



The [Center for Reproductive Rights](#) (“CRR”) and [Women Enabled, Inc.](#), both non-governmental organizations dedicated to ensuring gender equality and women’s human rights, jointly submit this statement concerning the Draft General Comment on Article 9 from the Committee on the Rights of Persons with Disabilities (CRPD Committee).

I. Introduction and Overview of Submission

The Draft General Comment on Article 9 outlines state obligations concerning accessibility and the rights of persons with disabilities. Our submission will suggest some ways the Draft General Comment could better reflect the particular barriers that women and girls with disabilities face in accessing services, including health services related to their sexual and reproductive rights.¹ Although the Draft General Comment currently dedicates a paragraph to health and makes two short references to the particular needs of women with disabilities both in that paragraph and elsewhere,² these references do not fully reflect the structural and attitudinal barriers that women with disabilities face in accessing services and realizing their rights, distinct from men with disabilities and other women. The current Draft General Comment also does not reflect the intersectional discrimination faced by women with disabilities, including that due to not only to the intersection of their gender and disability but also their race or ethnicity, age, HIV status, rural status, or other identities.

Ensuring reproductive rights is essential for ensuring human rights for all women, including women with disabilities, and accessibility of reproductive health information and services is part of respecting, protecting, and fulfilling those rights. International human rights law and political consensus documents such as the International Conference on Population and Development (ICPD) Programme of Action³ have recognized that the exercise of reproductive rights—including the right to decide freely on the number and spacing of one’s children as well as the rights to health, life, equality, information, and privacy and the rights to be free from discrimination and from torture and ill-treatment—is essential to ensuring that women can achieve equality and overcome discrimination. Too often, however, women face restrictions, in law or in practice, on the exercise of their reproductive rights, and state failure to take positive measures to ensure access to reproductive health services and to prevent and punish violations further contributes to the barriers women face in exercising their reproductive rights.

As the Convention on the Rights of Persons with Disabilities (CRPD) recognizes, women with disabilities are subject to multiple discrimination because of both their gender and disability.⁴ This discrimination can then be further compounded by racial or ethnic discrimination, age, migration status, and for women living in rural areas. The CRPD requires states to take measures to address this multiple discrimination, which also manifests itself in the exercise of reproductive rights and poses additional barriers to accessing reproductive health information and services. The CRPD recognizes the importance of fulfilling reproductive rights for persons with disabilities, particularly women and girls, and includes the most expansive language on reproductive rights of any UN human rights convention.⁵

This submission seeks to provide the CRPD Committee with information concerning the accessibility of reproductive health services for women with disabilities, including the barriers to that accessibility, with the hope that the CRPD Committee will include these gender-specific concerns in its Draft General Comment on Article 9. First, this submission will provide general guidance on the normative content of accessibility as it relates to the right to health, specifically the right to reproductive health, and the rights to equality and autonomy. Second, the paper will comment on states parties' obligations concerning accessibility and reproductive rights, with the duty to respect, protect, and fulfill human rights as a guide. Third, this submission will explore the specific concerns of women with disabilities and how the intersection of gender and disability creates particular barriers for women's access to reproductive health services. Finally, this paper provides concrete recommendations to the CRPD Committee to include in its General Comment on Article 9 as well as thoughts on how the CRPD Committee could more consistently address reproductive rights in its dialogue with states.

II. Normative Content

This section will explore some of the general content of the right to accessibility as it applies to the rights to health, gender equality, and autonomy. As part of its discussion of the content of Article 9, the CRPD Committee should include a discussion of how the term "accessibility" is understood in these contexts, particularly as it applies to women with disabilities and the accessibility of reproductive health services.

A. Accessibility and the Right to Reproductive Health

Many aspects of reproductive rights stem from the right to the highest attainable standard of physical and mental health, which was first elaborated in the International Convention on Economic, Social, and Cultural Rights and is also enumerated in Article 25 of the CRPD. The Committee on Economic, Social, and Cultural Rights (ESCR Committee) has then provided further guidance on the content of the right to health in its General Comment No. 14, finding that health services must be available, accessible, acceptable, and of good quality.⁶ In order to provide full accessibility, states must ensure non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility in the provision of health care services.⁷

Non-discrimination

According to the ESCR Committee, accessibility requires non-discrimination, including that "health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds."⁸ The Committee on the Elimination of Discrimination against Women (CEDAW Committee) has provided further guidance on non-discrimination in the provision of health services for women, noting that reproductive health services are services that primarily women need due to their reproductive capacity. The CEDAW Committee has then found in its General Recommendation No. 24 that states should not restrict access to health services or clinics to women "because they are women,"⁹ nor should they criminalize health services that only women need or punish women who seek those services.¹⁰

The CEDAW Committee has found that states should give special attention to the health needs of marginalized groups including women with disabilities,¹¹ and has required that "States parties provide information on disabled women in their periodic reports, and on measures take to deal with their particular situation, including special measures to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life."¹²

Physical Accessibility

Physical accessibility requires that "health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups..." including "adequate access to buildings for persons with disabilities."¹³ Article 25 of the CRPD further requires that health facilities be provided "as close as possible to people's own communities, including in rural areas."¹⁴ The CEDAW Committee has also

considered “distance from health facilities” to be a barrier to ensuring women’s health, noting in particular that “[w]omen with disabilities, of all ages, often have difficulty with physical access to health services.”¹⁵

Economic Accessibility (Affordability)

According to the ESCR Committee, economic accessibility requires states to ensure that health services and goods are affordable for everyone, with payment for services based on the principle of equity.¹⁶ Concerning reproductive health services, the CEDAW Committee in its General Recommendation No. 24 has asked states to “supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women.”¹⁷ The CEDAW Committee has further explained that states parties must provide “safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources”¹⁸ and also recommended that states provide free or low-cost contraception to women.¹⁹ Economic accessibility is particularly important for women with disabilities, who are often more economically disadvantaged than others in their communities.²⁰

Information Accessibility

The ESCR Committee has defined information accessibility to include “the right to seek, receive, and impart information and ideas concerning health issues,” including confidentiality related to health data.²¹ The CEDAW Committee in its General Recommendation No. 24 has emphasized the particular importance of health information for women, including information related to family planning.²² The CRPD also provides a right for persons with disabilities “to seek, receive, and impart information and ideas on an equal basis with others” through the provision of information in accessible formats and recognizes the importance of “access to age-appropriate information, reproductive and family planning education” in fulfilling the right to decide on the number and spacing of children.²³

B. Accessibility and Reproductive Equality and Autonomy

As noted above, non-discrimination is an essential part of ensuring the accessibility of health services, including sexual and reproductive health services, under the right to health.²⁴ This section explores in more detail the rights to non-discrimination and equality, including the right to autonomy, in the context of reproductive rights and accessibility for women, including women with disabilities.

1. Reproductive Equality

International human rights norms have recognized that reproductive rights are women’s rights, clarifying that violations of reproductive rights are primarily manifestations of discrimination, poverty, and violence. Where women’s rights to equality and non-discrimination are not fulfilled, women’s ability to access reproductive health services and make meaningful choices about their reproductive lives is limited. In addition, where women are unable to access 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 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.

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. 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.²⁵

For women with disabilities accessibility and reasonable accommodation are also essential to ensuring equality, including reproductive equality. As the CRPD Committee's Draft General Comment acknowledges, while accessibility is a right targeted at ensuring the human rights and equality of groups, reasonable accommodation helps ensure the human rights of particular individuals by requiring states to take steps to ensure, without undue burden, that services meet individual needs.²⁶ Reasonable accommodation is thus an important part of ensuring women's equality because, as will be explored more below, women may suffer from intersectional discrimination due to their gender, disability, and potentially other identities, requiring that services be tailored to overcome the particular barriers they face to access.

Treaty monitoring bodies have consistently called on states to ensure substantive equality for women, including concerning access to reproductive health services. In its General Recommendation No. 24, the CEDAW Committee confirmed that states must provide health services specific to the needs of women, including sexual and reproductive health services, and that legal barriers to providing those services are discriminatory.²⁷ The CEDAW Committee has also acknowledged the underlying causes of health inequalities for women and the role that stereotypes and traditional roles play in inequalities for women, stating that “[a]s a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices.”²⁸ Finally, the CEDAW Committee has called on states to ensure equal health outcomes for women, stating the “[s]tudies such as those which emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care.”²⁹

2. Reproductive Autonomy

As part of the obligation to ensure non-discrimination in access to health services, states must also ensure that women are able to fully exercise their rights to reproductive autonomy and self-determination, free from violence or coercion. The right to reproductive autonomy consists of three main components—the right to decide on the number and spacing of children, the right to legal capacity including informed consent, and the right to be free from violence, exploitation, and abuse—which exist in several places in human rights law.

The Right to Decide on the Number and Spacing of Children

The right to decide on the number and spacing of children appears in Article 23 of the CRPD, further elaborating that as part of this right, women with disabilities should “have access to age-appropriate information, reproductive and family planning education ... and the means necessary to enable them to exercise these rights...”³⁰ Article 16 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) first provided this right for all women as an essential part of ensuring their equality within the family.³¹

The right to decide on the number and spacing of children is essential to ensuring women's equality, because it allows women to determine not only what happens to their bodies but also allows them to control other parts of their lives, such as access to education and employment. This right, however, is dependent on the accessibility of reproductive health services. As such, the CEDAW Committee in its General Recommendation No. 24 has elaborated that “States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women.”³² The CEDAW Committee has also noted that states must overcome barriers to reproductive autonomy for women, including changing “laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.”³³

Legal Capacity and Informed Consent

Another important aspect of reproductive autonomy is the ability of women to make important life decisions about their health. As such, states must ensure that women have the legal right to make decisions about their health. This right is protected by Article 15 of the CEDAW and Article 12 of the CRPD, which includes the right to full exercise of legal capacity on an equal basis with others.³⁴ The CRPD Committee has consistently interpreted Article 12 to mean that persons with disabilities should not be deprived of legal capacity and that states should replace current regimes of substituted decision-making, such as guardianship, with systems to support persons with disabilities in making decisions.³⁵ The Committee has explicitly stated that “a substitute decision-making model that overrides the wishes of the persons concerned ... runs counter to article 12 of the Convention.”³⁶

Informed consent is an important aspect of reproductive autonomy and a by-product of legal capacity. According to the UN Special Rapporteur on Health’s report on informed consent and the right to health, informed consent is “not mere acceptance of a medical intervention but a voluntary and sufficiently informed decision protecting the right of the patient to be involved in medical decision-making, and assigning associate duties and obligations to health-care providers, its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being.”³⁷ The CEDAW Committee in its General Recommendation No. 24 has also found that acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.³⁸

Numerous reports from UN bodies and medical associations indicate that the only valid form of informed consent is that which stems from the patients themselves. For instance, women with disabilities are particularly vulnerable to forced sterilizations, which are performed as the result of decisions made by their parents, guardians, or doctors without the individual woman’s consent. The CRPD Committee has considered forced sterilization and forced abortion as violations of the rights to bodily integrity, family and fertility, health, and legal capacity.³⁹ The Committee against Torture has condemned the practice of forced sterilization of persons with intellectual or mental disabilities as potentially amounting to torture or ill-treatment and called for the repeal of administrative decrees that allowed the practice.⁴⁰ The Special Rapporteur on Torture, in his recent report on torture and ill-treatment in healthcare settings, specifically set out that forced sterilization or abortion conducted on marginalized groups, including persons with disabilities, may amount to torture or ill-treatment, and called for the repeal of laws allowing this practice.⁴¹

The International Federation for Gynecology and Obstetrics (FIGO), a global organization of professionals in these fields seeking to promote the wellbeing of women and improve practice standards,⁴² recently released guidelines on female contraceptive sterilization that stress that surgical sterilization must be preceded by “the patient’s informed and freely given consent.”⁴³ The guidelines note that “[m]edical practitioners must recognize that, under human rights provisions and their own professional codes of conduct, it is unethical and in violation of human rights for them to perform procedures for prevention of future pregnancy on women who have not freely requested such procedures or who have not previously given their free and informed consent.”⁴⁴ These guidelines also specifically acknowledge the long history of forced sterilization of women with disabilities in many countries.⁴⁵

Freedom from Violence, Exploitation, and Abuse

Additionally, in order for women to be able to exercise their reproductive autonomy, they must be free from violence and coercion when making choices about their reproductive health. The CEDAW Committee in its General Recommendation No. 24 has in particular criticized forced and mandatory sexual and reproductive health services, elaborating that states “should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women’s rights to informed consent and dignity.”⁴⁶ The Special Rapporteur on Violence against Women has also classified several reproductive rights violations as forms of violence against women, including

forced sterilization and the unwanted pregnancies that result from denial of access to contraception.⁴⁷ This violence, which is experienced more often by women with disabilities, will be discussed in more detail below.

III. States Parties' Obligations

Under international human rights law, states have a duty to respect, protect, and fulfill all human rights, including the right to accessibility and reproductive rights. It is important to note that although states may be permitted to take some gradual steps towards implementing the right to accessibility, as the CRPD Committee's Draft General Comment suggests,⁴⁸ there are circumstances where states must meet a minimum core set of obligations, including in the context of sexual and reproductive rights, and must also take immediate steps to tackle discrimination.

Respect

States have a duty to respect the right to health for women with disabilities by refraining from interfering or denying equal access to health services, including for marginalized or underserved groups.⁴⁹ Article 25 of the CRPD applies this duty specifically to persons with disabilities, requiring that states "[p]rovide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes."⁵⁰

States must also abstain from promoting discriminatory health policies, including those related specifically to women's health, as well as from supplying coercive medical treatments.⁵¹ The ESCR Committee further elaborates that the duty to respect the right to health includes the need for states to "refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters."⁵²

The CEDAW Committee in its General Recommendation No. 24 provides further guidance on the obligation to respect the right to access reproductive health services for women by stating that states must "refrain from obstructing actions taken by women in pursuit of their health goals."⁵³ The CEDAW Committee goes on to state that states must ensure that laws and policies do not require the authorization of third parties for women to receive reproductive health services, that they should not be denied services because they are unmarried or because they are women, and that barriers to respecting the right to health also include the criminalization of health services that only women need.⁵⁴

Protect

States also have a duty to protect women with disabilities' right to accessibility and to reproductive health services, including from violations by third parties. According to the ESCR Committee, this requires states to "adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties..." and ensure that third parties do not limit access to information and services.⁵⁵ It also requires that states take adequate steps to ensure non-interference with access to reproductive health services and to prevent coercive procedures. Both the CEDAW Committee and the ESCR Committee have also emphasized the state duty to protect women from gender-based violence as part of ensuring their right to health, including by providing training to detect and treat the health consequences of violence against women.⁵⁶

The CRPD takes the duty to protect the right to health a step further for women with disabilities. Article 25 of the CRPD specifically enumerates that states should ensure that health care professionals provide the same quality of care to persons with disabilities as to other persons, including on the basis of free and informed consent, and that states prohibit discrimination against persons with disabilities in the provision of health and life insurance.⁵⁷ The

CRPD also requires states to “promote the physical, cognitive and psychological recover, rehabilitation and social reintegration of persons with disabilities who become victims of any form exploitation, violence or abuse,” including by ensuring that programs meet the gender- and age-specific needs of persons with disabilities.⁵⁸

The duty to protect also includes an obligation to ensure accountability for violations of human rights, including judicial or other appropriate remedies at the national and international levels, as well as reparations to victims.⁵⁹ The CRPD acknowledges this duty in Article 13, where it requires that states ensure effective access to justice for persons with disabilities, including by providing accommodations when needed so that persons with disabilities can participate and providing appropriate training for court personnel.⁶⁰ In the context of reproductive rights and violence against women, the duty to protect includes the enacting and enforcing laws that ban harmful traditional practices and ensuring effective complaint procedures for individuals when health care providers perpetuate violence against women.⁶¹

Fulfill

States have a duty to fulfill the right to health for all individuals. The ESCR Committee has stated that as part of this duty, states must take positive measures to fulfill the right to health and access to health services, including by responding specifically to the needs of marginalized groups and by “supporting people in making informed choices about their health.”⁶² Articles 25 and 26 of the CRPD provide further guidance on this point for women with disabilities, requiring states to provide health services specifically needed by persons with disabilities, including habilitation and rehabilitation.⁶³ States also have an obligation to ensure adequate training of health care providers, a sufficient number of health facilities throughout the country, sanitation, infrastructure for sexual and reproductive health including in rural areas, and health information.⁶⁴

Although the right to health is considered a right of progressive realization, there are several minimum core obligations related to the accessibility of health services, including reproductive health services, which states must fulfill regardless of resources. This includes ensuring that individuals are free from discrimination in the provision of health services.⁶⁵ Additionally, the ESCR Committee has called upon states parties to ensure that all drugs on the WHO Model List of Essential Medicines, which include a range of contraceptives, be made accessible⁶⁶ and has noted that access to drugs on this list is a core state obligation under the right to health.⁶⁷ The CEDAW Committee has further elaborated that the duty to fulfill requires states to take actions “to the maximum of their available resources to ensure that women realize their rights to health care,” and found that high incidence of maternal mortality or morbidity or unmet need for contraceptives are indications that states have not fulfilled this duty.⁶⁸ The UN Special Rapporteur on the Right to Health has further elaborated that states must take immediate steps to remove legal restrictions on accessing reproductive health services, as removing these restrictions does not entail resource constraints and thus does not require progressive realization.⁶⁹

IV. Intersectional Issues

Though data on women with disabilities is limited, women appear to be more likely to have a disability than are men—19.2% vs. 12%--meaning that disability affects a significant portion of women.⁷⁰ The CRPD in Article 6 recognizes that women with disabilities may face multiple forms of discrimination, due to both their gender and their disability.⁷¹ Indeed, intersectionality is an important component of gender equality, requiring states to ensure that they tackle the root causes of discrimination based on women’s multiple identities. Human rights treaties, treaty monitoring bodies, and the UN Special Rapporteur on Violence against Women have found that these women’s multiple identities can lead to discrimination that only affects them or affects them in different ways from men,⁷² including increased levels of violence.⁷³ The duty to protect individuals from intersectional discrimination may also require states to take further actions to meet women’s distinctive health needs, overcome barriers to their access to reproductive health services that stem from their multiple identities, and provide reasonable accommodation to individuals as appropriate.⁷⁴

This section explores the intersection of gender and disability in the right to accessibility, specifically as it relates to health, equality, and autonomy.

A. Accessibility and the Right to Health for Women with Disabilities

Physical Accessibility

Women with physical disabilities may face particular barriers to accessing reproductive health services because of the physical inaccessibility of health services. This includes not only the inaccessibility of clinic and hospital buildings but also the inaccessibility of equipment used in those facilities. For instance, the CRPD Committee has addressed the need to ensure physical accessibility in several of its concluding observations to states, noting concern about “poor accessibility in specialist and general medical services, including barriers preventing access to physical facilities and medical equipment and furnishings...”⁷⁵

The CRPD Committee has also commented in two sets of concluding observations about particular physical barriers faced by women in accessing sexual and reproductive health services. In particular, it has noted concern “about the discrimination against person with disabilities in terms of access to health, including sexual and reproductive health, caused by barriers including the lack of equipment suitable for use by all, for example for obstetrical and gynaecological care.”⁷⁶ It has also noted discrimination in the provision of sexual and reproductive health services and recommended that a state “take the necessary measures to ensure that all health services are fully accessible to persons with disabilities at all levels, including the community level, and that these measures incorporate the gender perspective.”⁷⁷

Financial Accessibility (Affordability)

As noted above, states must ensure that reproductive health services are provided at free or low-cost to all women. Financial barriers to accessing reproductive health services have a particular impact on women with disabilities, who are more likely to live in poverty. Although persons with disabilities make up 15% of the population worldwide, more than 20% of all people living in poverty are persons with disabilities.⁷⁸ Women with disabilities are more likely than others to live in poverty, because of discrimination they face due to both their gender and their disability in the workplace and in access to social services.⁷⁹ Indeed, the CRPD Committee has noted that women with disabilities are often underrepresented in the workforce and recommended that states ensure employment for women with disabilities.⁸⁰

When women with disabilities live in rural areas, they are likely to face even more barriers to accessing reproductive health services. Because poverty is more prevalent in rural areas, transportation may be unavailable or unaffordable, and even when it is available, it may be inaccessible to persons with physical disabilities.⁸¹ As a result, special consideration should be given to the transportation needs of women with disabilities living in rural areas so that they can receive reproductive health services. Indeed, the CRPD Committee has expressed concern about lack of available health services, particularly in rural areas, and its effect on access for persons with disabilities.⁸²

Information Accessibility

Accurate and timely information is essential to exercising autonomy and making an informed choice to undergo medical procedures. Access to information in health care settings is an issue that affects all women, as laws often restrict what information is available or require health care professionals to provide unnecessary or misleading information to women about their health. In some circumstances, the information that is provided reflects biases and prejudices about the role of women and the health services that should be available to them.⁸³

Women with disabilities may face barriers to accessing information about their reproductive health distinct from other women, because of physical barriers to entry into health care facilities or to the use of transportation,⁸⁴ and communication barriers or lack of reproductive health information in accessible formats and/or the failure to have sign language interpreters or alternative methods of communication available.⁸⁵ These communication limitations

are compounded for women with disabilities who are linguistic minorities. These barriers are particularly prevalent for women with disabilities in institutions, who are disproportionately women with intellectual or mental disabilities and usually do not receive sexuality education or information about reproductive health, including contraceptive options and testing for sexually-transmitted diseases.⁸⁶ Because of their institutionalized status, these women are not able to seek information or services outside the institution.⁸⁷

The information that is provided to women with disabilities about reproductive health care and parenting may undermine their rights, exposing a bias in the community that persons with disabilities are not able to care for their children.⁸⁸ Social science research has documented that women with disabilities face skepticism about their ability to care for children from family members, social service agencies and healthcare professionals.⁸⁹ 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.⁹⁰

Children with disabilities, particularly girls, are often shut out of education, including sexuality education.⁹¹ Thus, it is imperative that sexuality education not only begin at the earliest stages in school, but that governments initiate programs to reach the large number of young people outside the school system.⁹²

Although the CRPD Committee has yet to comment on the need for sexuality education or reproductive health information for persons with disabilities, the Committee has taken some steps to ensure that the rights to health and information in the CRPD are fulfilled. The Committee has commented on “systemic barriers that make it impossible for persons with disabilities to access health services...,” including “physical barriers, a dearth of accessible materials, [and] a lack of health-care professionals trained in the human rights model of disability ...”⁹³

B. Accessibility and Reproductive Equality and Autonomy for Women with Disabilities

The CRPD Committee has often used a substantive equality approach to analyze violations of the rights of women with disabilities. For instance, it has called on several countries to ensure adequate data on the situation of women and girls with disabilities in order to identify inequalities, address the underlying causes of inequalities including in employment, and offer services targeted specifically at the needs of women and girls with disabilities.⁹⁴ Women with disabilities also face inequalities in their access to reproductive health services.⁹⁵ The CRPD Committee should consider addressing the following issues in its Draft General Comment, in order to ensure women’s equality and autonomy in access to reproductive health services:

Stereotypes about Women with Disabilities

Both Article 8 of the CRPD and Article 5 of CEDAW emphasize the negative role that stereotypes can play in women’s lives, including women with disabilities. Under both conventions, states have an obligation “[t]o combat stereotypes, prejudices and harmful practices”⁹⁶ and to eliminate “prejudices and customary and all other practices.”⁹⁷ Article 8 of the CRPD recommends that States employ programs “to raise awareness throughout society, including at the family level... and to foster respect for the rights and dignity of persons with disabilities...including those based on sex and age...”⁹⁸ The CRPD goes further than the CEDAW in Article 6 by recognizing that gender and disability stereotypes may compound the effect of discrimination against women with disabilities.⁹⁹

One area of reproductive health in which these stereotypes are particularly prevalent is in access to contraception. It is commonly assumed that women with disabilities are not sexually active, and so not in need of reproductive health services, particularly contraception, but research shows that they are as likely to be sexually active as their non-disabled peers.¹⁰⁰ These negative attitudes about women with disabilities also make getting information about sexuality and safe sex practices difficult; indeed, women 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.¹⁰¹ Rates of contraceptive use and the types of contraception used differ significantly between women with disabilities and non-disabled women, often reflecting stereotypes about the sexuality of women with disabilities.

Women with disabilities are more likely to be given long-term contraceptive methods, such as sterilization or injectable contraceptives, and are less likely to receive short-term methods such as oral contraceptives. They are also less likely to be involved in decisions surrounding contraception and more likely to experience forced contraceptive practices.¹⁰²

Equal Results and Opportunities

Women with disabilities often suffer worse health outcomes than other women, particularly in the area of sexual and reproductive rights. As noted above, they are less likely to have access to health information and sexuality education. They are also less likely to access services when they become pregnant, including pre-natal, post-natal, and labor and delivery services.¹⁰³ This may stem from the fact that health care providers such as midwives, who may be the only option in some communities, refuse to treat women with disabilities because they do not feel like they have the expertise to do so.¹⁰⁴ Such practices result in a higher risk of maternal mortality and morbidity for women with disabilities.

Legal Capacity and Third-Party Authorization

All women may face barriers to accessing reproductive health services because of formal or informal requirements that they receive third-party authorization for those services from parents, spouses, judges, doctors, or hospitals. The effects of third party authorization requirements are compounded for women with disabilities, because there are more likely to be practices and/or laws in place that deny them legal capacity, thereby stripping them of decision-making power about many aspects of their lives.¹⁰⁵

Third-party authorization requirements may mean that women with disabilities are denied access to reproductive health services without the permission of a parent or guardian, or may be subjected to forced procedures such as forced sterilization, abortion, or contraception, as outlined below. Even where women with disabilities are not deprived of legal capacity, they may still be informally denied access to reproductive health services due to lack of training of medical professionals to work with women with disabilities and lack of support for women with disabilities in making decisions about their health.

Violence against Women with Disabilities, including Forced Sterilization

Women with disabilities are two to three times more likely than other women to experience violence, including sexual and domestic violence.¹⁰⁶ These statistics, compounded by the fact that women with disabilities are less likely than other women to have effective access to sexual and reproductive health services, places a particular burden on the human rights of women with disabilities.

Although women with disabilities generally experience the same types of violence as other women, the inequalities they experience due to both their gender and disability exacerbate the causes and consequences of violence. Women with disabilities are more likely to be in unstable and potentially violent relationships than other women, because women with disabilities may be considered less eligible for marriage.¹⁰⁷ Women with disabilities may also have fewer options to leave the relationship because of legal hurdles and social and economic barriers they face specifically because of their disability,¹⁰⁸ including dependence on a partner or spouse as a care-giver and the lack of availability of safe houses or shelters.¹⁰⁹

Women with disabilities who live in institutions, including long-term care centers, hospitals, and prisons, are also more likely than other women to face violence at the hands of institutions, where they have even less access to sexual and reproductive health services. The World Health Organization has suggested that health care providers specifically target the population of women and girls with disabilities in institutions to ensure they have access to sexual and reproductive health services.¹¹⁰

One form of violence against women targeted particularly at women with disabilities is forced or coerced sterilization. Although voluntary sterilization is an important part of ensuring that a wide range of contraceptive methods are available to women, when the procedure is forced or coerced it is traumatic and removes women's

decision-making power about their health and their reproduction and result in other serious health consequences.. For women with disabilities, who are disproportionately the targets of forced or coerced sterilization, this practice often reflects a lack of training and understanding by health care providers about how to work with, give information to, and obtain informed consent from women with disabilities creating and reinforcing barriers to accessing reproductive health services.¹¹¹

Forced or coerced sterilization of women and girls with disabilities is often undertaken as a way to control menstrual cycles¹¹² or because of misconceptions and discriminatory attitudes about the ability of women with disabilities to take care of children.¹¹³ The Special Rapporteur on Violence against Women in her 2012 report called forced sterilization of women with disabilities a form of violence and classified it as a “global problem.”¹¹⁴ 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.”¹¹⁵ As noted above, forced and coerced sterilization has also been classified as a form of torture or ill-treatment.

V. Conclusions and Specific Suggestions for the Draft General Comment on Article 9

Ensuring accessibility is an important part of the states’ obligation to respect, protect, and fulfill the reproductive rights of women with disabilities. The CRPD clearly recognizes that women with disabilities may face additional discrimination because of their gender and disability and acknowledges the rights of persons with disabilities to reproductive health care, including family planning information and services, and to decide on the number and spacing of children. With the additional barriers faced by women with disabilities in mind, the CRPD Committee should consider including the following in its Draft General Comment on Article 9 and in its work more generally on reproductive rights for women with disabilities.

Recommended Language for the Draft General Comment on Article 9

Normative Content

- The international human rights framework surrounding the right to health mandates that health services must be accessible. Accessibility in the context of health requires that states provide services that are physically and economically accessible and that information is provided in sensitive and accessible formats for all persons, including women with disabilities.
- Accessibility in the health care context also necessitates that women with disabilities can access health services on the basis of non-discrimination. This requires that women with disabilities can fully exercise their autonomy in making decisions about their lives and also that they are able to achieve equal outcomes for their health and for the direction of their lives. In order to overcome barriers to accessibility, states must address the root causes of discrimination in the health care context and take positive measures to ensure that all individuals have access to health care services, including by providing reasonable accommodation when necessary.

States Parties’ Obligations

- States parties must respect, protect, and fulfill the right to accessibility of health services, including reproductive health services for women with disabilities. Respecting the accessibility of these services requires that states ensure that laws do not discriminate against women with disabilities in access to health services and also do not limit the types of services available to women by criminalizing or restricting reproductive health procedures. It also requires that states protect women with disabilities from violence in health care settings, including forced procedures such as forced and coerced sterilization, abortion, and contraception, as well as other abuses of their reproductive rights by both public and private health care providers, which may inhibit access to those services. This includes the need to ensure effective accountability mechanisms for violations of reproductive rights, including those that affect the accessibility of health services for women with disabilities. Finally, states must ensure that they fulfill the right to accessibility of reproductive health services for women with disabilities by ensuring that a minimum core of services, such as contraception and maternal health services, are fully accessible to all

women and that states take positive measures and use a maximum of available resources to develop reproductive health services and ensure accessibility for women with disabilities.

Intersectional Issues

- For women with disabilities in particular, the obligations outlined in Article 9 overlap with many other rights in the Convention. These rights include the right to the highest attainable standard of health, including reproductive health information and services (Article 25), the rights to family and to decide on the number and spacing of children (Article 23), the right to gender equality (Article 6), the right to recognition under the law and exercise of legal capacity (Article 12), the right to be free from torture or ill-treatment (Article 15) and the right to be free from exploitation, violence, and abuse (Article 16).
- In the context of reproductive health, a service that women primarily need because of their reproductive capacities, women with disabilities may face multiple discrimination in accessing services due to both their disability and gender. As such, states must ensure that laws and policies do not limit women with disabilities' access to reproductive health services. This requires that states remove legal restrictions on reproductive health services and on the legal capacity of persons with disabilities. States must also undertake positive measures to promote access to the full range of reproductive health services for women with disabilities. This requires that states ensure the physical accessibility of health facilities and equipment, that information is in accessible formats for persons with disabilities, that reproductive health services are provided at free or low-cost, that health care providers are trained to meet their needs, and that women themselves are making decisions about their reproductive health.
- States must also protect women with disabilities from violence, discrimination, and coercion, and actively work to eliminate and prevent such violence and eliminate stereotypes about women with disabilities' capacity as decision-makers and caregivers in the medical community and the community at large. States must work to end forced reproductive health interventions, such as forced sterilization, forced abortion and forced contraception, to ensure that women with disabilities can trust the medical community and better promote their access to health services. States should take positive steps to ensure that women have the information they need to make reproductive health decisions by training health care providers to effectively communicate with women with disabilities, providing health information in accessible formats, providing support in making decisions when needed, and ensuring women with disabilities have access to sexuality education both inside and outside of school.

Recommendations for the CRPD Committee's State Reviews

- Recommend that states ensure access to the full range of reproductive health services, including contraception, safe abortion, and maternal health services, for women with disabilities without restrictions. Recommend that states overcome barriers to accessibility by ensuring that services are available in locations close to all communities, including rural communities. Recommend to States that such services are in facilities which are physically accessible, including medical equipment.
- Recommend that states produce reproductive health materials in accessible formats and if required or requested, provide support to women with disabilities who are seeking reproductive health information so that they can more effectively communicate with healthcare professionals and staff and make informed choices.
- Recommend that states provide comprehensive, accurate, and accessible sexuality education to all young women and girls with disabilities, inside and outside of school, in order to ensure that women can exercise their rights to health and life, to found a family, and to be free from violence, exploitation, or abuse.
- Recommend that states train and sensitize doctors and other health care providers and staff on disability rights and the reproductive rights requirements of the CRPD to ensure that women with disabilities receive unbiased and accurate information about their reproductive health.
- Recognize that women with disabilities are more often victims of sexual violence, and recommend that states remove restrictions on access to reproductive health services such as emergency contraception and abortion in order to avoid further violations of their human rights. Classify denial of these services in

cases of sexual violence as a violation of the rights to health, to decide on the number and spacing of children, and to be free from torture or ill-treatment.

¹ Unless otherwise noted, “women” will be used to refer to both women and girls throughout this submission.

² Committee on the Rights of Persons with Disabilities (CRPD Committee), *Draft General Comment on Art. 9*, (11th Sess., 2013), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, paras. 33 & 36, U.N. Doc. CRPD/C/11/3 (2013) [hereinafter CRPD Committee, *Draft Gen. Comment on Art. 9*].

³ *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995).

⁴ Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, art. 6, 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].

⁵ *Id.* arts. 23(b) & 25(a) (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 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.”).

⁶ Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*].

⁷ *Id.* para. 12(b).

⁸ *Id.*

⁹ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 14, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

¹⁰ *Id.*

¹¹ *Id.* para. 6.

¹² CEDAW Committee, *General Recommendation No. 18: Disabled women*, (10th Sess., 1991), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 243, U.N. Doc. HRI/GEN/1/Rev.6 (2003).

¹³ ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 12(b).

¹⁴ CRPD, *supra* note 4, art. 25(c).

¹⁵ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, paras. 21 & 25.

¹⁶ ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 12(b).

¹⁷ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 27.

¹⁸ *Id.*

¹⁹ CEDAW Committee, *Concluding Observations: Hungary*, para. 31(b), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

²⁰ WORLD HEALTH ORGANIZATION & THE WORLD BANK, *WORLD REPORT ON DISABILITY* (2011) [hereinafter *WORLD REPORT ON DISABILITY*].

²¹ ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 12(b).

²² CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 28.

²³ CRPD, *supra* note 4, arts. 21 & 23(1)(b).

²⁴ ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 12(b).

²⁵ 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).

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- ²⁶ CRPD Committee, *Draft Gen. Comment on Art. 9*, *supra* note 2, paras. 22-23.
- ²⁷ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 11.
- ²⁸ *Id.* para. 18.
- ²⁹ *Id.* para. 17.
- ³⁰ CRPD, *supra* note 4, art. 23(1)(b).
- ³¹ Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 16(e), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].
- ³² CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 14.
- ³³ *Id.*
- ³⁴ CEDAW, *supra* note 31, art. 15; CRPD, *supra* note 4, art. 12.
- ³⁵ CRPD Committee, *Concluding Observations: Tunisia*, paras. 22-23, U.N. Doc. CRPD/C/TUN/CO/1 (2011); *Spain*, paras. 33-34, U.N. Doc. CRPD/C/ESP/CO/1 (2011); *Peru*, paras. 24-25, U.N. Doc. CRPD/C/PER/CO/1 (2012); *Argentina*, paras. 19-20, U.N. Doc. CRPD/C/ARG/CO/1 (2012); *China*, para. 21-22, U.N. Doc. CRPD/C/CHN/CO/1 (2012); *Hungary*, paras. 25-26, CRPD/C/HUN/CO/1 (2012).
- ³⁶ CRPD Committee, *Concluding Observations: Argentina*, para. 19, U.N. Doc. CRPD/C/ARG/CO/1 (2012).
- ³⁷ 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*, para. 9, U.N. Doc. A/64/272 (August 10, 2009) (by Anand Grover); *See also* A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, para. 22, U.N. Doc. CEDAW/C/36/D/4/2004 (2006) (quoting CEDAW Committee, General Recommendation No. 21, para. 22 (1994)) (in the context of case about forced sterilization, "informed decision-making about safe and reliable contraceptive measures depends upon a women having 'information about contraceptive measures and their use, and guaranteed access to sex education and family planning services.'").
- ³⁸ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 22.
- ³⁹ 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); *Argentina*, paras. 31-32, U.N. Doc. CRPD/C/ARG/CO/1 (2012); *Peru*, para. 35, U.N. Doc. CRPD/C/PER/CO/1 (2012).
- ⁴⁰ The Committee Against Torture (CAT Committee), *Concluding Observations: Peru*, para. 19, U.N. Doc. CAT/C/PER/CO/6, (2012). The CAT Committee has also recognized forced sterilization schemes that were targeted at other marginalized groups, such as indigenous women or women from the Roma minority, as a form of torture or CIDT. *See* CAT Committee, *Concluding Observations: Czech Republic*, para. 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012).
- ⁴¹ Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, para. 48 & 88, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan E. Méndez).
- ⁴² *Mission & Vision Statement*, INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS, <http://www.figo.org/about/mission>.
- ⁴³ INTERNATIONAL FEDERATION OF OBSTETRICS AND GYNECOLOGY, GUIDELINES ON FEMALE CONTRACEPTIVE STERILIZATION, para. 2 (2011).
- ⁴⁴ *Id.* para. 6.
- ⁴⁵ *Id.* para. 5.
- ⁴⁶ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 22.
- ⁴⁷ Special Rapporteur on violence against women, its causes and consequences, *Rep. of the Special Rapporteur on violence against women, its causes and consequences*, *Rep. on violence against women with disabilities*, para. 28, U.N. Doc. A/67/227 (Aug. 3, 2012) (by Rashida Manjoo) [hereinafter SRVAW, *Rep. of the Special Rapporteur* (2012)].
- ⁴⁸ CRPD Committee, *Draft Gen. Comment on Art. 9*, *supra* note 2, para. 25.
- ⁴⁹ ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 34.
- ⁵⁰ CRPD, *supra* note 4, art. 25(a).
- ⁵¹ *Id.*
- ⁵² ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 34.
- ⁵³ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 14.
- ⁵⁴ *Id.*
- ⁵⁵ ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 35.
- ⁵⁶ *Id.*; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 15.
- ⁵⁷ CRPD, *supra* note 4, arts. 25(d) & (e).

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- ⁵⁸ *Id.* art. 16(4).
- ⁵⁹ ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 59.
- ⁶⁰ CRPD, *supra* note 4, art. 13.
- ⁶¹ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 15.
- ⁶² ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 37.
- ⁶³ CRPD, *supra* note 4, arts. 25(b) & 26.
- ⁶⁴ ESCR Committee, *Gen. Comment No. 14*, *supra* note 6, para. 36.
- ⁶⁵ *Id.* para. 43(a).
- ⁶⁶ *Id.* paras. 12(a), 43 (d) & 44 (a).
- ⁶⁷ *Id.* para. 43(d).
- ⁶⁸ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 9, para. 17.
- ⁶⁹ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, para. 20, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover).
- ⁷⁰ WORLD REPORT ON DISABILITY, *supra* note 20; *Some Facts about Persons with Disabilities*, UNITED NATIONS, available at <http://un.org/disabilities/convention/facts.shtml>.
- ⁷¹ CRPD, *supra* note 4, art. 6.
- ⁷² Committee on the Elimination of Racial Discrimination, *General Recommendation No. 25: Gender-related dimension of racial discrimination*, (Fifty-sixth session, 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 214, para. 1, U.N. Doc. HRI/GEN/1/Rev.6 (2003).
- ⁷³ SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 47, para. 28.
- ⁷⁴ CEDAW Committee, *Concluding Observations: Hungary*, para. 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- ⁷⁵ CRPD Committee, *Concluding Observations: Paraguay*, para. 59, U.N. Doc. CRPD/C/PRY/CO/1 (2013).
- ⁷⁶ CRPD Committee, *Concluding Observations: El Salvador*, para. 51, U.N. Doc. CCPR/C/SLV/CO/6 (2010).
- ⁷⁷ CRPD Committee, *Paraguay*, para. 60, U.N. Doc. CRPD/C/PRY/CO/1 (2013).
- ⁷⁸ WORLD REPORT ON DISABILITY, *supra* note 20.
- ⁷⁹ *Poverty and Disability*, THE WORLD BANK, <http://go.worldbank.org/IMVL0SHUT0>.
- ⁸⁰ CRPD Committee, *Concluding Observations: Australia*, para. 50, U.N. Doc. CRPD/C/AUS/CO/1 (2013).
- ⁸¹ WORLD HEALTH ORGANIZATION & UNFPA, *PROMOTING SEXUAL AND REPRODUCTIVE HEALTH FOR PERSONS WITH DISABILITIES: WHO/UNFPA GUIDANCE NOTE 23* (2009), available at http://whqlibdoc.who.int/publications/2009/9789241598682_eng.pdf [hereinafter *PROMOTING SEXUAL AND REPRODUCTIVE HEALTH: WHO/UNFPA GUIDANCE*].
- ⁸² CRPD Committee, *Concluding Observations: Peru*, para. 39, U.N. Doc. CRPD/C/PER/1 (2012).
- ⁸³ *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>.
- ⁸⁴ WORLD REPORT ON DISABILITY, *supra* note 20, at 70-71.
- ⁸⁵ *Id.* at 77-79.
- ⁸⁶ *PROMOTING SEXUAL AND REPRODUCTIVE HEALTH: WHO/UNFPA GUIDANCE*, *supra* note 81, at 13 & 23.
- ⁸⁷ *Id.*
- ⁸⁸ OPEN SOCIETY FOUNDATIONS, *AGAINST HER WILL: FORCED AND COERCED STERILIZATION OF WOMEN WORLDWIDE*, 6 (2011) [hereinafter *AGAINST HER WILL*].
- ⁸⁹ Suzanne Smeltzer, *Pregnancy in Women With Physical Disabilities*, 36 *JOURNAL OF OBSTETRIC, GYNAECOLOGIC, AND NEONATAL NURSING* 88, 88-96 (2007).
- ⁹⁰ 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).
- ⁹¹ WORLD REPORT ON DISABILITY, *supra* note 20, at 205-206; HUMAN RIGHTS WATCH, *HIV AND DISABILITY* 8 (2012); *see also* CENTER FOR REPRODUCTIVE RIGHTS, *THE REPRODUCTIVE RIGHTS OF ADOLESCENTS: A TOOL FOR HEALTH AND EMPOWERMENT* 6 (2008).
- ⁹² 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).

⁹³ CRPD Committee, *Concluding Observations: Argentina*, para. 39, U.N. Doc. CRPD/C/ARG/CO/1 (2012).

⁹⁴ CRPD Committee, *Concluding Observations: Australia*, para. 54, U.N. Doc. CRPD/C/AUS/CO/1 (2013); *Austria*, paras. 18 & 46, U.N. Doc. CRPD/C/AUT/CO/1 (2013); *El Salvador*, para. 29, U.N. Doc. CCPR/C/SLV/CO/6 (2010); *Paraguay*, para. 17 U.N. Doc. CRPD/C/PRY/CO/1 (2013); *Argentina*, para. 14, U.N. Doc. CRPD/C/ARG/CO/1 (2012).

⁹⁵ SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 47, para. 28.

⁹⁶ CEDAW, *supra* note 31, art. 5.

⁹⁷ CRPD, *supra* note 4, art. art. 8.

⁹⁸ *Id.* art. 8.

⁹⁹ *Id.* art. 6.

¹⁰⁰ *Id.* at 3; HIV AND DISABILITY, *supra* note 91 at 8.

¹⁰¹ HIV AND DISABILITY, *supra* note 91 at 8.

¹⁰² JOAN O'CONNOR, LITERATURE REVIEW ON PROVISION OF APPROPRIATE AND ACCESSIBLE SUPPORT TO PEOPLE WITH AN INTELLECTUAL DISABILITY WHO ARE EXPERIENCING CRISIS PREGNANCY, *available at* <http://www.nda.ie/CntMgmtNew.nsf/DCC524B4546ADB3080256C700071B049/200FC923F86AE299802577A4003355CF?OpenDocument>; *see also* CAROLYN FROHMADER & STEPHANIE ORTOLEVA, THE SEXUAL AND REPRODUCTIVE RIGHTS OF WOMEN AND GIRLS WITH DISABILITIES (Jul. 1, 2013), *available at* http://www.womenenabled.org/pdfs/issues_paper_srr_women_and_girls_with_disabilities_final.pdf.

¹⁰³ PROMOTING SEXUAL AND REPRODUCTIVE HEALTH: WHO/UNFPA GUIDANCE, *supra* note 81, at 10.

¹⁰⁴ *Id.*

¹⁰⁵ AGAINST HER WILL, *supra* note 88, at 6; SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 47, para. 28.

¹⁰⁶ UNITED STATES DEPARTMENT OF STATE & USAID, UNITED STATES STRATEGY TO PREVENT AND RESPOND TO GENDER-BASED VIOLENCE GLOBALLY 7 (Aug. 10, 2012), *available at* <http://www.state.gov/documents/organization/196468.pdf> (“Women with a disability are two to three times more likely to suffer physical and sexual abuse than women with no disability.”); *see also* SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 47, paras. 31-32.

¹⁰⁷ PROMOTING SEXUAL AND REPRODUCTIVE HEALTH: WHO/UNFPA GUIDANCE, *supra* note 81, at 10.

¹⁰⁸ *Id.*

¹⁰⁹ STEPHANIE ORTOLEVA & HOPE LEWIS, FORGOTTEN SISTERS: A REPORT ON VIOLENCE AGAINST WOMEN WITH DISABILITIES: AN OVERVIEW OF ITS NATURE, SCOPE, CAUSES AND CONSEQUENCES, 39-40 (2012).

¹¹⁰ PROMOTING SEXUAL AND REPRODUCTIVE HEALTH: WHO/UNFPA GUIDANCE, *supra* note 81, at 13.

¹¹¹ CAROLYN FROHMADER FOR WOMEN WITH DISABILITIES AUSTRALIA (WWDA), WOMEN WITH DISABILITIES & THE HUMAN RIGHT TO HEALTH: A POLICY PAPER (2010), *available at* <http://www.wwda.org.au/health2006.htm>.

¹¹² *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 by the Federal Sex Discrimination Commissioner and the Disability Discrimination Commissioner (2001).

¹¹³ AGAINST HER WILL, *supra* note 88, at 6.

¹¹⁴ SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 47, para. 28.

¹¹⁵ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, para. 38, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005) (by Paul Hunt).