



Women Enabled International Submission to OHCHR Report on Mental Health and Human Rights

I. Introduction

Women Enabled International (WEI) works at the intersection of women's rights and disability rights to advocate and educate for the human rights of all women and girls, emphasizing women and girls with disabilities, and works to include women and girls with disabilities in international resolutions, policies, and programs addressing women's human rights and development, in collaboration with disabled women's rights and women's rights organizations worldwide. WEI appreciates the opportunity to contribute to the Office of the High Commissioner for Human Rights's (OHCHR) forthcoming report on mental health and human rights.

Due to their gender and mental health status, women and girls with psychosocial disabilities¹ are frequently overlooked in efforts to ensure the rights of persons with disabilities. As such, they are subjected to unique human rights abuses in health care settings, including sexual and reproductive health care settings, such as forced institutionalization, forced and coerced reproductive health procedures, and other forced medical treatment. Additionally, although women with psychosocial disabilities experience higher rates of gender-based violence than do other women, they also face greater barriers to accessing justice because their accounts are doubted or they are not allowed or given reasonable accommodations to testify in court. At the root of these abuses is the assumption that women and girls with psychosocial disabilities are unable to make decisions for themselves, a situation that means that they are frequently formally or informally deprived of legal capacity and have their decision-making substituted for that of others.

This submission will address some of the human rights abuses faced uniquely or disproportionately by women and girls with psychosocial disabilities, as a means of contributing to OHCHR's forthcoming report on mental health and human rights. In particular, this submission will address human rights abuses that women and girls with psychosocial disabilities face when accessing sexual and reproductive health care services and when accessing justice for gender-based violence committed against them. This submission will also analyze relevant provisions of the Convention on the Rights of Persons with Disabilities (CRPD) and other human rights treaties and how they should be interpreted to respect, protect, and fulfill the rights of women and girls with psychosocial disabilities from violations in these contexts.

II. Abuses against Women and Girls with Psychosocial Disabilities in Sexual and Reproductive Health Care

Women with disabilities worldwide face a wide range of unique human rights abuses in health care settings, including sexual and reproductive health care settings, due to both their gender and disability. For women with psychosocial disabilities in particular, abuses in health care settings such as forced treatment² are based on stereotypes about their decision-making capacity, sexuality, and ability to parent and occur because they may be formally or informally deprived of legal capacity.³ In its General Comment No. 3 on women with disabilities, the CRPD Committee recognized that "[i]n practice, the choices of women with disabilities, especially women with psychosocial or intellectual disabilities are often ignored, [and] their decisions are often substituted by third parties, including legal representatives, service providers, guardians and family members."⁴ When women and girls with disabilities are subjected to substituted decision-making, this can "facilitate forced interventions, such as: sterilisation, abortion,

contraception, female genital mutilation, or surgery, or treatment performed on intersex children without their informed consent and forced detention in institutions.”⁵

Sexual and reproductive health care settings can create particular human rights issues for women and girls with psychosocial disabilities. As the CRPD Committee noted in its General Comment No. 1 on equal recognition before the law, women with disabilities generally “are often denied control of their reproductive health and decision-making, the assumption being that they are not capable of consenting to sex.”⁶ Due to discrimination and stigma associated with mental health, women and girls with psychosocial disabilities—alongside women and girls with intellectual disabilities—are more likely to be deprived of legal capacity than are other women, including other women with disabilities,⁷ and so therefore are also more likely to be subjected to forced and coerced reproductive health procedures, such as forced or coerced sterilization, abortion, and contraception.⁸ These procedures are often performed with the consent of parents, guardians, doctors, judges, or others, but without the consent of the woman herself. Forced or coerced sterilization of women and girls with psychosocial disabilities causes particular harms, because although in rare cases it may be reversible, female sterilization is considered a permanent form of contraception, meaning that women who undergo sterilization will not be able to have children.⁹

Forced and coerced reproductive health procedures against women and girls with psychosocial disabilities are often tacitly allowed without criminal or civil penalties, if not also legally sanctioned. For instance, in India, under the Medical Termination of Pregnancy Act, 1971 (as amended in 2002), guardians can consent to abortions for women with psychosocial disabilities, leading to forced abortions.¹⁰ Although the Supreme Court of India in 2009 found that guardians of women with “mild to moderate” intellectual disabilities cannot similarly provide consent to abortion on behalf of their wards, the Court did not strike down the provisions of the Medical Termination of Pregnancy Act, 1971, that allow for forced abortion of women with psychosocial disabilities. The Court in fact distinguished between psychosocial and intellectual disabilities, stating that, as per the law, a guardian could still provide consent for terminating pregnancies of women with psychosocial disabilities.¹¹

Ensuring rights protections for women and girls with psychosocial disabilities in sexual and reproductive health care settings requires that states recognize that all human rights are interdependent and indivisible. Protections in these settings consist of not only the right to health, but also the rights to equal recognition before the law and to the exercise of legal capacity on an equal basis with others; the rights to decide on the number and spacing of children and to found a family; the rights to physical and mental integrity and to be free from torture or ill-treatment; the right to privacy; the rights to equality, non-discrimination, and to be free from harmful stereotyping; and the right to accessibility, including in access to information and health care services.¹² These rights, interpreted alongside each other, create a right for women and girls with disabilities to the exercise of sexual and reproductive autonomy.¹³ Indeed, in 1994, 179 states agreed to these principles by signing on to the Programme of Action for the International Conference on Population and Development, which states that reproductive rights include the right “to make decisions concerning reproduction free of discrimination, coercion and violence.”¹⁴

In order to ensure equality and non-discrimination in the context of sexual and reproductive health care, women and girls with psychosocial disabilities should be ensured the right to make decisions for themselves about their sexuality and reproduction, with support when needed, and ensured that their decision-making authority will not be substituted for that of another person, such as a parent, guardian, doctor, judge, or the state.¹⁵ As such, they should be given the opportunity to provide informed consent for any medical procedure, on an equal basis with others. As the CRPD Committee found in its General Comment No. 1 on equal recognition before the law, the right to health “includes the right to health care on the basis of free and informed consent.”¹⁶ The right to health in conjunction with the right to legal capacity means that “States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities.”¹⁷ The International Federation of Obstetricians and

Gynecologists (FIGO) has also stated that “[o]nly women themselves can give ethically valid consent to their own sterilisation. Family members – including husbands, parents, legal guardians, medical practitioners and, for instance government or other public officers – cannot consent on any woman’s or girl’s behalf.”¹⁸ As such, if a reproductive health procedure is performed on a woman or girl without her informed consent—regardless of whether a parent, guardian, health care worker, judge, or other individual provides consent—it should be considered a forced or coerced procedure and subject to sanctions.¹⁹ Indeed, the Committee against Torture and the UN Special Rapporteur on Torture, Juan Mendez have found that forced or coerced reproductive health procedures may constitute forms of torture or ill-treatment, requiring that states ensure redress for victims of these human rights abuses.²⁰

In order to ensure the right to autonomy for persons with disabilities in health care settings, the CRPD Committee in its General Comment No. 1 on equal recognition before the law recommended that “States parties ensure that decisions relating to a person’s physical or mental integrity can only be taken with the free and informed consent of the person concerned”²¹ and found that “States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe.”²² Concerning girls with psychosocial disabilities in particular, as the UN Special Rapporteur on Health noted in his recent report on adolescent health, “[p]articular regard must be afforded to the barriers faced by adolescents with disabilities, as their views should be given due weight in accordance with age and maturity on an equal basis with others and as they must be provided with opportunities for supported decision-making.”²³

Supported decision-making is an especially valuable tool for ensuring that women and girls with psychosocial disabilities can exercise their sexual and reproductive autonomy. According to the CRPD Committee, “[s]upport in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision-making.”²⁴ Supported decision-making may take place through formal or informal arrangements, may consist of many different individuals providing support in various aspects of a person’s life, and may also require that institutions provide information in accessible formats to enable persons with disabilities to make decisions for themselves.²⁵ The support needed to make decisions will also vary from person to person and should therefore be flexible, while the decision of persons with disabilities not to accept support for decision-making should also be respected.²⁶

III. Access to Justice and Violence against Women with Psychosocial Disabilities

Effective access to justice is essential for ensuring the respect, protection, and fulfillment of all human rights. However, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has found that cultural and social factors lead justice systems to discount the testimony of women and undermine their ability to participate in the legal system.²⁷ These barriers are compounded for women with disabilities. As the CRPD Committee noted in its General Comment No. 3 on women with disabilities, “[w]omen with disabilities face barriers to accessing justice including with regard to exploitation, violence and abuse, due to harmful stereotypes, discrimination and lack of procedural and reasonable accommodations, which can lead to their credibility being doubted and their accusations being dismissed.”²⁸ The CEDAW Committee has also recognized that women with disabilities face particular barriers in accessing justice, including physical barriers, and in its General Recommendation No. 33 on access to justice has called on states to “[p]ay special attention to access to justice systems for women with disabilities.”²⁹ According to the CRPD Committee, barriers to accessing justice disproportionately affect women and girls with psychosocial disabilities worldwide, alongside women with intellectual disabilities, because their testimonies “are dismissed from court proceedings because of legal capacity, thus denying them justice and effective remedies as victims of violence.”³⁰

As the former UN Special Rapporteur on Violence against Women, Rashida Manjoo, recognized in her 2012 report on women with disabilities, barriers to accessing justice for women with disabilities are particularly acute in cases concerning gender-based violence where courts often rely on victims to provide key evidence.³¹ Indeed, women with disabilities are subjected to gender-based violence at higher rates than other women,³² and women and girls with psychosocial disabilities are at further risk of violence. For example, in the United Kingdom (UK), while approximately one in four women experiences domestic violence in their lifetime, nearly one in every two women with disabilities experience domestic violence.³³ A 2015 review from Public Health England found that persons with psychosocial disabilities were four times more likely to have experienced violence in the past year and that women with “anxiety disorder” or “depressive disorder” were two-to-four times more likely to have experienced domestic violence.³⁴ However, according to a 2014 study by the Metropolitan Police Services in the UK, women with psychosocial disabilities were 40% less likely than other victims to have sexual violence cases referred by police for prosecution, and the decision of a detective to refer a rape case for prosecutions was rarely subjected to outside scrutiny.³⁵ As the author of the 2014 report noted, “[v]ictim vulnerabilities effectively protect suspects from being perceived as credible rapists,” indicating that it is often the status of the victim herself as a woman with a disability and the stereotypes associated with that disability that leads to these low rates of referral.³⁶

Furthermore, worldwide, women and girls with psychosocial disabilities are also more likely to be deprived of their liberty and sent to psychiatric or long-term residential institutions, a situation that puts them at further risk of gender-based violence and inhibits their access to justice mechanisms.³⁷ This violence can include forced institutionalization, forced treatment, sexual violence, and physical, emotional, and mental abuse, among others.³⁸ As the CRPD Committee noted in its General Comment No. 3 on women with disabilities, “[p]erpetrators [of violence against women with disabilities in institutions] may act with impunity because they perceive little risk of discovery or punishment as access to judicial remedies is severely restricted, and women with disabilities subjected to such violence are unlikely to be able to access helplines or other forms of support to report such violations.”³⁹ For instance, a 2013 Human Rights Watch report about abuses against women with disabilities in institutions in India found that none of the 128 women who reported violence had been able to file First Information Reports or otherwise access redress mechanisms to address their forced institutionalization or the verbal, physical, or sexual abuse they suffered.⁴⁰

Furthermore, women with psychosocial disabilities in several countries may be specifically barred from testifying in court, because of their perceived lack of legal capacity or because they have been formally deprived of legal capacity. As the former UN Special Rapporteur on Violence against Women, Rashida Manjoo, recognized in her report on women with disabilities, perceptions about their credibility—as well as the “infantilisation” of and stereotypes about many women with disabilities—leads to a “systematic failure of the court system to acknowledge them as competent witnesses.”⁴¹ For instance, under the rules of evidence in Bangladesh, any person of “unsound mind”—a term that usually includes persons with psychosocial disabilities—may be barred from testifying in court if a judge determines that that person cannot rationally answer questions.⁴² Additionally, according to advocates in Japan, the Japanese Supreme Court has created a higher standard of “particular careful consideration” for victim testimony in cases of sexual violence, leading it to dismiss testimony from some more marginalized groups, including women with disabilities.⁴³ Furthermore, in cases of sexual violence in particular, justice system actors such as police and court personnel may hold particular stereotypes about the sexuality of women with disabilities—such as that they are asexual or, in the case of women with psychosocial disabilities, are hypersexual and cannot control themselves—leading them to doubt testimony or disregard complaints of violence.⁴⁴ Indeed, evidence of prior mental health treatment may be used against victims with psychosocial disabilities to discount their testimony.⁴⁵

Article 13 of the CRPD requires states to “ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.”⁴⁶ As such, the CRPD recognizes the importance of witnesses in the justice system generally, and the specific need to ensure that persons with disabilities can participate fully as witnesses in all stages of the judicial process.⁴⁷ In its General Comment No. 3 on women with disabilities, the CRPD Committee took particular note of situations where “women with intellectual or psychosocial disabilities are dismissed from court proceedings because of legal capacity, thus denying them justice and effective remedies as victims of violence,” classifying this violation as a form of direct discrimination.⁴⁸ These provisions indicate that states should remove laws and policies that block persons with psychosocial disabilities from participating in justice mechanisms, such as those that may bar persons deprived of legal capacity from testifying in court, while also undertaking training with the courts and the police and awareness-raising campaigns the public to overcome stereotypes about persons with psychosocial disabilities, including women with psychosocial disabilities.⁴⁹

The CRPD also requires that states ensure reasonable accommodation for all persons with disabilities, including persons with psychosocial disabilities, when accessing justice. This requires that states “promot[e] the training of professionals in the justice sector to ensure there are effective remedies for women with disabilities who have been subjected to violence.”⁵⁰ It also requires that states provide reasonable accommodation for ensuring access to justice, including by allowing persons with psychosocial disabilities to provide witness statements or testimony in circumstances that are comfortable for them, such as in their homes or via videolink, and with the support of an interpreter or other person.⁵¹

Thank you for your time and consideration of this submission. Should you have any questions regarding this submission, please do not hesitate to contact Stephanie Ortoleva, WEI’s President and Legal Director, at President@WomenEnabled.org or +1 202 630 3818.

¹ This submission will address the situation of women with disabilities throughout the life cycle. Any reference to “women with disabilities” should be interpreted to include girls with disabilities unless otherwise indicated.

² CRPD Committee, *General Comment No. 1: Article 12: Equal recognition before the law*, ¶ 42, U.N. CRPD/C/GC/1 (2014) (“Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities.”) [hereinafter CRPD Committee, *Gen. Comment No. 1*].

³ UN Special Rapporteur on Violence against Women, *Report of the Special Rapporteur on violence against women, its causes and consequences*, ¶¶ 28 & 36, U.N. Doc. A/67/227 (2012) [hereinafter SRVAW, *Report on women with disabilities*].

⁴ CRPD Committee, *General Comment No. 3: Article 6: Women and girls with disabilities*, ¶ 44, U.N. Doc. CRPD/C/GC/3 (2016) [hereinafter CRPD Committee, *Gen. Comment No. 3*].

⁵ *Id.*

⁶ CRPD Committee, *Gen. Comment No. 1*, *supra* note 2, ¶ 35.

⁷ *Id.*, ¶ 9.

⁸ CRPD Committee, *Gen. Comment No. 3*, *supra* note 4, ¶ 44.

⁹ World Health Organization, et al, *Eliminating forced, coercive or otherwise involuntary sterilization: An interagency statement 1* (2014), available at http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325_eng.pdf.

¹⁰ Medical Termination of Pregnancy Act, 1971, § 3(4)(a) (1971) (India).

¹¹ Supreme Court of India, *Suchita Srivastava & Anr vs Chandigarh* (2009), available at <https://indiankanoon.org/doc/1500783/>.

¹² See Convention on the Rights of Persons with Disabilities, adopted Dec. 13, 2006, arts. 5, 8, 9, 12, 15, 16, 23 & 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]; Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, arts. 1, 2, 5, 12 & 16, 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); Convention against Torture and Other Cruel, Inhuman or

Degrading Treatment or Punishment, adopted Dec. 10, 1984, arts. 2 & 3, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (entered into force June 26, 1987); International Covenant on Civil and Political Rights, adopted Dec. 16, 1966, arts. 7, 17 & 19, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force Mar. 23, 1976); CAT Committee, *General Comment No. 2: Implementation of article 2 by States parties*, ¶¶ 21-22, U.N. Doc. CAT/C/GC/2 (2008).

¹³ See, e.g., CRPD Committee, *Gen. Comment No. 3*, *supra* note 4, ¶ 44; CRPD Committee, *General Comment No. 1*, *supra* note 2, ¶ 35.

¹⁴ *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, ¶ 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995).

¹⁵ CRPD Committee, *General Comment No. 1*, *supra* note 2, ¶¶ 17 & 27-28.

¹⁶ *Id.*, ¶ 41.

¹⁷ *Id.*

¹⁸ International Federation of Gynecology and Obstetrics (FIGO), *Female Contraceptive Sterilisation*, ¶ 7 (June 2011), available at <http://www.figo.org/sites/default/files/uploads/wg-publications/ethics/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf>.

¹⁹ *Id.*

²⁰ See, e.g., Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez*, U.N. Doc. A/HRC/22/53 (2013); CAT Committee, *Concluding Observations: Peru*, ¶ 19, U.N. Doc. CAT/C/PER/CO/6, (2012); CAT Committee, *Concluding Observations: Czech Republic*, ¶ 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012).

²¹ CRPD Committee, *General Comment No. 1*, *supra* note 2, ¶ 42.

²² *Id.*

²³ Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, ¶ 61, U.N. Doc. A/HRC/32/32 (2016).

²⁴ CRPD Committee, *Gen. Comment No. 1*, *supra* note 2, ¶ 17.

²⁵ *Id.*

²⁶ *Id.*, ¶¶ 18-19.

²⁷ CEDAW Committee, *General Recommendation No. 21: Equality in Marriage and family relations*, cmt. 7 (1994).

²⁸ CRPD Committee, *Gen. Comment No. 3*, *supra* note 4, ¶ 52.

²⁹ CEDAW Committee, *General Recommendation No. 33 on women's access to justice*, ¶¶ 13 & 17(g), U.N. Doc. CEDAW/C/GC/33 (2015).

³⁰ CRPD Committee, *Gen. Comment No. 3*, *supra* note 4, ¶ 17(a).

³¹ SRVAW, *Report on women with disabilities*, *supra* note 3, ¶ 41.

³² United States Agency for International Development (USAID), *Untied States Strategy to Prevent and Respond to Gender-based Violence Globally 7* (Aug. 10, 2012), <http://www.state.gov/documents/organization/196468.pdf>. It is worth noting that no global data exists on the incidence of such violence, and studies draw on different sources of data.

³³ Women's Aid, *What is Domestic Violence/Forms of Domestic Violence* (2007), <http://www.domesticviolence.london.nhs.uk/1-what-is-domestic-violence-/21-domestic-abuse-perpetrated-against-people-with-disabilities.html>.

³⁴ PUBLIC HEALTH ENGLAND, *DISABILITY AND DOMESTIC ABUSE: RISK, IMPACTS AND RESPONSE 10* (2015), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf.

³⁵ Melanie Newman, *Rape has been 'decriminalised' for the most vulnerable says senior Met advisor*, THE BUREAU OF INVESTIGATIVE JOURNALISM, Feb. 28, 2014, available at <https://www.thebureauinvestigates.com/2014/02/28/rape-has-been-decriminalised-for-the-most-vulnerable-says-senior-met-adviser/>.

³⁶ *Id.*

³⁷ CRPD Committee, *Gen. Comment No. 3*, *supra* note 4, ¶ 53.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ HUMAN RIGHTS WATCH, "TREATED WORSE THAN ANIMALS": ABUSES AGAINST WOMEN AND GIRLS WITH PSYCHOSOCIAL OR INTELLECTUAL DISABILITIES IN INSTITUTIONS IN INDIA 69 (2014)

⁴¹ SRVAW, *Report on Women with Disabilities*, *supra* note 3, ¶ 41.

⁴² Evidence Act of 1872, § 118 (Bangladesh).

⁴³ See, e.g., IWRAW Asia-Pacific, *Partner Feedback to the Update on General Recommendation No. 19 on Violence against Women by the CEDAW Committee* 17 (2016).

⁴⁴ Stephanie Ortoleva and Hope Lewis, *Forgotten Sisters—A Report on Violence against Women with Disabilities: An Overview of Its Nature, Scope, Causes and Consequences* Sect. II (2012).

⁴⁵ *Id.*

⁴⁶ CRPD, *supra* note 12, arts. 12 & 13.

⁴⁷ Stephanie Ortoleva and Hope Lewis, *Forgotten Sisters—A Report on Violence against Women with Disabilities: An Overview of Its Nature, Scope, Causes and Consequences* Sect. II (2012).

⁴⁸ CRPD Committee, *Gen. Comment No. 3, supra* note 4, ¶ 17(a).

⁴⁹ CRPD, *supra* note 12, art. 8.

⁵⁰ CRPD Committee, *Gen. Comment No. 3, supra* note 4, ¶ 26.

⁵¹ CRPD Committee, *General Comment No. 2: Article 9: Accessibility*, ¶ 37, U.N. Doc. CRPD/C/GC/2 (2014).