**Center for Reproductive Rights**

**Submission to the Special Rapporteur on the Rights of Persons with Disabilities**

**Questionnaire on the right of persons with disabilities to the highest attainable standard of health**

**April 10, 2018**

The Center for Reproductive Rights (“the Center”), an international non-governmental legal advocacy organization dedicated to the advancement of reproductive freedom as a fundamental human right, submits this paper to the Special Rapporteur on the Rights of Persons with Disabilities following the mandate’s questionnaire on the right of persons with disabilities to the highest attainable standard of health. This submission includes an analysis of the legal framework on the right to health; discussion of the barriers faced by women and girls with disabilities in achieving their right to health; and recommendations for promoting the right to health for women and girls with disabilities.

1. **Legal framework on the right to health**
	1. Right to sexual health and reproductive health

The right to health, including sexual health and reproductive health, is enshrined in several international treaties, with the most relevant being the International Covenant on Economic, Social and Cultural Rights (CESCR)[[1]](#endnote-1) and the Convention on the Rights of Persons with Disabilities (CRPD). In its General Comment No. 14, the CESCR Committee sets forth four interrelated and essential elements of the right to health, finding that health facilities, goods, and services must be available, accessible, acceptable, and of good quality.[[2]](#endnote-2) In its subsequent General Comment No. 22, the CESCR Committee explicitly applies these principles to the right to sexual and reproductive health.[[3]](#endnote-3) This framework has also been utilized by other treaty monitoring bodies, including the Committee on the Rights of the Child (CRC Committee) and the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee).[[4]](#endnote-4)

As outlined by the CESCR Committee, the right to sexual and reproductive health includes a number of freedoms, including “the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health.”[[5]](#endnote-5) This right also requires entitlements, which include “unhindered access to a whole range of health facilities, goods, services and information.”[[6]](#endnote-6) The CRPD and CESCR Committees underscore that women and girls with disabilities have the same right to health as all women and girls, including the right to sexual and reproductive health.[[7]](#endnote-7)

The right to sexual and reproductive health includes sexual and reproductive health care but it also extends beyond to include the underlying determinants of sexual and reproductive health.[[8]](#endnote-8) These include “access to safe and potable water, adequate sanitation, adequate food and nutrition, adequate housing, safe and healthy working conditions and environment, health-related education and information, and effective protection from all forms of violence, torture and discrimination and other human rights violations that have a negative impact on the right to sexual and reproductive health.”[[9]](#endnote-9)

The CRPD recognizes the importance of fulfilling the right to sexual and reproductive health for persons with disabilities, particularly women and girls, and includes the most expansive language on reproductive rights of any UN human rights convention. The reproductive rights specifically enumerated in the CRPD include the rights “to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education,” to retain fertility on an equal basis with others, including for children and adolescents with disabilities, and to health on an equal basis with others, “including in the area of sexual and reproductive health and population-based public health programs.”[[10]](#endnote-10)

* 1. Right to non-discrimination and equality

The right to sexual and reproductive health is indivisible from and interdependent with other human rights, including the right to non-discrimination and equality.[[11]](#endnote-11) Where women’s rights to equality and non-discrimination are not fulfilled, women’s ability to access sexual and reproductive health services and make meaningful choices about their reproductive lives is limited. In addition, where women are unable to access sexual and reproductive health services, the inequalities and discrimination women face are exacerbated due to the differentiated impact that childbearing has on women’s health and lives, including in the spheres of access to education and employment. Gender inequalities create gender-specific barriers to the realization of women’s rights, including historical and systemic discrimination; gender stereotypes about women as mothers, caregivers, and child-bearers; and traditional and cultural beliefs about the role of women in society.

In its General Comment number 6, the CRPD Committee stresses that “[e]quality and non-discrimination are among the most fundamental principles and rights of international human rights law,”[[12]](#endnote-12) and in order to fulfil their obligations, “States parties are obliged to prohibit and prevent discriminatory denial of health services to persons with disabilities and to provide gender-sensitive health services, including those relating to sexual and reproductive health and rights.”[[13]](#endnote-13) According to the CRPD Committee and other treaty monitoring bodies, the principle of substantive equality, which is grounded in human rights, provides a framework by which to effectively recognize and address inequalities faced by women and girls, including those with disabilities. At its core, substantive equality requires states to identify the root causes of discrimination, such as power structures and social and economic systems reinforced by gender stereotypes and socialized gender roles, which lead to inequalities. Substantive equality also requires states to acknowledge that people experience inequality differently not only because of who they are as individuals but also because of the groups to which they belong. Finally, substantive equality requires that states measure progress on addressing inequalities by looking at equality of results for all persons, including the most marginalized, and ensuring equality of results, which may require enacting practices and policies targeting particular marginalized groups.[[14]](#endnote-14)

* 1. Right to autonomy and self-determination

Ensuring women’s right to non-discrimination and substantive equality requires that women are able to exercise autonomy and self-determination, as well as make important life decisions without undue influence or coercion. Autonomy is one of the foundational principles and core legal obligations outlined in the CRPD.[[15]](#endnote-15) According to the CRPD Committee, [a]t all times, including in crisis situations, the individual autonomy and capacity of persons with disabilities to make decisions must be respected.”[[16]](#endnote-16) Thus, State parties must “review the laws allowing for guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person’s autonomy, will and preferences.”[[17]](#endnote-17) Other Committees, including the CESCR, CEDAW, and Human Rights Committees, have underscored that women must be able to engage in autonomous decision-making about their health, which is necessary for the achievement of reproductive health and rights.[[18]](#endnote-18) States must ensure that women and girls have full exercise of autonomy, which requires that choices are meaningful, not limited by discrimination or lack of opportunities or possible results.[[19]](#endnote-19)

1. **Barriers to achieving the right to health**

The CRPD recognizes that women and girls with disabilities may face multiple forms of discrimination, due to both their gender and their disability,[[20]](#endnote-20) which undermine their reproductive autonomy and threaten their ability to access their right to sexual and reproductive health. Intersectional discrimination can hinder women and girls’ ability to achieve their right to sexual and reproductive health. This discrimination creates barriers that thwart the ability of women and girls with disabilities to achieve their rights, though the ways in which different barriers affect women with disabilities have not yet been widely studied.[[21]](#endnote-21) This section discusses two major barriers that prevent women and girls with disabilities from achieving the right to health: accessibility to health facilities, information, goods, and services, as well as forced or coerced sterilization.

* 1. Accessibility

An essential element of the right to sexual and reproductive health is that health facilities, information, goods, and services must be accessible.[[22]](#endnote-22) Because women and girls with disabilities may experience additional difficulties in accessing facilities, information, goods, and services, the needs of women and girls must be addressed through reasonable accommodation.[[23]](#endnote-23)

* + 1. *Access to health care facilities*

Women and girls with disabilities are sometimes unable to access reproductive and sexual health services because of physical barriers that prevent entry into healthcare facilities or to the use of transportation.[[24]](#endnote-24) For example, in Zimbabwe, a woman who injured her spine in a car accident and was using a wheelchair for mobility attempted to go to a local clinic to obtain information on sexual and reproductive health, but the clinic did not have ramps for people in wheelchairs to gain access to the buildings. When she asked the nurses for help, the nurses told the woman that they could not help her and that she should have brought her relatives to aid her. She was so humiliated and frustrated that she ultimately left the health care facility without receiving the information she sought.[[25]](#endnote-25)

* + 1. *Access to information*
			1. *In healthcare settings*

To be able to make informed decisions about their sexual and reproductive health, women and girls must be able to obtain medically accurate information. Access to sexual and reproductive health information in healthcare settings is an issue that affects all women and girls, as laws often restrict available information or require healthcare professionals to provide unnecessary or misleading information to women about their health.[[26]](#endnote-26)

Women with disabilities may face additional barriers to accessing information about their reproductive and sexual health distinct from other women due to communication barriers, lack of sexual and reproductive health information in accessible formats, or lack of opportunity to request the information from medical professionals.[[27]](#endnote-27) For instance, in Zimbabwe a disabled woman went to a clinic trying to gain information on sexual and reproductive health. The woman later explained that she was made to write what she wanted, but the nurses complained that they could not understand what she had written. After repeated conversations with five nurses coming in, the woman was so embarrassed that she left. She explained that she would not visit the hospital again.[[28]](#endnote-28) Another young woman with a disability in Latin America reported being humiliated by a gynecologist, who turned her away. The gynecologist told the young woman that she did not work with “abnormal people.”[[29]](#endnote-29) And, a young woman from Asia described not even knowing who to solicit for the desired information about sexual and reproductive health.[[30]](#endnote-30)

* + - 1. *Comprehensive sexuality education in schools*

Comprehensive and accurate sexuality education is a key component of ensuring that sexual and reproductive rights are fulfilled, by providing needed information at an early age so that people can make decisions about their sexual and reproductive health.[[31]](#endnote-31) Sexuality education is also important as a means to empower women and girls to protect themselves from unwanted pregnancies and STIs, such as HIV and AIDS, as well as to access sexual and reproductive health services.[[32]](#endnote-32) However, according to the World Health Organization, adolescents with disabilities are more likely to be excluded from sexuality education programs than other children.[[33]](#endnote-33)

Harmful stereotypes based on gender and disability constitute a core barrier hindering women and girls’ with disabilities access to comprehensive sexuality education. For example, girls with disabilities are sometimes perceived as asexual and, thus, sexuality education is believed to be unnecessary.[[34]](#endnote-34) One disabled woman in the United States explained, “As a society, we don’t talk about sex enough from a pleasure-based perspective. So much is focused on fertility and reproduction — and that’s not always something abled people think disabled people should or can do. We’re infantilized, stripped of our sexuality, and presumed to be non-sexual beings.”[[35]](#endnote-35) She explains that because people in the disability world are often infantilized and seen as asexual, they are not provided comprehensive sexual education, even when they want it.[[36]](#endnote-36)

Conversely, girls with disabilities may also be viewed as sexually uninhibited,[[37]](#endnote-37) and, therefore, they may be actively discouraged from having sex. Existing education for girls with disabilities often depicts sex as dangerous.[[38]](#endnote-38)

Even if sexuality education is available, educational materials are seldom made available in formats such as Braille, large print, simple language, pictures, sign language[[39]](#endnote-39) or digital fully accessible formats, among others appropriate, making it difficult for persons with disabilities to access health-related information, including sexuality education.[[40]](#endnote-40) Additionally, sexuality education rarely addresses distinct sexual and reproductive health needs and issues faced by women and girls with disabilities or the historical discrimination they face in accessing these services, including as a result of being subjected to forced or coerced sterilization, contraception, or abortion.[[41]](#endnote-41)

Moreover, the information that is provided to women and girls with disabilities about sexual and reproductive healthcare and parenting may actually undermine their rights, exposing a bias in the community that persons with disabilities are not able to care for their children.[[42]](#endnote-42) Social science research has documented that women with disabilities face skepticism about their ability to care for children from family members and healthcare professionals.[[43]](#endnote-43) Parents of children with intellectual disabilities in particular may be biased against the ability of their children to become parents, sometimes resulting in abusive practices such as forced sterilization.[[44]](#endnote-44)

* + 1. *Access to sexual and reproductive health goods and services*

Lack of access to modern contraceptive information and services means that women and girls are often unable to protect themselves from HIV and other sexually transmitted infections (STIs) or to control their fertility and reproduction, which results in negative consequences for their health and lives.[[45]](#endnote-45) Despite that contraception and other reproductive health goods and services are important for positive health outcomes, women and girls with disabilities are less likely to receive information about HIV prevention and safe sex, and are less likely to have access to prevention methods such as condoms.[[46]](#endnote-46) Contraceptive and abortion information and services may be unavailable to individuals with disabilities due to physical barriers, lack of accessible information, stigma, and discrimination.[[47]](#endnote-47)

Accordingly, women and girls with disabilities have an increased risk for HIV, STIs, and unwanted pregnancy. Furthermore, lack of access to and information about contraception and abortion can have particularly severe physical and mental consequences for women and girls who are victims of sexual violence.[[48]](#endnote-48) Women and girls with disabilities experience violence, including sexual violence, at higher rates than other women,[[49]](#endnote-49) making access to contraception and abortion essential for the exercise of their reproductive rights.

While all women, including women with disabilities, have difficulty navigating restrictive environments to fully exercise their reproductive rights,[[50]](#endnote-50) women with disabilities are placed at a particular disadvantage because of the additional difficulties they may face in accessing sexual and reproductive health services. Procedural barriers to abortion services, such as mandatory waiting periods and third-party authorization requirements, generally increase the burden associated with accessing abortion services and exacerbate existing barriers women and girls with disabilities may face in relation to accessible transportation.

* 1. Forced or coerced sterilization

Autonomy and equality are key principles for protecting women’s sexual and reproductive rights. There is broad consensus amongst the treaty monitoring bodies which recognizes that forced sterilization violates human rights and calls for an end to the practice. The CRPD Committee considers forced or coerced sterilization as a violation of the rights to bodily integrity, family and fertility, health, and legal capacity,[[51]](#endnote-51) noting that women with disabilities are subjected to high rates of forced sterilization because they are denied control over reproductive decision-making.[[52]](#endnote-52) The Committee Against Torture (CAT Committee) has found that forced sterilization violates women and girls’ right to be free from torture or ill-treatment.[[53]](#endnote-53) The CEDAW Committee has identified forced sterilization as a form of gender-based violence,[[54]](#endnote-54) and has called for complaints about forced sterilization to be duly investigated and for the provision of remedies and redress that are “adequate, effective, promptly granted, holistic and proportionate to the gravity of the harm suffered.”[[55]](#endnote-55) Other Committees, including the CRPD, CESCR Committee, and CRC Committees, have called on states to prohibit forced sterilization and provide reparations for women who have been victims of forced sterilization.[[56]](#endnote-56)

Women with disabilities are often forced to undergo sterilization,[[57]](#endnote-57) which takes away their reproductive capacity without free and informed consent. Forced or coerced sterilization of women and girls with disabilities is often used as a way to control menstrual cycles.[[58]](#endnote-58) It may also occur because of misconceptions and discriminatory attitudes about the ability of women with disabilities to take care of children.[[59]](#endnote-59) Women and girls with disabilities are particularly vulnerable to forced sterilizations performed under the auspices of legitimate medical care or as the result of decisions made by their parents, guardians, or doctors without the individual woman’s consent. The Special Rapporteur on Violence against Women called forced sterilization of women with disabilities a form of violence and classified it as a “global problem.”[[60]](#endnote-60) The UN Special Rapporteur on the Right to Health recognized that “[f]orced sterilizations, rape and other forms of sexual violence, which women with mental disabilities are vulnerable to, are inherently inconsistent with their sexual and reproductive health rights and freedoms.”[[61]](#endnote-61)

Despite that forced sterilization is a gross violation of human rights, many countries permit the of the practice on women and girls with disabilities. For instance, in the United States, the question of whether people with disabilities can exercise their legal capacity to provide consent remains a contentious legal issue, as courts are divided on the issue[[62]](#endnote-62) and at least ten states have statutory language authorizing a court to order the involuntary sterilization of a person with a disability.[[63]](#endnote-63) In France, five young women with mental disabilities brought suit in the European Court of Human Rights after they were forcibly sterilized.[[64]](#endnote-64) In Colombia, the Constitutional Court validated the practice of surgical sterilization of minors with intellectual and psychosocial disabilities. In its decision, the Court explained, “The decision to undergo surgical sterilization ensures more dignified living conditions for those who cannot make decisions related to the exercise of their reproductive freedom and that may be exposed to forced pregnancies in detriment of their dignity and personal integrity.”[[65]](#endnote-65)

Research has indicated that parents of children with intellectual disabilities may consider sterilization for their children because of perceptions that their children would not be good parents themselves, that other means of contraception would not be effective at preventing unwanted pregnancies, or that pregnancy may result from sexual abuse.[[66]](#endnote-66) In reality, however, parents may feel they need to sterilize their children because the parents lack support in caring for children with disabilities undergoing menstruation,[[67]](#endnote-67) or because support services are not available in the community for persons with disabilities who decide to have children.

1. **Recommendations**

States must guarantee that women and girls with disabilities are able to achieve their sexual and reproductive rights, which includes the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health.[[68]](#endnote-68) In order for women and girls to realize these rights, states should be recommended to take the following actions:

* Provide reasonable accommodation to ensure access to all health facilities, goods, services, and information.[[69]](#endnote-69)
* Provide reasonable accommodation to ensure that women and girls are physically able to access schools and health care facilities. This includes ensuring that women and girls have access to transportation and that hospital and educational facilities have ramps, elevators, and other features that ensure that women and girls will be able physically enter the buildings.
* Ensure that women and girls have access to medically accurate sexual and reproductive health information. This information must be presented in in a way that women and girls are able to read or hear and understand. This includes ensuring that publications are printed in Braille, large print, or with pictures, whenever possible. Educators and health care providers must also be able to communicate with the women and girls, providing translators whenever necessary.
* Ensure that girls with disabilities have access to quality sexuality education. According to the United Nations Educational, Scientific, and Cultural Organization (UNESCO) technical guidelines on sexuality education, sexuality education should be comprehensive with the aim of “[equipping] children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.”[[70]](#endnote-70) Because children with disabilities, particularly girls, are often shut out of formal education, including sexuality education,[[71]](#endnote-71) it is imperative that sexuality education be made available to women and girls both in school and outside of formal educational settings in order to reach the widest possible audience.[[72]](#endnote-72)
* Ensure that all women and girls who face unwanted pregnancy are able to obtain an abortion, if they so choose and that they are provided with the sufficient information and support to make this decision for themselves.
* Reform national laws and policies to ensure that abortion and other reproductive health services are legal and available to women and girls with disabilities. This is in line with the standards from treaty monitoring bodies, which have recognized that restrictive abortion laws cause women to seek out unsafe and clandestine abortions, and repeatedly called on states to liberalize restrictive abortion laws and guarantee women access to safe abortion services.[[73]](#endnote-73)
* Take all measures provide protection of women and girls with disabilities from all forms violence, torture and discrimination and other human rights violations, which have a negative impact on the right to sexual and reproductive health. This includes ending the forced or coerced sterilization of women and girls with disabilities.
* Ensure that women and girls with disabilities who have experienced violation of their right to sexual and reproductive health have access justice and effective remedy.[[74]](#endnote-74) According to the CESCR Committee, [r]emedies include, but are not limited to, adequate, effective and prompt reparation in the form of restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition, as appropriate.”[[75]](#endnote-75)
* Take measures to guarantee that women and girls are also able access to safe and potable water, adequate sanitation, adequate food and nutrition, adequate housing, safe and healthy working conditions and environment, and other human rights violations that have a negative impact on the right to sexual and reproductive health.

We are grateful for this opportunity to input in the SR’s GA report. Should the mandate need any additional information, please do not hesitate to reach out to Rebecca Brown, Director for Global Advocacy at rbrown@reprorights.org.

1. Convention on the Rights of Persons with Disabilities (CRPD), *adopted* Dec. 13, 2006, art, 25, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611, (*entered into force* May 3, 2008) [hereinafter CRPD]; International Covenant on Economic, Social and Cultural Rights (CESCR), *adopted* Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976). *See also* CESCR Committee, *General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, para. 1, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter CESCR Committee, *Gen. Comment No. 22*]; CESCR Committee, *General Comment No. 14: The Right to the highest attainable standard of health (art. 12)*, paras. 2, 8, 11, 16, 21, 23, 34, & 36, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR Committee, *Gen. Comment No. 14*]. [↑](#endnote-ref-1)
2. CESCR Committee, *Gen. Comment No. 14*, *supra* note 1, at para. 12. [↑](#endnote-ref-2)
3. CESCR Committee, *Gen. Comment No. 22*, *supra* note 1, at para. 39. [↑](#endnote-ref-3)
4. *See* CRC Committee, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee*, Gen. Comment No. 15*]; CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, U.N. Doc. A/54/38/Rev. 1, chap.I (1999) [hereinafter CEDAW Committee, *Gen. Comment. No. 24*]. [↑](#endnote-ref-4)
5. *See* CESCR Committee, *Gen. Comment No. 22*, *supra* note 1, at para. 5. [↑](#endnote-ref-5)
6. *Id*., at para. 5. [↑](#endnote-ref-6)
7. *See* CRPD Committee, *General comment No. 3 (2016) on women and girls with disabilities*, para. 38, U.N. Doc. CRPD/C/GC/3 (2016) [hereinafter CRPD Committee, *Gen. Comment No. 3*]; CESCR Committee, Gen. Comment No. 22, *supra* note 1, at para. 24. *See also* CESCR Committee, *General Comment No. 5: Persons with Disabilities,* para. 34, U.N. Doc. E/1995/22 (1994). [↑](#endnote-ref-7)
8. *See* CESCR Committee, *Gen. Comment No. 22,* *supra* note 1, at para. 7. [↑](#endnote-ref-8)
9. *See id.* at para. 7. [↑](#endnote-ref-9)
10. CRPD, *supra* note 1, art. 23. [↑](#endnote-ref-10)
11. CESCR Committee, *Gen. Comment No. 22*, *supra* note 1, at para. 7. [↑](#endnote-ref-11)
12. CRPD Committee, *General Comment No. 6 (2018) on equality and non-discrimination,* Advance Unedited Version, para. 4, U.N. Doc. CRPD/C/GC/6 (2018). [↑](#endnote-ref-12)
13. *Id*. at para. 66. [↑](#endnote-ref-13)
14. *Id*. at paras. 10-11. *See also* ESCR Committee, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3 of the International Covenant on Economic, Social and Cultural Rights)*, (34th Sess., 2005), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies,U.N. Doc. E/C.12/2005/3 (2005); CEDAW Committee, *General Recommendation No. 25: Article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures,* (30th Sess., 2004), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies; CEDAW Committee, *General Recommendation No. 28:* *On the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women,* (47th Sess., 2010), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. CEDAW/C/GC/28 (2010). [↑](#endnote-ref-14)
15. CRPD, *supra* note 1, art. 3 (a). [↑](#endnote-ref-15)
16. CRPD Committee*, Gen. Comment No. 1: Article 12: Equal recognition before the law,* (11th session, 2014), para. 35, U.N. Doc. CRPD/C/GC/1 (2014) [hereinafter CRPD Committee, *Gen. Comment No. 1*] [↑](#endnote-ref-16)
17. *See* id*.* at para. 26. [↑](#endnote-ref-17)
18. *See* CESCR Committee, *Gen. Comment No. 22*, *supra* note 1, at paras.10, 25; CEDAW Committee, *Decision 57/II Statement by the Committee on the Elimination of Discrimination against Women on sexual and reproductive health: beyond the 2014 review of the International Conference on Population and Development*, U.N. Doc. A/69/38 (2014); K.L. v. Peru, Human Rights Committee, Commc’n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). [↑](#endnote-ref-18)
19. *See* CESCR Committee, *Gen. Comment No. 22*, *supra* note 1, at paras.10, 25, 34; CEDAW Committee, *Gen. Recommendation No. 24, supra* note 4, at para. 31 (e); CEDAW Committee, *Concluding Observations: Sierra Leone*, para. 32 (b), U.N. Doc. CEDAW/C/SLE/CO/6 (2014). [↑](#endnote-ref-19)
20. CRPD, *supra* note 1, art. 6. [↑](#endnote-ref-20)
21. *See* Clair Kaplan, *Special Issues in Contraception: Caring for Women with Disabilities,* 51J. of Midwifery & Women’s Health 450 (2011). [↑](#endnote-ref-21)
22. CESCR Committee, *Gen. Comment No. 22*, *supra* note 1, at para. 39; *see also* CESCR Committee, *Gen. Comment No. 14*, *supra* note 1, at para. 12. [↑](#endnote-ref-22)
23. *See* CRPD Committee, *General Comment No. 2 (2014) Article 9: Accessibility*, paras. 25, 26, 40, U.N. Doc. CRPD/C/GC/2 (2014) [hereinafter CRPD Committee, *Gen. Comment No. 2*]. [↑](#endnote-ref-23)
24. WHO, World Report on Disability 70-71 (2011). [↑](#endnote-ref-24)
25. Tafadzwa Rugoho & France Maphosa, *Challenges faced by women with disabilities in accessing sexual and reproductive health in Zimbabwe: The case of Chitungwiza town,* 6 African Journal of Disability 252 (2017) [hereinafter Rugoho & Maphosa, *Challenges faced by women with disabilities*]. [↑](#endnote-ref-25)
26. *See Mandatory Delays and Biased Counseling for Women Seeking Abortions*, Center for Reproductive Rights (Sept. 30, 2010), <http://reproductiverights.org/en/project/mandatory-delays-and-biased-counseling-for-women-seeking-abortions>. [↑](#endnote-ref-26)
27. WHO, World Report on Disability, *supra* note 24, *at* 77-79. [↑](#endnote-ref-27)
28. Rugoho & Maphosa, *Challenges faced by women with disabilities, supra* note 25, at 252. [↑](#endnote-ref-28)
29. Plan International, Let me Decide and Thrive: Global discrimination and exclusion of girls and young women with disabilities (2017). [↑](#endnote-ref-29)
30. *Id*. [↑](#endnote-ref-30)
31. CEDAW Committee, *Gen. Recommendation No. 24, supra* note 4, para. 28; Human Rights Committee, *Concluding Observations: Paraguay,* para. 13, U.N. Doc CCPR/C/PRY/CO/3 (2013); CRC Committee, *Gen. Comment No. 15*, *supra* note 4, at para. 69. [↑](#endnote-ref-31)
32. United Nations Educational, Scientific, and Cultural Organization, The rationale for sexuality education: International Technical Guidance on Sexuality Education 20 (2009).  [↑](#endnote-ref-32)
33. WHO, Disability and health (reviewed Jan. 2018), <http://www.who.int/mediacentre/factsheets/fs352/en/> (last visited Apr. 10, 2018). . [↑](#endnote-ref-33)
34. United Nations Educational, Scientific, and Cultural Organization (UNESCO), International technical guidance on sexuality education: An evidence-informed approach, 25 (2018) [hereinafter UNESCO, International Technical Guidance on Sexuality Education] [↑](#endnote-ref-34)
35. Ariel Henley, *Why Sex Education for disabled People is so Important*, Teen Vogue (Oct. 5, 2017), *available at* https://www.teenvogue.com/story/disabled-sex-ed. [↑](#endnote-ref-35)
36. *Id*. [↑](#endnote-ref-36)
37. UNESCO, International Technical Guidance on Sexuality Education, *supra* note 34, at 25. [↑](#endnote-ref-37)
38. *Id*. at 25. [↑](#endnote-ref-38)
39. *See,* as an example of barriers to health services in the USA, including HIV prevention for deaf persons, Center for AIDS Prevention, University of California, San Francisco, *What Are Deaf Persons’ HIV Prevention Needs?*, *available at* http://caps.ucsf.edu/archives/factsheets/deaf-persons. [↑](#endnote-ref-39)
40. World Health Organization (WHO)/United Nations Population Fund (UNFPA), Promoting sexual and reproductive health for persons with disabilities 7 (2009) [hereinafter Promoting sexual and reproductive health]. [↑](#endnote-ref-40)
41. CRPD Committee*, Gen. Comment No. 1, supra* note 16, at para. 35; see also Human Rights Watch, “As if We Weren’t Human”: Discrimination and Violence against Women with Disabilities in Northern Uganda 46-47 (2010). *See* Desjardin M., *The sexualized body of the child, parents and the politics of ‘voluntary’ sterilization of people labelled intellectually disabled in* Sex and Disability (R McRuer and A Mollow) (2012). [↑](#endnote-ref-41)
42. Open Society Foundations, Against Her Will: Forced and Coerced Sterilization of Women Worldwide, 6 (2011) [hereinafter Against Her Will]. [↑](#endnote-ref-42)
43. *See* Roxanne Mykitiuk & Ena Chadha, *Sites of Exclusion: Disabled Women’s Sexual, Reproductive, and Parenting Rights*, in Critical perspectives on human rights and disability law 35 (Marcia Rious, Lee Ann Basser, & Melinda Jones, eds., 2011); Suzanne Smeltzer, *Pregnancy in Women With Physical Disabilities*. 36 Journal of Obstetric, Gynaecologic, and Neonatal Nursing 88, 88-96 (2007). [↑](#endnote-ref-43)
44. M. Aunos & M.A. Feldman, *Attitudes towards Sexuality, Sterilization and Parenting Rights of Persons with Intellectual Disabilities*, 15 Journal of Applied Research in Intellectual Disabilities 285, 289 (2002). On the other hand, as Women with Disabilities Australia has noted, women with disabilities who ask for support services to help them parent often see that request used as proof that they are not capable of being parents. Women with Disabilities Australia, Parenting Issues for Women with Disabilities in Australia 2009, 12 (2009). [↑](#endnote-ref-44)
45. *See* Center for Reproductive Rights, Access to Contraceptives: The Social and Economic Benefits and Role in Achieving Gender Equality 1 (2009). [↑](#endnote-ref-45)
46. Human Rights Watch, HIV and Disability 8 (2012) [hereinafter HIV and Disability]. [↑](#endnote-ref-46)
47. *See* Promoting sexual and reproductive health, *supra* note 39, at 6-7. [↑](#endnote-ref-47)
48. *See* CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013).  [↑](#endnote-ref-48)
49. Special Rapporteur on violence against women, its causes and consequences, *Rep. of the Special Rapporteur on violence against women, its causes and consequences*, para. 60, U.N. Doc. A/67/227 (Aug. 3, 2012) (by Rashida Manjoo) [hereinafter SRVAW, *Rep. of the Special Rapporteur* (2012)]; *see also* Stephanie Ortoleva & Hope Lewis, Forgotten Sisters: A Report on Violence against Women with Disabilities: An Overview of its Nature, Scope, Causes and Consequences(2012). [↑](#endnote-ref-49)
50. Human Rights Watch, Illusions of Care: Lack of Accountability for Reproductive Rights in Argentina 35 (2010). [↑](#endnote-ref-50)
51. CRPD Committee, *Concluding Observations: Spain*, paras. 37-38, U.N. Doc. CRPD/C/ESP/CO/1 (2011); *China*, para. 34, U.N. Doc. CRPD/C/CHN/CO/1 (2012); *Peru*, paras. 34-35, U.N. Doc. CRPD/C/PER/CO/1 (2012). [↑](#endnote-ref-51)
52. CRPD Committee, *Gen. Comment No. 1, supra* note 16, at para. 35; *see also* CEDAW Committee, *Concluding Observations: Thailand*, paras. 38-39, U.N. Doc. CEDAW/C/THA/CO/6-7 (2017). [↑](#endnote-ref-52)
53. *See, e.g.,* CAT Committee, *Concluding Observations: Peru*, para. 19, U.N. Doc. CAT/C/PER/CO/5-6, (2012);CAT Committee, *Concluding Observations: Czech Republic,* para. 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012). *See also* CEDAW Committee, *Gen. Recommendation No. 35 on gender-based violence*

*against women, updating general recommendation No. 19*, para. 18. U.N. Doc. CEDAW/C/GC/35 (2017). [↑](#endnote-ref-53)
54. *Id., at* para. 18. [↑](#endnote-ref-54)
55. CEDAW Committee, *Concluding Observations: Slovakia*, para. 33(d), UN Doc. CEDAW/C/SVK/CO/5-6 (2015); *see also* CEDAW Committee, *Gen. Recommendation No. 33 on women’s access to justice*, para. 19(d), U.N. Doc. CEDAW/C/GC/33 (2015); CEDAW Committee, *Concluding Observations: Barbados*, paras. 41-42 U.N. Doc. CEDAW/C/BRB/CO/5-8 (2017). [↑](#endnote-ref-55)
56. See CEDAW Committee, *Concluding Observations: Ukraine*, para. 44 (b), U.N. Doc. CEDAW/C/UKR/CO/8 (2017); *Finland,* paras. 28-29, U.N. Doc. CEDAW/C/FIN/CO/7 (2014); *Belgium*, para. 35, U.N. Doc. CEDAW/C/BEL/CO/7 (2014); *Montenegro,* paras. 40-41, U.N. Doc. CEDAW/C/MNE/CO/2 (2017); *Thailand,* para. 39, U.N. Doc. CEDAW/C/THA/CO/6-7 (2017); *Hungary*, paras. 32-33. U.N. Doc CEDAW/C/HUN/CO/7-8 (2013); CRC Committee, *Concluding Observations: Brazil*, paras. 51-52,U.N. Doc. CRC/C/BRA/CO/2-4 (2015); *Romania*, para. 32, U.N. Doc. CRC/C/ROU/CO/5 (2017); CESCR Committee, *Concluding Observations: Australia*, paras. 45-46, U.N. Doc. CESCR/C/AUS/CO/5 (2017). [↑](#endnote-ref-56)
57. For purposes of this paper, forced sterilization refers to the situation in which a person is sterilized after expressly refusing the procedure, without her knowledge or is not given an opportunity to provide consent. Coerced sterilization occurs when financial or other incentives, misinformation, or intimidation tactics are used to compel an individual to undergo the procedure. [↑](#endnote-ref-57)
58. *See, e.g.,* Susan Brady et al., Human Rights and Equal Opportunity Commission, The Sterilisation of Girls and Young Women in Australia: Issues and Progress*,* A report commissioned bythe Federal Sex Discrimination Commissioner and the Disability Discrimination Commissioner (2001) [hereinafter Sterilisation of Girls and Young Women in Australia]. [↑](#endnote-ref-58)
59. Against her Will, *supra* note 42, at 6. [↑](#endnote-ref-59)
60. SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 49, at para. 28. [↑](#endnote-ref-60)
61. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Advancement of Women*, para. 38, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005) (by Paul Hunt). [↑](#endnote-ref-61)
62. *Compare* Matter of A.W., 637 P.2d 366 (Colo. 1981); Estate of C.W., 640 A.2d 427 (Pa. Super. Ct. 1994); Matter of Terwilliger, 450 A.2d 1376 (Pa. Super. Ct. 1982); *and* Conservatorship of Person and Estate of Maria B., 160 Cal. Rptr. 3d 269 (Cal. Ct. App. 2013); *with* Wentzel v. Montgomery General Hosp., Inc., 447 A.2d 1244 (Md. 1982); Matter of Truesdell, 329 S.E.2d 630 (N.C. 1985); Conservatorship of Valerie N., 40 Cal. 3d 143 (Cal. 1985); *and* Matter of Romero, 790 P.2d 819 (Colo. 1990). [↑](#endnote-ref-62)
63. Arkansas (Ark. Code Ann. §20-49-101 (2016)); Colorado (Colo. Rev. Stat. §25.5- 10-233 (2016)); Delaware (16 Del. Code Ann. §5712 (2016)); Georgia (Ga. Code. Ann. §31-20-3 (2016)); Maine (34-B Me. Rev. Stat. §7010 (2016)); North Carolina (N.C. Gen. Stat. §35A-1245 (2010)); Oregon (Or. Rev. Stat. §436.225 (2016)); Utah (Utah Code Ann. §62A-6-102 (2016)); Vermont (18 Vt. Stat. Ann. §8705 (2016)); Virginia (Va. Code Ann. §54.1-2975 (2016)). [↑](#endnote-ref-63)
64. Gauer and Others v. France, App. No. 61521/08, Eur. Ct. H.R. (2012). [↑](#endnote-ref-64)
65. *See* Press Release*, Organizations in several countries reject decision of the Colombian Constitutional Court allowing for sterilization of minors with disabilities without their consent*, Center for Reproductive Rights (Mar 18, 2014), available at https://www.reproductiverights.org/press-room/Organizations-in-several-countries-reject-decision-of-the-Colombian-Constitutional-Court. [↑](#endnote-ref-65)
66. Houngmai H. Pham, *In the patient’s best interest? Revisiting sexual autonomy and sterilization of the developmentally disabled*, 175 World J. of Medicine 283 (2001). [↑](#endnote-ref-66)
67. Although parents may have concerns handling girls with disabilities who are undergoing menstruation, many requests for sterilization of girls with disabilities actually occur before menstruation even begins. *See, e.g.,* Sterilisation of Girls and Young Women in Australia, *supra* note 58. [↑](#endnote-ref-67)
68. *See* CESCR, Gen. Comment No. 22, *supra* note 1, at para. 5. [↑](#endnote-ref-68)
69. *Id*., at para. 5; CRPD Committee, *Gen. Comment No. 2, supra* note 22, at paras. 25, 26, 40. [↑](#endnote-ref-69)
70. UNESCO, International Technical Guidance on Sexuality Education, *supra* note 34, at*.* 16. [↑](#endnote-ref-70)
71. World Report on Disability, *supra* note 23, at 205-206; HIV and Disability, *supra* note 46, at 8. [↑](#endnote-ref-71)
72. UNESCO, International Technical Guidance on Sexuality Education, *supra* note 34*.* at 28-29; Susheela Singh et al., *Evaluating the need for sex education in developing countries: sexual behaviour,*

*knowledge of preventing sexually transmitted infections/HIV and unplanned pregnancy*, 5(4) Sex Education 307, 310 (2005). [↑](#endnote-ref-72)
73. *See, e.g.,* L.C. v. Peru, CEDAW Committee, Commc’n No. 22/2009, para. 12(b), U.N. Doc. CEDAW/C/50/D/22/2009 (2011); K.L. v. Peru, Human Rights Committee, Commc’n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc’n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011); Human Rights Committee, *Concluding Observations: Ireland*, para. 9, U.N. Doc. CCPR/C/ IRL/CO/4 (2014); CEDAW Committee, *Concluding Observations: Paraguay*, para. 31(a), U.N. Doc. CEDAW/C/PRY/CO/6 (2011). [↑](#endnote-ref-73)
74. CESCR Committee*, Gen. Comment No. 22,* at para. 64, *supra* note 1; CRPD Committee, *Gen. Comment No. 3, supra* note 7, at paras. 52-53. [↑](#endnote-ref-74)
75. CESCR Committee*, Gen. Comment No. 22,* at para. 64, *supra* note 1. [↑](#endnote-ref-75)