

**Day of General Discussion on art 5. – August 25, 2017**

**Session on Intersectional Discrimination**

**How does intersectional discrimination look like on the ground?**

**Andrea Parra, Director, Advocacy, CREA**

**aparra@creaworld.org**

Good morning, Madame Chair and Honorable Members of the Committee on the Rights of People with Disabilities. I am honored to be here to offer some additional elements of reflection and consideration for the drafting of a General Comment on article 5 of the CRPD. My name is Andrea Parra and I am the Advocacy Director at CREA, a feminist organization with over 10 years of experience working in the Global South to advance the sexual and reproductive rights of all people, in particular, of marginalized persons such as women with disabilities, trans persons, adolescents and sex workers.

Throughout the day, important discussions on the concepts surrounding the materialization of the right to equality and non-discrimination as enshrined in article 5 will take place. In the next few minutes, I would like to share with you stories and cases that illustrate the need to incorporate an intersectional perspective to recognize disability-based discrimination as it interlocks with other forms of exclusion, in particular on the basis of gender, gender expression, gender identity and sexual orientation. The information that I am sharing with you today about particular situations arises from the work in alliance with various DPO organizations and grassroots groups, located in India, Kenya, Nepal, and Colombia. They will show how this kind of discrimination operates and the kinds of barriers people with disabilities are facing and that the States have within their powers to remove.

In the area of sexuality and sexual and reproductive rights, compound stereotyping of women, trans and intersex persons results in specific forms of discrimination.

For example, and particularly in the case of women with intellectual disabilities, harmful stereotypes about their inability to raise children or about their asexuality or hypersexuality, result in legally-endorsed forced sterilization, forced abortion, removal of child custody and institutionalization.

**Sterilization**

With regards to the right to reproduce, the law and government institutions treat people with disabilities differently than people without disabilities, perpetuating a situation of disability and gender-based exclusion in violation of article 5.

Guardianship procedures in Colombia are generally the way through which the law condones intersectional discrimination: A family judge in a guardianship decision dated 2016 authorized the sterilization of an adolescent male with an intellectual disability affirming: “*He has a poor reproductive diagnosis and therefore, the risk-benefit allows for him to be a candidate for a definite sterilization procedure in his benefit, the benefit of his family and society*”.

Health providers and educators continue to advise parents of children and adolescents with disabilities that they should request sterilization, which is still seen as a way to address sexual violence: In decision T-303 of 2016 of Colombia’s Constitutional Court the mother of a woman with an intellectual disability who had requested the sterilization of her daughter and was denied, is quoted stating that “*due to the denial of her request her quality of life has changed because she is a mother head-of-household and must work to provide for her home, which means she has to leave her daughter alone for extended periods of time”.*

Decision T-063 of 2012 also illustrates these kinds of stereotypes: The reason to request the sterilization is that *“she runs away from home and doesn’t know how to assess the consequences of her actions, since unscrupulous persons or men could abuse her taking advantage of her situation and they could give her any sexually transmitted disease”*.

Despite the existence of comprehensive laws on gender-based violence, in Colombia forced sterilization of people with disabilities (who are largely women) does not activate any of the gender-based violence mechanisms and does not get registered as a case of violence.

In Kenya, a woman who had been sterilized without her consent stated in an interview conducted by the Mental Disability Advocacy Center: *“I don’t think I would get children. I will tell you something; you see here [lifts up the blouse and reveals a scar on her stomach] here I was made an operation. This is contraceptive, all of us had been done like this, we cannot get children. Nobody asked me. They should have asked me, because I love children […]. I feel bad, but what can I do now”.*

**Sexual Violence, Domestic Violence and Institutionalization**

There is pervasive discrimination in the identification, registration, investigation and response to sexual violence when the victim is a person with a disability. In Colombia, different agencies register cases of sexual violence against people with disabilities differently, making it extremely difficult to have a reliable assessment. As the Office of the High Commissioner on Human Rights’ study on art. 5 states “*Article 31 of the Convention requires States to collect data, including statistical and research data, to assess the de facto equality of persons with disabilities and to identify situations of structural discrimination. Data collected should contribute to the development of human rights indicators in order to assess comprehensively compliance with the Convention*”.

Women members of Colombian collective “Polimorfas”, in particular those with psychosocial disabilities have shared their experiences of attempted sexual assaults while they were forcibly institutionalized: *“I was institutionalized for the first time in Our Lady of Peace Clinic in Bogotá. I was very close to being sexually abused by two male nurses, who took advantage of the fact that I was under the effects of strong medications and could not resist. Someone made noise and they left but I could never denounce what happened because there were no witnesses . . . I was internalized there a second time and because I was afraid they would abuse me so I demanded to shower by myself and they would punish me by leaving me naked and not passing me my clothes.”*

It is virtually impossible for a person who is institutionalized to denounce these facts creating a situation of structural discrimination against them. States must find mechanisms to identify, investigate and redress sexual violence that occurs in institutional settings and ensure that victims are aware of their rights and can access legal counsel.

Poverty is a key factor in the way in which these types of intersectional discrimination take place. I represented an 18 year-old young woman who became pregnant at 17. Her mother took her to the Family Welfare Institute to ask for help and they proceeded to institutionalize her at a center for pregnant teens. One day she was masturbating and they took her to a psychiatrist who medicated her. Given that she was on psychiatric medication when she gave birth, she could not breastfeed her baby who the Institute placed at a separate protective center for babies. The now 18 year-old mother was transferred to a separate protective center where only children and adolescent with disabilities were housed, located two hours outside of the city. She did not see her baby for the first three months and had mastitis. They continued to medicate her to a point that her family found her unrecognizable because she couldn’t speak or relate to them. After she reached the age of 18, a judge denied a habeas corpus petition stating that because she had a disability, Protective Services could continue to house her beyond her 18th birthday.

In another case, a Deaf girl was being abused by her mother. A teacher in her school noticed the situation and took the girl to the authorities to tell what was happening. One way in which the abuse occurred is that the mother only knew signs for insults and only sign that to the daughter. Because they had no interpreter at the Family Commissary, the teacher was asked to play the role of interpreter. The mother was called and upon learning that the teacher had been the one bringing the case to the authorities, the family threatened her and she had to move. The lack of accommodations resulted in a denial of justice to the girl. The elements outlined in the study of the Office High Commissioner on Human Rights regarding reasonable accommodations are key to address these kinds of situations.

**Forced Psychiatry of Transgender and Lesbians as persons with a perceived impairment and of LGBT persons with disabilities.**

In several countries, among them Colombia, transgender persons are perceived to have a mental impairment and the State requires a psychiatric evaluation to grant access to gender-affirming hormone therapy or physical body modification.

On many occasions, the psychiatric evaluation performed aims at demonstrating that a person is “really transgender” and that they accommodate to specific gender stereotypes such as the kind of toys they used when they were children, to how many sexual partners they have had.

Another form of forced psychiatry performed on mostly lesbian women is the so-called “conversion therapy” where usually religiously-affiliated centers adopt a series of processes to “cure” someone of their lesbianism.

This form of psychiatric pathologization must be understood as a form of breaching the CRPD mandate under 5 and States should align all policies and practices to end it.

Homophobia and ableism combined result in particular forms of abuse, such as the one experienced by one of my clients in Colombia, who identifies as lesbian and who had been diagnosed with bipolar disorder. Her mother, to prevent her from seeing her girlfriend, called a psychiatric ambulance stating that her daughter was having a crisis and had her institutionalized for a month so she could not be in touch with her partner or any other members of her support network.

**Sexual Education**

In Colombia, a sexual education curriculum is mandatory in any formal education institution. Because inclusive education is not yet a reality in the country, segregation in education means that children with disabilities do not receive proper sex education, which should be considered another form of discrimination under art. 5.

Disinformation among children and adolescents with disabilities, as well as among families and service providers about sexuality is widespread.

For example, in India, one trainer on disability and sexuality said - *“Girls need to know about this, we feel that they need this information. Parents don’t want us to talk about this and are uncomfortable with this. But students and alumni are keen. Parents often feel that such talk ‘induces’ feelings within their children, but children are by their very nature, very curious about these things.”*

* A few quotes below provide a glimpse into lack of understanding on sexuality, gender and rights that some organizations might have:
	+ *“For persons with disabilities male or female problems are the same. Girls with disabilities of course we need to keep more restrictions on time and all.”*
	+ *“And when boys are sexually abused, they become homosexuals. However the parents do not want that boys will be taught about sexual abuse.”*
	+ *“Human beings have not degraded so much that they will harass or abuse the blind woman. In thirteen years we haven’t heard a single case.”*
	+ *“There are a bit of homosexual tendencies. I tried to separate them. From their body language and attitude I could make out. Percentage is very less. So forcibly I sent the girls home.”*
	+ *“We should have a standard for whether a person is fit for marriage.”*

**Positive Sexuality**

Finally, I would like to end this presentation referring to the need for States to engage in campaigns that promote positive sexuality among people with disabilities. Most commonly, persons with disabilities’ sexuality is discussed solely through a lens of violence, instead of a question of pleasure, desirability, enjoyment.

As a resident of Lumbini Park Mental Hospital, in Calcutta, India, who has been in the confines of the institution for over ten years put it:

*“No one thought that I can be in love or have physical needs. Do they not think that I am human? I loved him a lot. But the sheer fact that I showed some abnormal actions at times of my episodes, he used to shoo me away the moment he saw me looking at him. My mother would beat me up if I spoke about wanting a man. Why can’t I have wants?”*

Thank you very much.