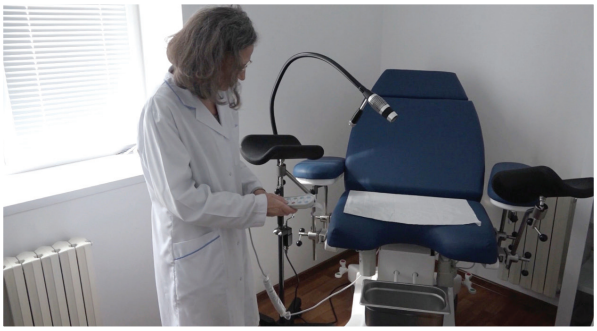
SRHR services. Training-of-trainers programmes enabled women and girls with disabilities from both banks of the Nistru River, including the Transnistrian region, to become peer educators and local advocates, strengthening community knowledge and promoting greater awareness of sexual and reproductive rights.

The initiative has contributed to improving the accessibility of reproductive healthcare services for women and girls with disabilities, increasing awareness of SRHR among persons with disabilities and healthcare providers, and reducing stigma surrounding disability and sexuality. By combining accessible infrastructure, professional training, peer education, and multi-stakeholder cooperation, the programme has strengthened the recognition of sexual and reproductive health and rights as fundamental human rights that must be accessible to all women and girls without discrimination.

The practice demonstrates how coordinated action between public institutions, organizations of persons with disabilities, and international partners can improve both the accessibility and quality of SRHR services. By addressing physical, institutional, and attitudinal barriers simultaneously, it provides a comprehensive and replicable model for promoting disability-inclusive reproductive healthcare.

Additional information:

- 2017, UNFPA Moldova – Accessible SRHR services and Youth-Friendly Health Centres
- 2020, Diaspora, health centers from Moldova with gynecological chairs adapted for women with disabilities
- Training sessions for adolescents and women with disabilities
- Training sessions for youth
- Training sessions for caregivers
- CIDSR Launches the "Inclusive and Accessible for All" Project
- Training Sessions on Sexual and Reproductive Health for Persons with Disabilities from Transnistria Region
- Training-of-trainers programmes



Good Practices from the Republic of Moldova

7.2. Sexual facilitation and parenting support within personal assistance services, Norway

Background

In Norway, Medvind Assistanse has developed an innovative practice that integrates sexual and reproductive health and rights (SRHR) into personal assistance services. The initiative is based on the understanding that independent living, personal assistance, and SRHR are closely interconnected, and that access to sexuality, intimate relationships, and parenthood should be considered fundamental aspects of autonomy and self-determination for persons with disabilities.

The practice was developed to address a common gap within disability support services: the lack of clear guidance and support regarding sexuality, intimate relationships, and reproductive rights for individuals who use personal assistance services. Recognising that both service users and personal assistants may face uncertainty regarding roles, boundaries, and support needs, the organisation introduced a structured approach to sexual facilitation and sexual guidance within its services.

Description

A key component of the initiative was the development of a handbook on sexuality and personal assistance. The handbook provides practical guidance for people with disabilities who employ and direct their own personal assistants, outlining rights, responsibilities, boundaries, and good practices related to intimacy and sexuality. The organisation also established procedures allowing service users and staff to access advice from sexual health advisors and sexologists when needed.

Moreover, Medvind Assistanse delivered training and awareness-raising activities for staff working closely with persons with disabilities. These activities aimed to increase understanding of SRHR, clarify professional boundaries, and ensure that sexuality could be addressed openly and respectfully within support services.

Impact

The initiative has generated several positive outcomes. Service users have reported greater opportunities to express their sexuality and pursue intimate relationships, contributing to increased well-being and quality of life. The development of clear procedures and guidance has also reduced misunderstandings and conflicts between personal assistants and service users. Furthermore, the establishment of clear boundaries and professional standards has strengthened safeguarding measures and contributed to the prevention of sexual abuse and exploitation.

Building on this work, Medvind Assistance also developed guidance and support processes for persons with disabilities using personal assistance services who wish to become parents. This initiative recognizes parenting as an important aspect of independent living and seeks to ensure that persons with disabilities receive appropriate support to exercise their reproductive rights and enjoy family life on an equal basis with others.

This practice demonstrates how SRHR can be embedded within independent living and personal assistance frameworks. By combining practical guidance, professional support, staff training, and rights-based approaches, the initiative contributes to greater autonomy, safety, and inclusion for persons with disabilities.

Additional information:

- Medvind Assistanse
- Sexuality handbook for personal assistance users
- Parenting guidance resource for personal assistance users

7.3. Advancing SRHR for women with disabilities through inclusive healthcare access, training, and community advocacy in Georgia

Background

This good practice originates from the work of the Ozurgeti Independent Living Center in Georgia, implemented in the Guria region through the project "We Are Women with Disabilities." The initiative focuses on promoting sexual and reproductive health and rights (SRHR) of women and girls with disabilities and improving their access to inclusive, barrier-free healthcare services in a context where disability, sexuality, and reproductive rights remain highly stigmatized and insufficiently addressed.

The initiative responds to multiple and intersecting barriers faced by women with disabilities in accessing SRHR services, including stigma, limited awareness among healthcare providers, lack of accessible infrastructure, and weak communication between patients and medical professionals. It also addresses the broader structural gap in rights-based, disability-inclusive approaches within reproductive healthcare systems at local level.

Description

A central component of the project was strengthening collaboration between women with disabilities and healthcare professionals, particularly gynecologists, to improve mutual understanding and ensure more inclusive service provision. A two-day training held on 23–24 November 2024 in Ozurgeti brought together 14 participants, including women with disabilities and healthcare professionals. The training, led by reproductive health specialist Dr. Eka Kvirkvelia, focused on reproductive health rights, disability-inclusive communication, informed consent, bodily autonomy, and respectful healthcare practices. This dual-target approach strengthened both empowerment of rights holders and capacity-building among duty bearers.

In addition to training activities, the project included practical measures to improve access to healthcare services. In January 2025, four women with disabilities were supported in accessing cervical and breast cancer screening services at the Lanchkhuti Screening Center through transportation assistance. This component highlighted the importance of addressing not only attitudinal and informational barriers, but also logistical and financial barriers to healthcare access. During the screening process, an early-stage breast cancer diagnosis was identified for one beneficiary's family member, demonstrating the life-saving potential of accessible preventive healthcare services.

The initiative also incorporated a public awareness and advocacy component through the social media campaign "We Are Women," implemented via the Ozurgeti Independent Living Center's Facebook platform. The campaign included three short video reels addressing reproductive health rights and challenging stigma around disability and womanhood. The content was further

amplified through professional networks and public engagement, including reposting by Dr. Eka Kvirkvelia, contributing to broader outreach and visibility.

Impact

Key outcomes of the project include increased awareness of sexual and reproductive health rights among women with disabilities, improved sensitivity and understanding among healthcare professionals regarding disability-inclusive care, and enhanced public dialogue on SRHR in a region where such topics are often limited or considered taboo. The initiative also demonstrated the effectiveness of combining training, practical service support, and awareness-raising to create more inclusive healthcare pathways.

The target group of the initiative includes women and girls with disabilities in the Guria region of Georgia, as well as healthcare professionals involved in reproductive health service delivery.

The project demonstrates a community-based, rights-oriented approach that integrates empowerment, professional capacity-building, and advocacy to advance SRHR for women with disabilities in a local context.

Additional information:

- https://www.facebook.com/share/18k1m6DxVZ/
- https://www.facebook.com/share/18XzuXcUaB/
- https://www.facebook.com/share/v/17UEGDZUzC/
- https://www.facebook.com/share/v/18pzz1HgeB/
- https://www.facebook.com/share/v/1KbLEy959J/

7.4. Advancing SRHR and Independent Living for women and girls with disabilities in Kyrgyzstan and Central Asia

Background

This good practice originates from the work of the Public Association "Union of People with Disabilities Ravenstvo" in Kyrgyzstan, in cooperation with the Central Asian Network of Women with Disabilities and regional partners across Kazakhstan, Tajikistan, and broader Central Asia. The initiative focuses on strengthening access to sexual and reproductive health and rights (SRHR), protection from violence, independent living services, and justice for women and girls with disabilities.

The practice responds to persistent and intersecting barriers faced by women and girls with disabilities in Kyrgyzstan and the wider Central Asian region, including stigma, discrimination, dependency, denial of informed consent, violence, exploitation, forced and early marriage, and limited access to accessible healthcare and SRHR services. It also addresses gaps in protection systems and the lack of disability-inclusive support services for survivors of violence.

Description

A central component of the initiative is the establishment of the first Independent Living Center in Kyrgyzstan and shelter specifically adapted for women and girls with disabilities who have experienced violence. This service provides accessible temporary accommodation and a safe environment for recovery and support. The initiative also offers peer-to-peer counselling, psychosocial support, legal assistance, and referrals to SRHR and protection services, ensuring a holistic response to the needs of survivors.

In addition, the practice includes structured capacity-building and awareness-raising activities aimed at both rights holders and duty bearers. Women and girls with disabilities are supported through independent living skills training, leadership development, and empowerment activities designed to strengthen autonomy and participation in decision-making processes. At the same time, healthcare providers, police officers, emergency services, social workers, and local authorities receive training on disability-inclusive, rights-based, and gender-sensitive approaches to SRHR and violence prevention.

The initiative also places strong emphasis on advocacy and systemic change. It promotes the development of disability-inclusive laws and policies aligned with the CRPD and strengthens regional cooperation through the Central Asian Network of Women with Disabilities. This regional dimension enables knowledge exchange, joint advocacy, and collective action across countries.

Impact

Key achievements of the initiative include providing hundreds of women and girls with disabilities with psychosocial support, legal aid, and access to safe accommodation. It has also contributed to increased awareness among service providers and state institutions regarding disability inclusion, informed consent, accessible communication, and prevention of violence. Furthermore, it has strengthened the leadership and meaningful participation of women with disabilities in advocacy processes and decision-making spaces, while improving regional collaboration and visibility of SRHR issues affecting women with disabilities in Central Asia.

By combining direct services, capacity-building, advocacy, and regional cooperation, this initiative demonstrates a comprehensive, disability-led, and rights-based approach to SRHR and independent living. Moreover, it contributes to increased safety, autonomy, and inclusion of women and girls with disabilities.

Additional information:

- Union of People with Disabilities Ravenstvo: www.ravenstvo.kg

7.5. Advancing SRHR through inclusive healthcare access, parenting support, and legal advocacy for persons with disabilities in Adjara, Georgia

Background

This good practice originates from the work of the Alliance of Women with Disabilities (AWD Georgia) in the Adjara region of Georgia. The initiative takes a comprehensive approach to advancing sexual and reproductive health and rights (SRHR) for persons with disabilities by combining access to inclusive healthcare services, economic support mechanisms, policy advocacy, and responses to sexual violence.

The initiative responds to multiple structural barriers faced by persons with disabilities in relation to SRHR, including financial constraints limiting access to healthcare, persistent stigma surrounding disability and parenthood, and systemic exclusion from reproductive health services. It also addresses the critical issue of sexual violence against persons with disabilities, including children and adolescents, and the lack of effective protection and accountability mechanisms.

Description

A central component of the practice is the establishment of a partnership with the "Medfem" clinic in Batumi, through which free cancer screening services and educational sessions are regularly provided to women with disabilities. This collaboration has improved access to preventive healthcare services and strengthened awareness of SRHR among women with disabilities in the region.

The initiative also includes strong advocacy efforts that led to the introduction of a one-time financial support programme of 2,000 GEL by the Government of the Autonomous Republic of Adjara. This programme is available to women with disabilities starting from pregnancy and is also extended to men with disabilities registered in Adjara who have children under three years old. Since its implementation, approximately 120 individuals have benefited from this support, the majority being fathers with disabilities. The programme represents an important recognition of the parenting roles and rights of persons with disabilities.

Further advocacy efforts contributed to the inclusion of persons with disabilities as a priority group in regional state-funded in-vitro fertilization (IVF) programmes, marking a significant step toward improving equitable access to reproductive health services and supporting the right to family life.

In addition, the organisation undertakes rights protection and legal advocacy work in response to sexual violence. This includes public awareness campaigns and cooperation with investigative authorities, such as the Prosecutor's Office, to support accountability in cases of sexual violence against girls and women with disabilities.

Impact

Key outcomes of the initiative include improved access to preventive cancer screening services, the establishment of a targeted financial support mechanism benefiting persons with disabilities in their parenting roles, increased inclusion of persons with disabilities in reproductive health policy frameworks, and strengthened visibility and accountability in cases of sexual violence. The initiative has also contributed to challenging stigma related to disability, sexuality, and parenthood in the Adjara region.

The target group includes women and men with disabilities in the Adjara region of Georgia, with a particular focus on persons of reproductive age and parents with disabilities, as well as survivors of sexual violence.

This practice demonstrates a multi-dimensional, rights-based approach to SRHR that integrates healthcare access, economic support, policy advocacy, and protection mechanisms to advance equality and inclusion for persons with disabilities.

Additional information:

- Official Facebook page: https://www.facebook.com/AWDgeorgia/
- Awareness-raising activities (Video): https://www.facebook.com/AWDgeorgia/videos/6010132187831 23/
- Awareness-raising activities (Post): https://www.facebook.com/AWDgeorgia/posts/pfbid0BNePZFouZsTdevP5RNpUi95qf5B1w2EGtZncBCxDurDrxaUmRkisiCJ5qGsJZ8drl
- Media coverage regarding fight against sexual violence: https://batumelebi.netgazeti.ge/news/481865/

7.6. Promoting SRHR for persons with disabilities through an accessible online platform and peer exchange in Albania

Background

This good practice originates from the development and launch of the online platform "PakTabu" in Albania, implemented through the cooperation of UNFPA Albania and the "Se Bashku" Foundation, within the framework of the project "Reduce Gender-based Violence and harmful practices through Gender Responsive Governance," funded by the Government of Italy and implemented by UNFPA in partnership with the Albanian Government.

The initiative responds to persistent barriers faced by persons with disabilities in accessing comprehensive sexual and reproductive health and rights (SRHR) information, including limited availability of accessible and inclusive sexuality education, stigma around disability and sexuality, and significant obstacles in reporting and responding to gender-based violence. It also addresses gaps in accessible information and communication, as well as the lack of safe spaces where persons with disabilities can share experiences and access peer support.

Description

A central component of the initiative is the creation of "PakTabu," an accessible online platform designed to provide information on sexuality and disability in Albanian. The platform offers comprehensive sexuality education content and includes an interactive forum where users can discuss experiences, ask questions, and receive peer support. It is designed both for persons with disabilities and for wider audiences interested in understanding disability and sexuality, thereby contributing to broader awareness-raising and stigma reduction.

The platform was developed with the contribution of an Italian activist and web designer with expertise in sexual and reproductive health and rights for persons with disabilities, ensuring that both accessibility and content reflect inclusive and rights-based approaches. The initiative was

officially launched on 7 May 2026 during a national roundtable event in Tirana, followed by additional dissemination activities and media engagement to increase visibility and outreach.

In addition to the platform itself, the initiative includes the dissemination of findings from an inquiry on accessibility in infrastructure, information, and communication for persons with disabilities in the municipalities of Dibër, Tirana, and Vlorë. The inquiry examined barriers faced by persons with disabilities in accessing and reporting gender-based violence and assessed the accessibility of key institutions, including municipalities, police stations, shelters for women, and health centres.

The roundtable event also provided a space for exchange among government representatives, international organisations, and disability rights actors, including UNFPA Albania, the Italian Agency for Development Cooperation, and national partners. Discussions focused on improving accessibility in services, strengthening SRHR information systems, and ensuring meaningful participation of persons with disabilities in policy and service design.

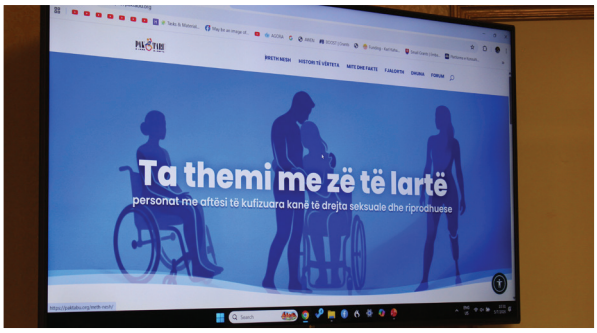
Impact

Key outcomes of the initiative include the establishment of a dedicated national-level online resource on sexuality and disability in the Albanian language, increased opportunities for peer exchange and information-sharing among persons with disabilities, and improved public visibility of SRHR issues at the intersection of disability and gender-based violence. The initiative has also contributed to strengthened multi-stakeholder collaboration between civil society, government institutions, and international partners working on disability inclusion and SRHR.

The target group includes persons with disabilities in Albania, particularly those seeking accessible information on sexuality, relationships, and SRHR, as well as professionals, caregivers, and wider stakeholders engaged in disability inclusion and gender-based violence prevention.

Additional information:

- Pak Tabu
- Foundation Se Bashku



7.7. Advancing sexual and reproductive health and rights for persons with spina bifida and hydrocephalus through youth-led advocacy, research and peer support

Background

The International Federation for Spina Bifida and Hydrocephalus (IF) has developed a comprehensive and participatory approach to advancing the sexual and reproductive health and rights (SRHR) of persons with Spina Bifida and Hydrocephalus (SBH). The initiative responds to persistent barriers faced by persons with SBH, including stigma and misconceptions about disability and sexuality, inaccessible sexuality education, limited opportunities to discuss sexuality and relationships with healthcare professionals, and insufficient recognition of SRHR within disability-related policies and services.

Through youth-led research, advocacy, policy development, awareness-raising, and peer support activities, IF has worked to challenge these barriers and strengthen the recognition of the sexual rights, autonomy, and wellbeing of persons with SBH across the life course.

Description

A key component of this work was the 2019 International Youth Sexuality Project, which included a global survey involving 399 participants from Europe, Africa, the Americas, Oceania, and South West Asia/North Africa. Led by the IF Youth Group, the survey explored issues such as self-confidence, body image, relationships, sexuality, and access to information. The findings highlighted the impact of stigma, inaccessible sexuality education, and inadequate support on the wellbeing of young people with SBH. The project also produced practical resources to support awareness and discussion of sexuality and relationships while placing lived experience at the centre of knowledge generation.

Building on this evidence, IF has promoted disability-inclusive SRHR through advocacy and policy dialogue. In 2020, the organisation convened an international online event with disability organisations, policymakers, healthcare advocates, and representatives of the disability movement to address disability rights and sexual health. The event highlighted the importance of inclusive sexuality education, accessible healthcare services, and the implementation of SRHR in line with the CRPD.

The organisation has also translated lived experiences into policy recommendations through its *Statement on Mental, Physical and Sexual Health for Youth with SBH*. Developed through youth-led advocacy, the statement addresses barriers related to healthcare, sexuality education, mental health, social participation, relationships, and transition to adulthood, while providing recommendations for policymakers, healthcare professionals, and other stakeholders to promote more inclusive and accessible services.

In addition, IF regularly organises peer-support webinars and international exchanges that create opportunities for persons with SBH of different ages to discuss independent living, relationships, sexuality, wellbeing, and participation in society. These initiatives promote mutual learning, empowerment, and community-building by enabling participants to share experiences and practical strategies across countries and generations. Recent examples include webinars organised for International Youth Day and the International Day of Older Persons.

A distinctive feature of IF's work is the leadership role played by young people with SBH, who have acted not only as beneficiaries but also as researchers, advocates, knowledge producers, and contributors to policy development. By centering lived experience and meaningful participation, the organisation has ensured that its activities reflect the priorities and realities of persons with SBH themselves.

Impact

Through these activities, IF has generated international evidence on the sexuality experiences of persons with SBH, increased visibility of often-neglected SRHR issues, strengthened peer support networks across countries, and contributed to policy and advocacy efforts promoting disability-inclusive healthcare, sexuality education, and wellbeing. IF's work demonstrates a holistic and rights-based approach that combines participatory research, advocacy, policy development, awareness-raising, and peer support to advance the sexual and reproductive rights of persons with SBH internationally.

Additional information:

- International Federation for Spina Bifida and Hydrocephalus: website
- Survey report: IF Sexuality Survey Report
- Resources: IF Sexuality Project Resources
- Event summary: IF Event on Disability Rights and Sexual Health
- Policy statement: IF Statement on Mental, Physical and Sexual Health for Youth with SBH
- International Day of Older Persons webinar: International Day of Older Persons 2025 Event
- International Youth Day webinar: International Youth Day Webinar

7.8. Peer support for sexual health and disability through experiential coaching, workshops, professional training, and advocacy in France

Background

This good practice originates from the work of SEXPAIR, based in Strasbourg, France, and led by Laetitia Rebord, a professional peer supporter specialising in sexual health and disability. The initiative focuses on advancing sexual and reproductive health and rights (SRHR) for persons with disabilities through peer-led approaches that centre lived experience, autonomy, and the deconstruction of ableist norms.

The initiative responds to systemic ableism that restricts or denies the affective and sexual lives of persons with disabilities. This includes widespread societal perceptions that persons with disabilities are asexual, infantilised, or incapable of consent, as well as the absence of accessible sexual education and the exclusion of disabled voices from sexual health discourse. It also addresses institutional overprotection and medico-social practices that limit autonomy and reinforce dependency, as well as the social isolation experienced by many disabled individuals in relation to intimacy and relationships.

Description

A central component of the practice is professional peer coaching delivered to persons with disabilities. This one-to-one support focuses on rebuilding self-esteem, addressing internalised ableism, and supporting individuals in developing strategies for autonomous and self-determined intimate and relational lives. The approach is grounded in experiential knowledge and peer support methodologies.

The initiative also includes structured peer-led training for professionals working in medico-social and healthcare settings, including sexologists, midwives, and social care staff, as well as families and caregivers. These trainings aim to challenge prejudices, strengthen understanding of the impact of ableism on sexual development, and promote a shift from protective or risk-avoidance approaches towards rights-based accompaniment that respects autonomy and informed consent.

In addition, SEXPAIR facilitates peer support groups for disabled adolescents, adults, and parents, creating safe and confidential spaces where participants can discuss desire, relationships, consent, and sexuality without judgment. These spaces contribute to breaking isolation and fostering collective empowerment through shared lived experience.

The initiative also carries out advocacy and awareness-raising activities, including workshops and public conferences. These activities promote the idea that "the private is political," challenging dominant medicalised narratives of disability and reinforcing a social and rights-based understanding of disability and sexuality. Through these actions, the initiative contributes to shifting public and institutional discourse on disability and sexual autonomy.

Impact

Key achievements of the practice include the empowerment of persons with disabilities to reclaim bodily autonomy and articulate their needs and desires in relationships, as well as a noticeable shift among participating professionals and families towards more rights-based, autonomy-oriented approaches. The initiative has also increased the visibility of the sexual lives and rights of persons with disabilities in public and professional debates, while contributing to the development of accessible pedagogical tools integrating gender, disability, and sexuality.

The target group includes persons with disabilities of all ages, including individuals with physical, sensory, cognitive, and invisible disabilities, as well as neurodivergent persons. Secondary target groups include families and informal caregivers, medico-social professionals, sexual health practitioners, and policy-makers.

This initiative demonstrates a peer-led, rights-based model for addressing sexuality and disability that combines individual support, professional capacity-building, and structural advocacy to advance SRHR and challenge ableist norms in France.

Additional information:

- Sexpair – https://www.sexpair.fr/

7.9. Advancing SRHR through feminist disability advocacy, peer support, and public awareness in Iceland (Tabú)

Background

This good practice originates from Tabú, a feminist disability movement in Iceland created by and for women with disabilities. The initiative focuses on advancing sexual and reproductive health and rights (SRHR), gender equality, bodily autonomy, and protection from sexual violence through community-based advocacy and peer support.

The initiative responds to persistent stigma, discrimination, and paternalistic attitudes towards women with disabilities in Icelandic society and service systems. These barriers often limit opportunities for self-determination, silence discussions on sexuality and sexual violence, and reinforce exclusion from equality and rights-based frameworks.

Description

A central component of the practice is the creation of safe, feminist, and disability-led spaces where women with disabilities can openly discuss sexuality, relationships, bodily autonomy, and lived experiences of discrimination and violence. Through peer support, community engagement, and public discussions, Tabú promotes collective empowerment and challenges dominant stereotypes surrounding disability and sexuality.

The initiative also carries out advocacy and awareness-raising activities aimed at shifting public discourse and increasing visibility of the sexual and reproductive rights of women with disabilities. These activities contribute to breaking long-standing taboos and promoting a rights-based understanding of sexuality as part of equality and citizenship.

Impact

Key outcomes of the initiative include increased visibility of disability and sexuality in public discourse, strengthened peer support networks among women with disabilities, and improved awareness of gender-based violence and sexual rights violations. The initiative has also contributed to creating safer spaces for dialogue and empowerment at community level.

The target group includes women with disabilities in Iceland, with a particular focus on those experiencing intersectional discrimination related to gender, disability, and sexuality.

Additional information:

- Tabú – feminist disability movement: https://tabu.is

7.10. Raising awareness on SRHR among young medical professionals through co-created learning and dialogue in Lithuania

Background

This good practice originates from the "Sex-Ability 2" project, implemented by the Association "The Fifth Corner" (Asociacija "Penktas Kampas") between 14 October 2024 and 14 October 2025, with funding from the European Youth Foundation. The project built on the earlier "Sex-Ability" initiative implemented in 2023 and aimed to strengthen awareness of the sexual and reproductive health and rights (SRHR) of young persons with disabilities among future healthcare professionals.

The initiative responds to the limited attention given to disability and sexuality in healthcare education in Lithuania, persistent stereotypes surrounding the sexuality of persons with disabilities, and the lack of opportunities for meaningful dialogue between persons with disabilities and medical professionals. It also addresses the need for practical guidance to support more inclusive and rights-based healthcare practices.

Description

The project actively involved young persons with disabilities in the co-design and implementation of a two-day in-person workshop held on 5–6 April 2025 in Kaunas, Lithuania. The workshop brought together 20 participants under the age of 30, including six young persons with different types of disabilities and 14 medical and health-related students and early-career professionals, such as nursing, medical psychology, and physiotherapy students.

The educational programme was based on the principles of non-formal education and Human Rights education. Before the workshop, participants with disabilities were consulted to ensure that the programme was accessible, inclusive, and reflected their priorities and experiences. The workshop was facilitated by three experienced trainers, including Laura Alčiauskaitė, an ENIL member and trainer.

Following the workshop, participants collaborated over a three-month period to co-create a set of practical recommendations on addressing the sexual and reproductive rights of persons with disabilities within healthcare settings. The recommendations combined the lived experiences of young persons with disabilities, perspectives from medical and nursing students, and expert input from professional sexologists. They were published in both digital and printed formats and disseminated to Lithuanian healthcare institutions, professional associations, and organisations representing doctors, nurses, psychologists, and other healthcare professionals.

Throughout the project, particular emphasis was placed on fostering dialogue and equal participation between persons with disabilities and future healthcare professionals. Interactive methods, including Fishbowl discussions and peer learning activities, created opportunities for participants to openly discuss experiences, challenge stereotypes, and jointly explore rights-based approaches to SRHR.

Impact

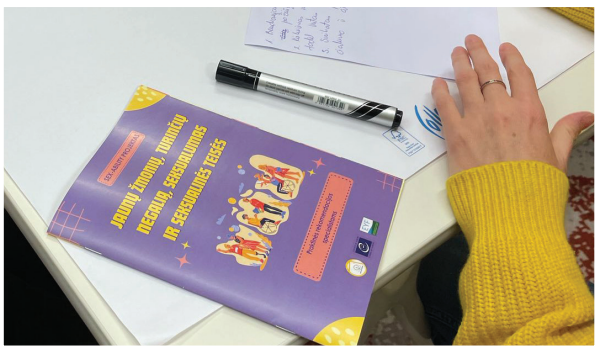
The project created a rare opportunity in Lithuania for young persons with and without disabilities to learn together in an inclusive environment. Participants reported that the workshop fos-

tered mutual understanding, empathy, and lasting professional and personal connections. The group continued exchanging information after the project by creating an active online community where participants share resources and discuss disability rights and SRHR.

Young persons with disabilities highlighted that the project provided a safe space where they felt heard, respected, and recognised as experts of their own experiences. Many emphasised that discussions around sexuality and disability remain highly taboo in Lithuania and valued the opportunity to contribute directly to recommendations that could influence future healthcare practice.

Medical and nursing students reported significant changes in their understanding of disability and sexuality. Many encountered the social model of disability for the first time and gained greater awareness of the barriers that persons with disabilities experience within healthcare settings. Participants expressed increased confidence in addressing SRHR issues in their future professional practice and recognised the importance of challenging stigma within both healthcare services and wider society.

Beyond the direct participants, the project contributed to increasing the availability of practical, Lithuanian-language resources on disability and SRHR. The dissemination of the recommendations to healthcare organisations and educational institutions has the potential to improve healthcare professionals' knowledge and contribute to more inclusive and respectful healthcare services. More broadly, the initiative supports longer-term change by promoting disability awareness, strengthening dialogue between healthcare providers and persons with disabilities, and fostering greater social inclusion and respect for sexual and reproductive rights in Lithuania.



Good Practices from Lithuania

7.11. Promoting inclusive participation and sexual and relational rights of persons with intellectual disabilities through participatory research and equality work in Iceland (Jafnrétti Fyrir Alla)

Background

This good practice originates from the Icelandic equality initiative Jafnrétti Fyrir Alla ("Equality for All"), which implements inclusive and participatory approaches to gender equality and rights-based inclusion, with a focus on persons with intellectual disabilities.

The initiative responds to gaps in meaningful participation and recognition of the sexual and relational rights of persons with intellectual disabilities, as well as limited opportunities to engage in discussions on masculinity, relationships, sexuality, and equal rights within structured equality frameworks.

Description

A central component of the practice is participatory research that actively involves men with intellectual disabilities as contributors and knowledge-holders. The project explores themes such as masculinity, sexuality, relationships, participation, and access to rights-based opportunities, ensuring that lived experience is positioned at the centre of knowledge production.

The initiative also promotes empowerment and awareness-raising by creating inclusive spaces for dialogue and reflection on equality, relationships, and self-determination. This participatory approach strengthens recognition of persons with intellectual disabilities as active participants in shaping knowledge and policy discussions on equality and rights.

Impact

Key outcomes include increased awareness of relational and sexual rights among participants, strengthened empowerment and self-advocacy among men with intellectual disabilities, and improved visibility of disability-related equality issues within broader gender equality discourse in Iceland.

The target group includes persons with intellectual disabilities, particularly men, as well as stakeholders involved in equality, disability inclusion, and social policy development.

Additional information:

- Jafnrétti Fyrir Alla: https://www.facebook.com/jafnrettifyriralla/?locale=is_IS
- Reykjavík initiative: https://reykjavik.is/sites/default/files/jafnretti_fyrir_alla_ekki_bara_konur_og_kalla.pdf

7.12. Neuroqueer women: an exploration of sexual identity and barriers to sexual citizenship in Ireland

Background

This good practice originates from the Master's research of Jane Madden, completed as part of the Disability Studies, Rights and Inclusion programme at University of Leeds. The study explored the experiences of neurodivergent women and non-binary people in relation to sexuality, identity, and sexual citizenship in Ireland. The research contributes to a growing body of evidence highlighting the importance of neurodiversity-affirming approaches within SRHR frameworks.

Description

A central contribution of the research is its challenge to common stereotypes that portray neurodivergent people as either asexual, sexually inappropriate, or incapable of navigating intimate relationships. Instead, the study recognizes neurodivergent women and non-binary people as sexual beings with diverse desires, identities, relationship preferences, and ways of expressing intimacy. It emphasizes the importance of respecting self-identification and allowing flexibility in how individuals understand and describe their gender and sexuality.

The research also highlights the need for accessible, explicit, and inclusive communication in sexuality education and relationship support. It recommends the use of clear, direct, and concrete language when discussing consent, relationships, sexual health, and identity. The findings underline the importance of fact-based, secular, and universally designed sexuality education that avoids ambiguity and is accessible to people with different communication styles and learning needs. The study further encourages explicit communication between partners regarding consent, emotional needs, sensory preferences, and boundaries before, during, and after sexual activity.

Another relevant area addressed is the pressure many neurodivergent people experience to conform to traditional gender norms. The study advocates for challenging assumptions that associate femininity with passivity, submissiveness, or heterosexuality and calls for the creation of environments where neurodivergent individuals can safely express themselves without the need to mask their identities or conform to social expectations. It also highlights the importance of respecting body dysphoria, gender nonconformity, and evolving identities.

The research additionally promotes stigma-free exploration of sexuality and relationships. It encourages open discussion of queer identities, self-pleasure, sex toys, and diverse relationship structures without moral judgement. By recognizing the diversity of sexual expression among neurodivergent people, the study contributes to a more inclusive understanding of sexual citizenship and bodily autonomy.

Impact

The work represents an evidence-based practice for advancing disability-inclusive and neurodiversity-affirming approaches to SRHR, providing practical recommendations for educators, healthcare professionals, support services, and policymakers seeking to create more accessible, respectful, and empowering environments for neurodivergent people.

Additional information:

- #ZeroCon26, interview with researcher Jane Madden

7.13. Other emerging and complementary good practices across Europe

Alongside structured national and organisational good practices, several emerging initiatives and developments across Europe illustrate how SRHR, intimacy, and disability are increasingly entering public, cultural, academic, and service-related domains. While varying in scope, institutionalisation, and accessibility, these examples collectively contribute to expanding visibility, debate, and experimentation in the field of disability and sexuality.

In **Portugal**, initiatives related to sexual assistance for persons with disabilities are gradually being introduced, contributing to broader public and professional discussions on autonomy, intimacy, and the recognition of sexual rights. Although still in an early stage of development and not yet consistently regulated or widely implemented, these initiatives reflect an emerging recognition of sexuality as part of independent living.[32]

In **Greece**, disability and sexuality have gained visibility through documentary filmmaking and cultural production. Documentaries such as *Sexability: A Story About Duchenne Muscular Dystrophy and Love and The Stuff We Are Made Of* explore experiences of intimacy, relationships, and sexuality among persons with different impairments. While representation remains limited in diversity and depth, these productions contribute to reducing stigma and opening public space for discussion on disability and sexuality.[33]

In **Norway**, academic research has begun to examine the intersection between personal assistance services and sexual health. A study published in the Scandinavian Journal of Disability Research explored how personal assistance can influence autonomy, attitudes towards sexuality, and access to intimate life for persons with disabilities. This contributes to an emerging evidence base on the role of support services in enabling or restricting sexual rights within independent living frameworks.[34]

In the **Netherlands**, the Snoezelzorg Foundation provides services related to sexuality and intimacy for older persons, persons with disabilities, and persons with psychosocial support needs. The organisation offers both counselling and practical support tailored to individual needs, addressing intimacy, sensory experience, and sexual wellbeing within care settings.[35]

In **Belgium**, Aditi vzw (AditiWB) provides training and guidance for professionals supporting sexual assistance and intimacy services for persons with disabilities. The organisation contributes to professional capacity-building in the field of sexuality and disability, although challenges remain in ensuring full accessibility of information and communication tools, including digital platforms.[36]

In **Germany**, Weibernetz e.V., the nationwide political advocacy network of disabled women, continues to campaign for improved living conditions and for the full implementation of SRHR for disabled women and girls. The network has also produced a short animated film featuring women with different impairments advocating for better access to gynaecological care. Anoth-

32 To read more: https://link.springer.com/article/10.1007/s13178-026-01353-2.

33 To read more: https://www.imdb.com/title/tt36041698/ and https://en.aiff.gr/international_documentaries_competition_2025/arthro/the_stuff_we_are_made_of-15557183/.

34 To read more: https://sjdr.se/articles/10.16993/sjdr.1090?utm_source=chatgpt.com.

35 To read more: https://www.snoezelzorg.nl/.

36 To read more: https://www.aditiwb.be/accompagnement-sexuel/.

er important initiative is Fachstelle Gewaltschutz bei Behinderung, a collective of disabled and non-disabled women working to combat violence against disabled women and people of other genders. The organisation provides counselling services, educational materials, and awareness-raising activities focused on violence prevention and bodily autonomy.[37]

7.14. From principles to practice: consolidated outcomes

These good practices illustrate the concrete and transformative ways in which sexual and reproductive health and rights for disabled people can be advanced across different contexts. They are crucial because they move beyond abstract commitments and demonstrate how rights can be implemented in practice through healthcare reform, inclusive service delivery, peer support models, participatory research, advocacy, and legal and policy change. The examples collected show how barriers to access to health services, information, and support can be reduced through accessible infrastructure, professional training, peer-led education, and the development of tools such as handbooks, online platforms, policy frameworks, and research-based recommendations.

Concretely, these initiatives have contributed to improving access to healthcare (including gynaecological services, cancer screening, and reproductive health care), strengthening independent living through personal assistance and support services, expanding access to parenting rights and reproductive choices, and improving preventive responses to gender-based and sexual violence. They also play a key role in deconstructing normative and ableist understandings of sexuality by challenging stereotypes around asexuality and infantilisation, affirming the right to desire, intimacy, pleasure, and self-determination for persons with disabilities.

At the same time, several initiatives have produced evidence and tools that are directly transferable to policy and practice, including surveys, participatory research projects, national and international policy statements, training curricula, accessibility assessments, and legislative or funding reforms supporting disability-inclusive SRHR. These outputs provide a concrete basis for system change, informing healthcare protocols, education programmes, protection systems, and rights-based legislation.

Hence, these experiences should be understood as resources for exchange, dialogue, inspiration, training, and education across countries and sectors. They demonstrate that when disabled people are meaningfully involved as researchers, advocates, service users, and leaders, it is possible to build more inclusive systems that improve health outcomes, prevent violence, expand access to parenthood, ensure equal opportunities for pleasure and relationships, and strengthen sexual and reproductive autonomy on an equal basis with others.

37 To read more: https://www.weibernetz.de/association-weibernetz.html and https://www.maedchenhaus-bielefeld.de/gewaltschutz-bei-behinderung.html.

8

Conclusion

Sexual and reproductive health and rights are often treated as a specialised area of healthcare. This report demonstrates that they are something much more fundamental: they are a condition for Independent Living.

The barriers described throughout this report are not isolated failures within health systems. They reflect a broader denial of disabled people's autonomy and equal citizenship. When disabled people cannot obtain accessible information, cannot enter a clinic, cannot make legally recognised decisions about their own bodies, cannot access personal assistance to attend an appointment or maintain a relationship, cannot become parents without scrutiny, or continue to face forced sterilisation, institutionalisation, violence and discriminatory assumptions, their rights are restricted far beyond the healthcare setting. Their freedom to shape their own lives is constrained.

Independent Living is built on the idea that disabled people have the same right as everyone else to make choices, take risks, form relationships, create families, experience intimacy, and participate fully in community life. Sexual and reproductive rights are therefore inseparable from the principles of self-determination, dignity and equality. Control over one's body is inseparable from control over one's life.

The evidence collected for this report shows that barriers exist at every level. Physical and communication inaccessibility continues to exclude many disabled people from basic services. Inaccessible information prevents informed choices. Financial hardship, inaccessible transport and the shortage of community-based services make rights impossible to exercise in practice. Guardianship systems continue to deny legal capacity and transfer deeply personal decisions to others. Institutionalisation deprives people of privacy, intimacy and opportunities to build relationships. Persistent ableism, infantilisation and desexualisation lead healthcare professionals, families and society to question disabled people's capacity to consent, become parents or express their sexuality. At the same time, many disabled people – particularly women, people with intellectual or psychosocial disabilities, LGBTIQ+ people, migrants, racialised communities and those living in poverty or rural areas – experience multiple and intersecting forms of discrimination that further deepen exclusion.

These barriers are interconnected because the Independent Living pillars are interconnected. Accessible information, personal assistance, legal capacity, accessible transport, housing, peer support, supported decision-making, adequate income, inclusive education and protection from violence all directly influence whether disabled people can exercise their sexual and reproductive rights. Progress in one area cannot fully compensate for failures in another. This is why recognising SRHR as an Independent Living pillar is both necessary and overdue.

The experiences presented throughout this report also demonstrate that disability policy and sexual and reproductive rights policy cannot continue to develop in parallel. Disability strategies that overlook bodily autonomy, sexuality, family life and reproductive justice remain incomplete. Equally, SRHR policies that fail to address accessibility, reasonable accommodation, legal capacity and community-based support exclude disabled people in practice, regardless of their formal rights.

8.1. Recommendations to policy and decision makers

Realising this pillar requires a comprehensive rights-based approach grounded in the CRPD. Therefore, we call on Governments to take the following steps, as a matter of priority:

- Fully abolish forced sterilisation, forced contraception and all forms of reproductive coercion;
- Replace guardianship regimes with supported decision-making;
- Guarantee accessible, affordable and community-based SRHR services;
- Invest in disability-inclusive and intersectional training for healthcare professionals and educators;
- Provide comprehensive sexuality education in accessible formats;
- Strengthen personal assistance and peer support;
- Close down institutional settings that deprive people of privacy and autonomy;
- Ensure effective protection from gender-based and sexual violence;
- Recognise disabled people's equal rights to relationships, parenthood, intimacy and pleasure;
- Support research and dialogue on sexual assistance, including models, legal frameworks and safeguards that uphold disabled people’s rights, autonomy and choices;
- Develop awareness-raising initiatives to challenge stigma and stereotypes about disabled people’s sexuality, relationships and reproductive choices.

8.2. Nothing without us

These measures must be developed together with disabled people and their representative organisations, recognising lived experience as essential expertise in policymaking.

Ultimately, this report calls for a shift in perspective. Disabled people should no longer be viewed as passive recipients of care or protection, but as rights holders whose choices, identities and aspirations deserve equal respect. Independent Living is not achieved simply by enabling people to live outside institutions, but it is realised when disabled people have free control over every aspect of their lives, including their bodies, their relationships, their reproductive choices and their future.

Without sexual and reproductive health and rights, Independent Living remains incomplete. When these rights are respected, protected and fulfilled, disabled people gain not only access to healthcare, but the freedom to live, love, participate and belong as equal members of society.

Glossary

Ableism
Discrimination, prejudice and systems that privilege non-disabled people while devaluing disabled people. Ableism is expressed through attitudinal, physical, communication, sensory, institutional and digital barriers that prevent disabled people from participating equally in society and exercising their rights. It also reinforces the idea that non-disabled bodies and minds are the norm or more valuable than others.

Bodily autonomy
The right of every person to make free and informed decisions about their own body, sexuality, health and reproduction without coercion, violence or discrimination.

CEDAW
The *Convention on the Elimination of All Forms of Discrimination against Women*, a United Nations human rights treaty that protects the rights of women and girls, including sexual and reproductive rights.

Chronic pain
Pain that persists for more than three months or beyond the expected period of healing. Chronic pain can affect physical health, mental well-being, participation and quality of life, and may require ongoing healthcare and support.

Comprehensive sexuality education (CSE)
Evidence-based, age-appropriate education about relationships, sexuality, consent, human rights, health and diversity that enables people to make informed decisions and develop respectful relationships.

CRPD
The *United Nations Convention on the Rights of Persons with Disabilities*, the international human rights treaty that recognises disabled people as rights holders and establishes states' obligations to ensure equality, accessibility, autonomy and inclusion.

Desexualisation
The harmful assumption that disabled people are not sexual beings or do not have sexual identities, desires, relationships or families.

Disabled People's Organisation (DPO)
An organisation that is led, governed and represented by disabled people and advocates for their rights, participation and self-determination.

Easy Read
Information presented in plain language with clear layout and, where appropriate, images or symbols to make information more accessible, particularly for people with intellectual impairments and others who benefit from simplified communication.

Endometriosis
A chronic condition in which tissue similar to the lining of the uterus grows outside the uterus. It can cause severe pain, fatigue, heavy menstrual bleeding and, for some people, fertility challenges.

Fetishisation
Treating a person's impairment as an object of sexual fascination or curiosity rather than recognising them as a person with equal dignity, autonomy and rights.

Forced contraception

The use or administration of contraception without a person's free and informed consent or through coercion or pressure.

Forced sterilisation

A permanent medical procedure that removes a person's reproductive capacity without their free and informed consent. It is recognised internationally as a serious human rights violation.

Gender-affirming care

A range of social, psychological and healthcare services that support a person's gender identity. Depending on individual needs, this may include counselling, social transition, hormone therapy or other forms of care.

Gender-based violence (GBV)

Violence directed against a person because of their gender or that disproportionately affects people of a particular gender. It includes physical, sexual, psychological and economic violence.

Gender dysphoria

Distress or discomfort that some people may experience when their gender identity differs from the sex assigned to them at birth. Not all transgender or gender-diverse people experience gender dysphoria.

Guardianship

A legal arrangement in which another person is authorised to make decisions on behalf of someone else. Guardianship may restrict a person's legal capacity and decision-making rights and is increasingly being replaced by supported decision-making in line with the CRPD.

Hypersexualisation

The harmful stereotyping of a person as excessively sexual or lacking control over their sexuality because of prejudice or discrimination.

Independent Living

The right of disabled people to have choice and control over their own lives, including where and with whom they live, with access to the support and services necessary to participate fully and equally in society.

Independent Living Pillars

The key rights, supports and conditions identified by the Independent Living movement as necessary for disabled people to live independently and participate fully in society.

Infantilisation

Treating disabled adults as though they are children by denying their autonomy, decision-making, privacy or adulthood.

Institutionalisation

The segregation of people in residential institutions or other settings where they lack choice and control over their daily lives and are separated from the wider community.

Intersectionality

A framework recognising that people may experience multiple and overlapping forms of discrimination based on disability, gender, race, ethnicity, sexual orientation, gender identity, age, migration status, class or other characteristics.

Legal capacity

The right of every person to make their own decisions and have those decisions recognised by law, with support where necessary.

LGBTIQ+

An inclusive acronym referring to lesbian, gay, bisexual, transgender, intersex and queer or questioning people, with the "+" recognising the diversity of sexual orientations, gender identities and sex characteristics.

Libido

A person's sexual desire or interest in sexual activity. Libido varies throughout life and may be influenced by health, hormones, medication and personal circumstances.

Menstrual health

A state of physical, mental and social well-being related to the menstrual cycle, including access to accurate information, menstrual products, healthcare, sanitation and support.

Menstrual poverty

Limited access to affordable menstrual products, appropriate sanitation facilities or menstrual health information, affecting health, dignity and participation in everyday life.

Neurodivergent

A term used by many people whose brains function differently from what society considers typical, including many autistic people, people with ADHD, dyslexia and other forms of neurodivergence. Neurodiversity recognises these differences as part of natural human variation.

OHCHR

The *Office of the United Nations High Commissioner for Human Rights*, the United Nations body responsible for promoting and protecting human rights worldwide.

Personal assistance

User-led support that enables disabled people to live independently, exercise choice and control, and participate fully in all aspects of life.

Premenstrual Dysphoric Disorder (PMDD)

A severe form of premenstrual syndrome characterised by significant emotional, psychological and physical symptoms before menstruation that can substantially affect daily life.

Reasonable accommodation

Necessary and appropriate modifications or adjustments that enable disabled people to enjoy their human rights and fundamental freedoms on an equal basis with others, without imposing a disproportionate or undue burden.

Reproductive coercion

Behaviour that interferes with a person's reproductive autonomy through pressure, manipulation or control over decisions about contraception, pregnancy, abortion or parenthood. It may be perpetrated by intimate partners, family members, caregivers, institutions or professionals.

Reproductive health

A state of physical, mental and social well-being in all matters relating to the reproductive system. It includes the ability to make informed decisions about reproduction and to access quality healthcare throughout the life course.

Reproductive rights

Human rights that guarantee individuals the freedom to make informed decisions about whether, when and how to have children, and to access the information, services and support needed to exercise those choices free from discrimination, coercion and violence.

Sexual citizenship

The recognition that everyone has equal rights to intimacy, relationships, sexual expression, pleasure and bodily autonomy, and to participate fully in society as sexual and relational beings, without discrimination.

Sexual health

A state of physical, emotional, mental and social well-being in relation to sexuality. It requires respect for sexual rights and the possibility of having safe, satisfying and consensual sexual experiences.

Sexual rights

Human rights related to sexuality, including the right to bodily autonomy, consent, privacy, access to information and healthcare, and the freedom to make decisions about one's sexual life without discrimination, coercion or violence.

SRHR (Sexual and Reproductive Health and Rights)

A set of human rights that guarantee everyone the freedom to make informed decisions about their bodies, sexuality and reproduction, together with access to quality healthcare, information and services that are available, accessible, acceptable and of good quality.

Supported decision-making

A process through which a person receives the support they choose to make and communicate their own decisions while retaining full legal capacity and control over their life.

Trauma

The physical, emotional, psychological or social impact of distressing or harmful experiences, including violence, abuse, discrimination, coercion or institutionalisation. Trauma affects people differently and may have long-term effects on health and well-being.

Trauma-informed approach

An approach to healthcare, education and support services that recognises the widespread impact of trauma, seeks to avoid re-traumatisation, and promotes safety, trust, collaboration, choice and empowerment.

UNFPA

The *United Nations Population Fund*, the United Nations agency working to ensure universal access to sexual and reproductive health and rights.

Universal health coverage (UHC)

A health system in which everyone can access quality health services without experiencing financial hardship.

About the European Network on Independent Living

The European Network on Independent Living (ENIL) is a disabled-led, cross-disability network of disabled people and their representative organisations. ENIL promotes the right to independent living, as set out in Article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD), its General Comments and the *Guidelines on deinstitutionalisation, including in emergencies*. ENIL's work is guided by the CRPD and the Independent Living principles, enshrined in the Independent Living Pillars. ENIL is active at the European level, and internationally, through cooperation with Centres for Independent Living from around the globe. ENIL's actions and activities are based on the social and the human rights models of disability, and on the principles of inclusive equality, self-determination, solidarity and intersectionality.

ENIL has participatory status with the Council of Europe (i.e. is a member of the Conference of INGOs) and consultative status with ECOSOC.

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