



**Women Enabled International
Submission on Deprivation of Liberty and Women and Girls with Disabilities
to the Working Group on the issue of Discrimination against Women in Law and in Practice**

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I. Introduction

[Women Enabled International](#) (WEI) appreciates the opportunity to provide this additional information to the United Nations Working Group on the issue of Discrimination against Women in Law and in Practice (the Working Group) to inform its forthcoming Report on the issue of deprivation of liberty and its impact on women. WEI's submission focuses on deprivation of liberty and how it impacts women and girls with disabilities. WEI works at the intersection of women's rights and disability rights to advance the rights of women and girls with disabilities around the world. Through advocacy and education, WEI increases international attention to—and strengthens international and regional human rights standards on—issues such as violence against women, sexual and reproductive health and rights, access to justice, education, legal capacity, and humanitarian emergencies. Working in collaboration with women with disabilities rights organizations and women's rights organizations worldwide, WEI fosters cooperation across movements to improve understanding and develop cross-cutting advocacy strategies to realize the rights of all women and girls.

Under international human rights law, the right to liberty encompasses the right of every person not to be subjected to arbitrary detention and to be brought before a court to question that detention.¹ Persons with disabilities are subjected to specific forms of deprivation of liberty, sometimes supported by legislation, especially criminal and mental health laws. Drawing on both regional and international human rights standards, this submission focuses on how women and girls² with disabilities, in particular, experience deprivation of liberty due to their gender and disability statuses. The submission identifies isolation, segregation, and institutionalization as specific forms of deprivation of liberty that women with disabilities disproportionately experience as compared to men with disabilities and non-disabled women. The submission then examines how gender-based violence against women with disabilities is both a cause and consequence of such deprivation of liberty and identifies specific barriers that women with disabilities face in accessing justice in connection with these various forms of deprivation of liberty. The submission concludes with some specific recommendations about how the Working Group can strengthen international human rights protections for women and girls with disabilities in the context of deprivation of liberty.

II. Women and Girls with Disabilities and Deprivation of Liberty

1. Women and girls with disabilities experience disproportionate rates of detention in prison and health care settings, violating their right to be free from arbitrary detention.

Persons with disabilities are subjected to specific forms of deprivation of liberty, sometimes supported by legislation, especially criminal and mental health laws. For example, persons with disabilities in conflict with law may be confined for undetermined periods of time in psychiatric institutions without due process guarantees. They can also be institutionalized against their will as a result of their actual or perceived impairment, or their alleged dangerousness, or merely because of the lack of services in the community to address their needs. Substituted decision-making regimes such as guardianship contribute to high rates of institutionalization. Often, guardians have the decision-making authority to place a woman with a disability in an institution. As long as a woman remains deprived of legal capacity, her ability to

challenge her institutionalization is limited, even if that institutionalization goes against her own will and preferences.

Women with disabilities, in particular, are disproportionately represented in jails and prisons. While women with disabilities account for roughly one-fifth of the world's population of women,³ one study found that female prisoners were five times more likely to have a mental health-related disability (usually referred to as a “psychosocial disability”), than the general population,⁴ while another study found that as many as 80% of female detainees in jails had a psychosocial disability.⁵

In some countries, the closure of psychiatric and other institutions has not been accompanied by sufficient community-based support services for people with disabilities, particularly psychosocial and intellectual disabilities.⁶ Without adequate support, persons with psychosocial disabilities in particular may be discriminatorily perceived as more “dangerous” to themselves or others, contributing to higher rates of incarceration or other forms of detention.⁷ The evidence bears this out. For instance, one study from **France** estimated that over seven out of ten women in prison and eight out of ten men in prison were people with psychosocial disabilities.⁸ In the **United States**, jails actually house more persons with psychosocial disabilities than all of the country's psychiatric hospitals combined.⁹ The percentage of women with disabilities who are incarcerated in the United States is very high compared to men with disabilities. According to the United States Bureau of Justice Statistics, 40 percent of women prisoners reported having some sort of disabilities compared to 31% of males. The number in jails is even higher with nearly half (49%) of the women have disabilities while only 39% of male inmates have disabilities.¹⁰

Persons with disabilities in conflict with the law may also be confined in psychiatric institutions as a “security measure,” rather than placed in the regular prison population, which can lead to disparate outcomes in access to justice. For instance, in **Kenya**, women with psychosocial disabilities in conflict with the law are institutionalized in Kenya's Mathare Mental Hospital in maximum security where cases can languish for years.¹¹

Furthermore, women with disabilities are disproportionately detained in institutions, including psychiatric hospitals and long-term residential care institutions, as compared to men with disabilities. All persons with disabilities—particularly psychosocial disabilities and intellectual disabilities (sometimes referred to as cognitive disabilities or learning disabilities)—are vulnerable to being placed in institutions against their will or without their consent, based on their disability status. They may be institutionalized against their will as a result of their actual or perceived impairment, their perceived dangerousness, or merely because of the lack of services in the community to support their independent living. However, according to the former Special Rapporteur on the Right to Housing, Miloon Kothari, women with disabilities worldwide are more likely to be institutionalized than men.¹² Furthermore, according to UNICEF, girls and young women with disabilities are also more likely to be institutionalized than are boys with disabilities.¹³

Under international human rights law, the right to liberty encompasses the right of every person not to be subjected to arbitrary detention and to be brought before a court to question the detention.¹⁴ The Convention on the Rights of Persons with Disabilities (CRPD) contains specific protections against arbitrary detention for persons with disabilities. Article 14 of the CRPD enumerates that States have an obligation to “ensure that persons with disabilities, on an equal basis with others, ... are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and *that the existence of a disability shall in no case justify a deprivation of liberty.*”¹⁵ As the Committee on the Rights of Persons with Disabilities (CRPD Committee) asserted in a guidance note on Article 14, this article contains an “absolute prohibition of detention on the basis of impairment,” actual or perceived, noting that detention on the basis of disability is discriminatory in nature and thus amounts to an arbitrary deprivation of liberty.¹⁶ According to the CRPD Committee, detention on the basis of disability includes involuntary commitment of persons with disabilities on both disability and health care-related grounds, such as “risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or

health diagnosis.”¹⁷ The CRPD Committee notes that persons with intellectual or psychosocial disabilities may be considered dangerous to themselves or others for exercising their right to withhold consent from medical or therapeutic treatments,¹⁸ which means that the allegedly neutral “dangerousness” grounds for detention may still be discriminatorily applied to them. Accordingly, the CRPD Committee expresses its “concern about security measures that involve indefinite deprivation of liberty and the absence of regular guarantees in the criminal justice system” and “recommend[s] eliminating security measures, including those which involve forced medical and psychiatric treatment in institutions.”¹⁹

Other international human rights experts have reinforced this interpretation. For instance, the U.N. Working Group on Arbitrary Detention has also found that “the involuntary committal or internment of persons on the ground of the existence of an impairment or perceived impairment, particularly on the basis of psychosocial or intellectual disability, is prohibited.”²⁰ This Working Group also affirms that the “detention [of persons with disabilities] in institutions against their will, without their consent or with the consent of a substituted decision-maker constitutes arbitrary deprivation of liberty in violation of international law.”²¹ Furthermore, the U.N. Office of the High Commissioner for Human Rights (OHCHR) has found that Article 14 of the CRPD establishes an absolute ban on deprivation of liberty on the basis of an impairment, thus precluding non-consensual institutionalization and treatment.²² The former Special Rapporteur on Torture, Manfred Novak, has further affirmed that arbitrary detention on the basis of disability may amount to ill treatment in violation of the Convention against Torture.²³

Moreover, the CRPD protects the rights of persons with disabilities to make important life decisions on an equal basis with others,²⁴ and the CRPD Committee has emphasized that in conjunction with this right, “States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities.”²⁵ In this respect, laws and policies that allow a person with a disability to be institutionalized with the consent of a guardian or conservator, against the will of that individual, facilitate high rates of deprivation of liberty of persons with disabilities in violation of the CRPD.

2. Isolation in the home and institutionalization stem from harmful stereotypes and violate the right of women and girls with disabilities to be included in the community and constitute a unique form of deprivation of liberty.

Women with disabilities also experience isolation, segregation, and dependency on others—other forms of deprivation of liberty—more often than men with disabilities or other women.²⁶ Families may isolate women with disabilities due to shame about having a woman with a disability in the family or may segregate them for protection from violence and harassment. But isolation, segregation, and dependency may also be forms of violence against women with disabilities, used as methods of control over a population that already faces significant barriers to participating in society on an equal basis with others.²⁷

a) Harmful gender and ableist stereotypes contribute to high rates of isolation and institutionalization of women with disabilities

Women with disabilities are frequently viewed as being unable to fulfill the traditional, and discriminatory, gender role as mothers and caregivers.²⁸ Deriving from both patriarchal gender stereotypes and abelist stereotypes, this perception leads families and society to view women with disabilities as “burdens.” This in turn leads to assumptions about the roles disabled women can assume in the family and community and contributes to an historic undervaluing of women with disabilities. At the same time, due to their gender, women with disabilities have less power to make decisions within the family.²⁹

Both of these circumstances increase the chances that women with disabilities will be placed in institutions or isolated in their homes rather than supported to participate in society. As the CRPD Committee has noted, “Cultural norms and values may adversely restrict the choices and control of women and girls with disabilities over their living arrangements, limit their autonomy, oblige them to live

in particular living arrangements, require them to suppress their own requirements and instead serve those of others and take certain roles within the family.”³⁰

In **India**, CREA, a feminist human rights organization based in India, reported that forced institutionalization disproportionately impacts women with disabilities because of their disempowerment within families, leading to even greater isolation and disempowerment.³¹ In **Argentina**, a report made by Centro de Estudios Legales y Sociales (CELS), Centro Provincial por la Memoria and Movimiento por la Desmanicomialización del Romero analyzes the differentiated impact of psychiatric institutionalization on women and states that they experience a juxtaposition of oppressions based on the fact that “they are women, they are poor, and they are ‘mad.’”³² The report suggests that the more women do not fulfill the patriarchal stereotype that society demands, the greater the likelihood of institutionalization. For example, the report notes that workers from the hospital recall the case of a 40-year-old woman who was taken to the hospital by her partner, who said that “first, she stopped working, and now she does not do any housework, not even take care of children.”³³

Isolation occurs not only in institutions but also at home or when women are segregated from their communities due to the stigma and stereotypes, protective reasons, and the lack of basic services in the community. In **Nigeria**, for example, the National Policy on Rehabilitation of Persons with Disabilities, which pre-dates Nigeria’s ratification of the CRPD, notes that women with disabilities “suffer double jeopardy” due to both their gender and disability statuses, based on negative attitudes, stereotypes, and lack of understanding of women with disabilities.³⁴ For example families of women with mental disabilities in Nigeria have reported that they had forcibly confined or sterilized women with disabilities for protective reasons.³⁵ Also, Nigerian women with disabilities experience a wide variety of discrimination and stereotypes about their capabilities and role in society, what makes them economically dependent and leaves them with no alternative than to stay at her family’ or partners’ home, in spite of their will. For example, women with disabilities face higher rates of unemployment and increased barriers to receiving income support, and they are also more likely to live in poverty than men with disabilities.³⁶ Particularly in rural areas, are viewed as useless or unhelpful because they are perceived as not being able to farm.³⁷ This economic dependence is aggravated due to discriminatory laws that prevent women with disabilities from inheriting property and land, carrying on the family name, and making family decisions, while allowing men to engage in these activities.³⁸ Stereotypes about persons with disabilities also cause isolation or segregation, as women with disabilities are seen as “less human, faulty, witches, less productive, illiterate and repulsive.”³⁹ Indeed, persons with disabilities who are perceived as witches may also be blamed for a community’s misfortunes, including violence that arises because of conflict, a situation that exacerbates the exclusion because many persons with disabilities are already segregated from their communities due to stigma and poverty.⁴⁰

A **South African** academic study published in 2015 showed that, because of the dearth of community-based support services and the prevalence of resentment towards women with disabilities, families sometimes choose to institutionalize women with disabilities to enable these families to “just get on with their lives.”⁴¹ Forced institutionalization is itself a form of violence, and because institutionalization also leads to isolation and dependence, frequently without adequate oversight, institutionalizing women with disabilities in both State and non-State facilities increases their vulnerability to violence.⁴²

Lack of inclusive education and gender stereotypes that de-prioritize the education of girl children can contribute to isolation and segregation for girls with disabilities. As the CRPD Committee has noted, “[g]irls with disabilities experience social isolation, segregation and exploitation inside the family, including by ... being forbidden from attending school.”⁴³ Moreover, when children with disabilities are segregated in special schools, or where they lack access to education at all, they are more likely to be placed in institutions.

Discriminatory gender stereotypes and other intersecting forms of discrimination and exclusion,⁴⁴ including socioeconomic status, can result in different levels of social inclusion for girls with disabilities

as compared to boys with disabilities. In **Poland**, for example, men with disabilities are generally more educated than women with disabilities, which opens up more opportunities for men with disabilities in the labor market.⁴⁵ Girls with disabilities in families with greater resources are more likely to complete their education, including university.⁴⁶ However, barriers in the education system, cultural norms, and the low socio-economic status of the majority of families of girls with disabilities perpetuate their segregation and exclusion in all levels of education. Recent developments concerning the Polish educational system indicate that the government continues to believe that education for some children with disabilities should be segregated, rather than inclusive. For instance, following a decision by the Ministry of Education, starting in September 2018, many children with disabilities who had been offered individual education within public schools are now denied this educational trajectory and instead will have to be homeschooled and remain isolated from their peers.⁴⁷

In **Colombia**, “special” education institutions do not provide appropriate educational services or follow legal subjects and curriculums.⁴⁸ As a consequence, persons with disabilities are often excluded from formal educational spaces from early ages, which affects their professional and economic future and perpetuates the cycle of social exclusion.⁴⁹ Also, lack of school attendance has been shown to increase the risks of sexual violence and unwanted teenage pregnancies,⁵⁰ which in turn can further perpetuate isolation from the community.

b) Financial inequalities contribute to high rates of institutionalization and isolation for women with disabilities.

Economic independence has long been recognized as a major factor in preventing and responding to violence against women, particularly domestic violence.⁵¹ Women with disabilities are more likely than men with disabilities or other women to live in poverty and generally also have lower rates of employment, situations that affect their opportunity to live independently.⁵² Furthermore, some families may feel as if they have no choice but to institutionalize women with disabilities, because they do not have the resources to care for them, fear that they may be abused in their communities, and are concerned otherwise about their limited life prospects, which are influenced by both their gender and disability.⁵³

In **Argentina**, for example, forced institutionalization of girls and young people with disabilities persists. The CRPD Committee recognized in its concluding observations that the National Mental Health Law - that orders the creation of a network of community-based services- has a human rights approach, which should result in the deinstitutionalization of children and adolescents.⁵⁴ However, the law is still not implemented effectively, which led the CRPD Committee to recommend the adoption of an implementation plan.⁵⁵ A report by CELS, Comisión Provincial por la Memoria, and Movimiento por la Desmanicomialización del Borda states that the population of the psychiatric hospital reflects the fact that women typically are poorer than men.⁵⁶ Most women do not have property or property guarantees to rent a house, there are no sustainable employment opportunities and, in the absence of adequate social protection policies, the monthly pensions or subsidies that women are not enough to leave the institution.⁵⁷ On the other hand, some of them have their own money and assets, but do not know the resources they have at their disposal to be able to leave the institution.⁵⁸

Many families in **South Africa** are dependent on older women or minor children for their livelihoods and support due to high rates of HIV-related deaths and the lack of health services.⁵⁹ For such families already struggling financially, a family member with a disability is often viewed as a substantial responsibility.⁶⁰ This view is exacerbated by the lack of services and supports for persons with disabilities and their families, which fosters resentment towards the person with a disability.⁶¹ This resentment can increase a woman’s vulnerability to violence or lead to her being left at home without support on a regular basis, itself a form of violence as identified by the CRPD Committee.⁶²

In **India**, women with disabilities and their families often lack access to or information about care or support services outside of institutions and within local communities,⁶³ which can lead families to institutionalize women with disabilities without their consent, as they see no alternative.

In **Kenya**, the Mental Health Act permits forced treatment of persons with psychosocial disabilities.⁶⁴ The Act also mandates loss of liberty on account of disability where women with psychosocial disabilities are placed in institutional settings without their consent. Families also place them in institutions because parents feel it is a burden to take care of their children; this is exacerbated by poverty resulting in many girls with disabilities being institutionalized all their life denying them the right to parental care, family, education and the right to live in society. In these institutions there are cases of sexual and physical violence. A large number of children remain in orphanages that are unregistered as noted by the Committee on the Rights of the Child in its last evaluation of Kenya.

c) Isolation and institutionalization violate the rights of women with disabilities to live independently and be included in their communities

Under the CRPD, persons with disabilities have the rights to live independently and be included in their communities. Article 19 of the CRPD recognizes “the equal right of all persons with disabilities to live in the community, with choices equal to others,” with States that have ratified the CRPD committing to “take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community.”⁶⁵ According to the CRPD Committee, Article 19 entails “the obligation to release all individuals who are confined against their will in mental health services or other disability-specific forms of deprivation of liberty”⁶⁶ and adopt a “strategy and a concrete plan of action for deinstitutionalization.”⁶⁷ States also have an obligation to ensure that persons with disabilities can choose their place of residence and with whom to live on an equal basis with others. They have also the obligation to guarantee access to specific services to support living and inclusion in the community, and that “community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.”⁶⁸ The CRPD Committee has moreover noted that the right of women with disabilities to live independently is often “adversely affected by cultural norms and patriarchal family values.”⁶⁹ Thus, the CRPD Committee has found that Article 19 requires States to take measures to tackle discrimination and barriers women with disabilities face in accessing social services needed for independent living and to address violence, as well as supports for entering the labor market.⁷⁰

In his 2018 report to the Human Rights Council, the U.N. Special Rapporteur on the Right to Health, Dainius Puras, also supports the right to live in the community, and particularly the provision of mental health services in community—rather than institutional—settings. He calls on states to “radically reduce the use of institutionalization in mental health-care settings, with a view to eliminating such measures and institutions” while recognizing that although it might be challenging to radically reduce and eliminate non-consensual institutionalization and treatment, “[f]ailure to take measures towards such change is no longer acceptable....”⁷¹ He urges States to “[e]nhance community-based facilities that empower and promote recovery and healthy relationships, while radically reducing and progressively eliminating non-consensual measures and institutionalization in mental health-care settings.”⁷²

Similarly, in its 2015 report, the U.N. Working Group on Arbitrary Detention finds that, not only must States ensure that institutions arbitrarily detaining persons with disabilities release them immediately and cease any forced treatment, but also finds that States must “establish a public authority to provide for access to housing, means of subsistence and other forms of economic and social support in order to facilitate de-institutionalization and the right to live independently and be included in the community” for persons with disabilities.⁷³ It further notes that “[s]uch assistance programmes should not be centred on the provision of mental health services or treatment, but free or affordable community-based services, including alternatives that are free from medical diagnosis and interventions.”⁷⁴

The right to live in the community has further been recognized by the Inter-American Commission on Human Rights (IACHR) in its jurisprudence and monitoring processes. In 2012, the IACHR issued precautionary measures to protect the life and integrity of 334 persons, including many women and girls with disabilities, who were detained in degrading conditions in the Federico Mora Hospital in Guatemala and were subjected to abuse and violations of their sexual and reproductive rights. When following up on Guatemala's compliance with the precautionary measures, the IACHR found that "[the] lack of support and community services for persons with disabilities and their families creates incentives to institutionalize these persons and, consequently, violates their right to live in the community"⁷⁵ and that "the measures adopted have not been focused on the creation of community-based services and that despite the notable increased hospital budget, these resources have not been used to create alternatives in the community."⁷⁶ Quoting the CRPD Committee in its Concluding Observations to Guatemala, the IACHR stated that "the lack of services designed to meet the needs of the patients of this institution in the community leads to their indefinite segregation."⁷⁷ The IACHR recommended that Guatemala "guarantee community living for these persons, by creating and establishing community-based services."⁷⁸

3. Gender-Based Violence is both a Cause and Consequence of Deprivation of Liberty for Women with Disabilities

Women with disabilities are at least two to three times more likely than women without disabilities to experience gender-based violence,⁷⁹ and they are more likely to experience abuse over a longer period of time, resulting in more severe injuries.⁸⁰ Gender-based violence can contribute to greater isolation for women with disabilities, increasing their deprivation of liberty. Gender-based violence can also occur as a result of deprivation of liberty, as women with disabilities in both prisons and institutions are at heightened risk of gender-based violence.

a) Gender-based Violence Contributes to Isolation and Segregation of Women with Disabilities

Domestic violence against women with disabilities often leads to greater isolation for them as they may be more physically, emotionally, or financially dependent on abusers (who are frequently also caregivers), and have fewer legal, economic, and social options to leave abusive relationships.⁸¹ In domestic violence situations, women with disabilities may fear leaving an abuser because of emotional, financial or physical dependence.⁸² Women with disabilities may also fear losing custody of their children if they report domestic violence or leave a violent relationship.⁸³ Some of those who provide assistance may inflict violence through purposeful neglect to "punish" or manipulate women with disabilities, while others may confine a woman with disabilities to her home or institution or isolate her from other human contact.⁸⁴

In **India**, the Women with Disabilities India Network has documented the stories of women with disabilities who have experienced gender-based violence in the private sphere, ranging from harassment and emotional abuse to rape and physical violence.⁸⁵ Frequently this violence is a result of either the perceived vulnerability of women with disabilities or the stigma associated with disability itself, particularly within families and marital homes.⁸⁶ A 2013 study of women with disabilities in Mumbai, India indicated that they experienced a continuum of violence in the home, including neglect and isolation.⁸⁷

The lack of accessible support services can deepen the isolation caused by gender-based violence. For instance, in a 2007 survey of 30 women with disabilities in the **United Kingdom (UK)** who were victims of domestic violence, all of them reported that being disabled worsened the abuse and also put up barriers to them leaving abusive homes.⁸⁸ Women with disabilities in the UK reported that they were sometimes physically unable to flee abusive homes, particularly where public transportation is inaccessible.⁸⁹ In a small qualitative study in 2012, women with intellectual disabilities in the UK reported particular problems with accessing support services, stating that they received inappropriate or unhelpful responses to their requests for help.⁹⁰ Because of the unhelpfulness of these services and lack of services targeted specifically for women with intellectual disabilities, two of the five women in the study reported that they

had to stay in their abusive homes and felt even more powerless in the face of domestic violence.⁹¹ Also in the UK, according to a 2014 study conducted by Women’s Aid, women with disabilities may be particularly at risk of financial abuse both because of their disability and because of the disability benefits they receive.⁹² Family members and partners often control access to women’s disability benefits, increasing their isolation.⁹³

In **South Africa**, restrictions of personal liberty are caused by the numerous barriers that women face when trying to access gender-based violence services for women with disabilities are numerous. A number of studies across South Africa reveal a range of barriers that women with disabilities face in accessing gender-based violence services⁹⁴ including due to inaccessible or costly transportation⁹⁵ and patriarchal family dynamics that compel women to stay in abusive and exploitative relationships.⁹⁶

In **Poland**, besides these disability-related challenges, women with disabilities experience difficulties with seeking help and redress for violence that are similar to those experienced by other victims of violence, including shame, codependency, justifying the perpetrator’s behavior, and feelings of weakness and helplessness.⁹⁷ One 2009 survey conducted by the Institute of Psychology of the Polish Academy of Sciences found that over 30% of Poles knew of cases of violence against persons with disabilities.⁹⁸ These abuses included hitting or beating, tugging or pushing, isolating or locking up individuals, and depriving them of material goods.⁹⁹ In addition, women with disabilities in Poland are more likely than other women to be economically dependent on their abusers.¹⁰⁰ All of these issues intersect to isolate women with disabilities, both physically and socially, rendering them more vulnerable to suffer from violence, isolation, and other restrictions of their liberty than men with disabilities and other women.

As the CRPD Committee has stated, Article 19 right to live independently creates an obligation “to tackle discrimination and barriers women with disabilities face in accessing social services needed for independent living and to address violence.”¹⁰¹ International human rights bodies have recognized the obligation of States to ensure that protection services are accessible to women with disabilities to ensure that they are able to escape situations of intimate partner or family violence. The CRPD Committee, for instance, regularly urges States to offer services and information that are targeted at and accessible to women with disabilities.¹⁰² In particular, the CRPD Committee has recommended that States fund accessible helplines,¹⁰³ shelters,¹⁰⁴ victim support services,¹⁰⁵ and therapies and other measures aimed at both psycho-social and physical recovery¹⁰⁶ for women with disabilities who experience domestic and other forms of gender-based violence. In its recent General Recommendation 35, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) similarly emphasized the obligation of States to provide appropriate and accessible protective mechanisms to prevent further or future violence, including by removing communications barriers for women with disabilities.¹⁰⁷ Isolation in the family home or the inability to leave an abusive relationship—especially due to a lack of appropriate, adequate, and accessible services to facilitate independence from an abuser—should be considered not only a violation of the right to living independently but also a violation of the right to liberty.

b) Women with Disabilities experience heightened risk of forced medical interventions and other forms of gender-based violence when deprived of their liberty.

i. Forced Medical Interventions

Women with disabilities experience numerous consequences of deprivation of liberty that disproportionately affect their rights, due to both their gender and disability. One of the most significant of these issues is forced medical interventions¹⁰⁸—which have been classified as forms of torture or ill-treatment, as well as violations of the rights to bodily integrity, to health, and to found a family.¹⁰⁹ Indeed, medical treatment is sometimes the reason given for the institutionalization of a person with a disability, and forced institutionalization occurs because the individual did not agree to the treatment.¹¹⁰ Forced reproductive health interventions typically target women with disabilities in particular; forced sterilization, forced abortion, and forced contraception are performed specifically on women and girls

with disabilities to make care easier for caregivers (e.g., so that caretakers do not have to assist with menstrual hygiene) or to prevent them from becoming pregnant and having a child while institutionalized, including following sexual abuse.¹¹¹

In **Argentina**, for example, high rates of over medicalization of childhood are observed, in the absence of public policies of support, especially due to lack of personnel with tools for their care.¹¹² Although Argentina has made progress in recognizing legal capacity for all persons with disabilities and this has strengthened the legal requirements on informed consent in general, it is still possible to sterilize a child with a disability without his or her consent. Persons detained in psychiatric institutions are assigned a public defender who may assume their legal representation and take decisions on their behalf.¹¹³ Also, article 3 of Law 26.310 still accepts the presentation of requests of judicial authorization for forced sterilization by guardians or legal representatives. While it is not possible to know the frequency with which these procedures are performed, because there is no reliable information on the number of forced sterilizations that occur in Argentina, women under the guardianship system, and especially but not only those detained in institutions are at a high risk of being forcibly sterilized. Indeed, the report by CELS and other organizations above cited documents forced sterilization of women that had been institutionalized against their will. One example is of a woman who was institutionalized in a psychiatric hospital after she left the juvenile institution where she was abused. After giving birth to her first son the doctor tied her fallopian tubes without her consent.¹¹⁴ Another case documented is about a woman diagnosed with moderate mental retardation. She also suffered abuse and violence as a child, was then admitted to a juvenile institution, and became pregnant. The Director of the juvenile institution issued an order to have her fallopian tubes tied when she gave birth to her son. She was never consulted, and when she spoke out she was subjected to violence.¹¹⁵ Additionally, it has been documented that health care professionals utilize injectable contraceptives to women against their knowledge or will, to prevent them from getting pregnant when they are in the process of leaving the institution.¹¹⁶

In **Poland**, recent research conducted specifically on women with disabilities suggests that women with intellectual disabilities living in institutions are sterilized against their will or without their informed consent.¹¹⁷

In **India**, there are several reports from the 1990s of women and girls undergoing forced sterilizations in institutions,¹¹⁸ and as recently as 2008, the government of Maharashtra supported a policy of forcibly sterilizing “mentally challenged” women and girls in institutions as a means of ensuring “menstrual hygiene” or the elimination of periods.¹¹⁹ There is no existing legal provision that prohibits non-consensual sterilization, and in recent years, sterilization methods using certain drugs has been tested on a large scale instead of teaching women with disabilities to manage menstrual hygiene and ensuring that they are protected from rape.¹²⁰ Forced treatment in Indian institutions also includes electroconvulsive therapy (ECT), which can have many side effects, with only the consent of guardians or psychiatrists and often without women even being aware they are receiving ECT.¹²¹ Human Rights Watch found that ECT was sometimes used as a threat against women with disabilities in Indian institutions to get them to adhere to certain behaviors or consent to other treatments.¹²²

Human rights law recognizes forced reproductive health interventions violate fundamental human rights. Indeed, both the European Court of Human Rights and the U.N. Special Rapporteur on Torture, Juan E. Mendez, have determined that women who are forcibly sterilized are denied many basic human rights, including the right to be free from cruel, inhuman, and degrading treatment and in certain instances the right to be free from torture.¹²³ In its General Comment No. 3, the CRPD Committee notes that, because forced contraception and sterilization are particularly common for women in psychiatric and other institutions as well as women with disabilities in custody, States should ensure “that the legal capacity of women with disabilities should be recognized on an equal basis with that of others and that women with disabilities have the right to found a family and be provided with appropriate assistance to raise their children” for women in these situations.¹²⁴ The CEDAW Committee, in its General Recommendation No. 35, similarly recognized that States have an obligation to repeal legislation that allows, tolerates, or

condones forms of gender-based violence, including medical procedures performed on women with disabilities without their informed consent.¹²⁵

The Inter-American system of human rights has also recognized forced medical interventions as a violation of human rights protections. The IACHR addressed the issue when deciding the precautionary measure in favor of the patients of the Federico Mora Hospital in Guatemala above cited. The IACHR acknowledged that women were in a particularly vulnerable situation because they were the main victims of sexual abuse, rape, and other kinds of violations, like forced contraception and limitation of movement. In its decision, IACHR recommended that Guatemala adopt the necessary measures to guarantee the life and personal integrity of the people interned in the Federico Mora Hospital. In particular, it requested the State “to implement immediate prevention measures with the aim to ensure that all patients, particularly women and children, are not subjected to acts of physical, psychological and sexual violence by other patients, security agents or hospital officials.”¹²⁶ The Inter-American Court of Human Rights, in the case of *I.V. v. Bolivia*, determined that sterilization without consent violates a number of rights, including the rights to personal integrity and personal freedom.¹²⁷

ii. Heightened risk of gender-based violence

The U.N. has recognized that “[w]omen prisoners with disabilities are at a particularly high risk of manipulation, violence, sexual abuse and rape.”¹²⁸ The psychological trauma of rape that occurs in prison is compounded because the victim has very limited options to escape the perpetrator.¹²⁹ Additionally, people who are raped in prison may suffer humiliation or stigmatization from other inmates and prison staff because the assaults are often known throughout the prison. Those trying to cope with the psychological trauma of prison rape and sexual assault are often in facilities that do not offer rape counseling or mental health treatment.¹³⁰

For instance, in the **United States**, estimates indicate that at least 13% of inmates have been sexually assaulted; many have experienced repeated assaults.¹³¹ Prisoners with physical disabilities may be actively targeted based on their disabilities or suffer the effects of having their disability-related needs neglected.¹³² Furthermore, most prison staff are not adequately trained to prevent or respond to inmate sexual assaults and prison rape often goes unreported and untreated.¹³³

Gender based violence against women with disabilities also occurs while they are institutionalized. Because institutionalization also leads to isolation and dependence on third parties, frequently without adequate oversight, institutionalization of women with disabilities in both State and non-State facilities in turn increases their vulnerability to violence.

One notable example of this took place in **South Africa**, when a woman with a psychosocial disability was raped in an unlicensed community-based non-governmental residential care facility following her transfer from Life Esidimeni, a government-run institution.¹³⁴ Testimony about the sexual assault was proffered as part of the 2017 hearings regarding the deaths of 144 people with psychosocial disability due to negligent transfers from the Life Esidimeni institutional setting to unlicensed non-governmental service providers, highlighting the grave deficiencies in service provision and oversight in South Africa.¹³⁵ Evidence presented at the hearings revealed that a similar incident had occurred as recently as 2016 and that the facility was unlicensed and ill-equipped to provide safe services to persons with disabilities.¹³⁶

In the **United States**, as many as 83% of female adults with developmental disabilities are victims of sexual assault,¹³⁷ and women with disabilities living in institutions and nursing homes are particularly at risk.¹³⁸ Women with disabilities living in institutions and nursing homes report a “33% prevalence” of experiencing interpersonal violence, compared to 21% of women without disabilities in such institutions.¹³⁹ Their abuser may also be their caregiver, someone that the individual is reliant on for personal care or mobility. Women with disabilities frequently do not report the violence and are not

always privy to the same information available to non-disabled women, particularly where such information is not available in alternative formats.¹⁴⁰

In **India**, women with disabilities—particularly psychosocial and intellectual disabilities—face violence as the result of continued institutionalization in state- and privately-run care homes and hospitals. These women can be institutionalized without their consent and often without recourse to challenge this institutionalization.¹⁴¹ The Women with Disabilities India Network has documented repeated instances of forced institutionalization and abuses in institutions¹⁴² and has reported that forced institutionalization disproportionately impacts women with disabilities because of their disempowerment within families.¹⁴³ Forms of violence experienced by women in institutions include forced treatment, emotional abuse, forcing them to stay naked, and physical abuse as a form of punishment.¹⁴⁴ A 2014 Human Rights Watch report documented forced treatment of women with disabilities in institutions in India, including physical abuse aimed at forcing them to take medicines.¹⁴⁵ Many staff members in Indian institutions are also not adequately trained to work with persons with disabilities, potentially exacerbating abuse.¹⁴⁶

The CRPD Committee has frequently expressed concern about violence and abuse against individuals with disabilities living in institutions,¹⁴⁷ noting that women and girls¹⁴⁸ and children and adolescents¹⁴⁹ face a heightened risk of violence in institutional settings. In at least two instances, the CRPD Committee has expressed concern about the use of institutionalization as the primary recourse in dealing with women and children with disabilities who have been abandoned or abused.¹⁵⁰ The CRPD Committee has called on a number of States to develop appropriate guidelines, protocols, and strategies to monitor institutions that care for persons with disabilities¹⁵¹ to prevent and eliminate violence in institutional settings¹⁵² and to promote access to justice.¹⁵³

The Inter-American Court on Human Rights (Inter-American Court) has also underscored that gender-based violence violates the fundamental rights protected in the American Convention on the Rights of Man. Specifically, in *Miguel Castro Castro Prison v. Peru*, the Inter-American Court found that when women deprived of their liberty are exposed to sexual violence, including forced nudity (which the Inter-American Court recognizes as a form of sexual violence), such practices violate their right to humane treatment.¹⁵⁴

4. Women and Girls with Disabilities Face Additional Human Rights Violations as a Result of their Deprivation of Liberty

Lack of appropriate training for prison staff, inability to make reasonable accommodations for female prisoners with disabilities, and lack of facilities to house women with disabilities can lead to a range of human rights abuses. For instance, female prisoners with disabilities are routinely misclassified as to their risk level due to a lack of facilities to accommodate prisoners with disabilities. The U.N. has recognized this problem, noting “[d]ue to the limited accommodation available for female prisoners, in a number of countries they are housed in security levels not justified by their risk assessment undertaken on admission.”¹⁵⁵ This is exemplified in **Australia**, for instance, where a prisoner who would normally be placed in an open facility can instead be placed in secure custody if a member of the medical, psychological, or psychiatric staff decide that the medical and support services required are unavailable in open custody.¹⁵⁶ The Anti-Discrimination Commission Queensland described this practice as “*prima facie* direct discrimination on the basis of disability.”¹⁵⁷ It is further compounded by the lack of facilities able to house women with “impairments,” meaning that “[b]ecause of these access and support issues, it would appear that female prisoners with certain physical, mental health or intellectual disabilities are much less likely to be located in one of the low security facilities compared to women without a disability.”¹⁵⁸

Solitary confinement and/or the use of restraints is another abuse to which female prisoners with disabilities are often exposed. For instance, the U.N. Special Rapporteur on torture has found that “both prolonged seclusion and restraint may constitute torture and ill-treatment,” and emphasizes that there must be “an absolute ban on all coercive and non-consensual measures, including restraint and

solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.”¹⁵⁹ Both the U.N. Human Rights Committee and the European Court of Human Rights have also found that the incarceration of persons with disabilities without necessary services or accommodations, irrespective of any abusive intent, can constitute inhuman and degrading treatment.¹⁶⁰

Abuses committed against women with disabilities surrounding deprivation of liberty can also constitute violations of their right to health. In his 2018 report to the Human Rights Council, the U.N. Special Rapporteur on the Right to Health found that detention in prisons or other involuntary confinement has a significantly greater impact on women’s right to health. He noted that “[p]ower and authority in prisons and other places of detention and confinement, such as large psychiatric institutions, emerge from historical patriarchal, hyper-masculinist constructions of punishment and control... the acceptability of such environments for the realization of the right to health and for the wellbeing of women is thus questionable.”¹⁶¹ He also found that violations of the right to health are aggravated for women with disabilities, given that “[m]any prisons fail to provide reasonable accommodation to people with disabilities, which has significant consequences on their enjoyment of the right to health and, in some cases, may violate prohibitions against torture and ill-treatment.”¹⁶² The U.N. Special Rapporteur on the Rights of Persons with Disabilities, Catalina Devandas, has urged governments to “respect, in particular, the right to life and the inherent dignity of detainees with disabilities and “provide reasonable accommodation in detention.”¹⁶³

The Inter-American Court has similarly affirmed states’ obligations to provide accommodations and appropriate health care to persons with disabilities deprived of their liberty, including in both state and privately-run institutions. The Inter-American Court has said, for instance, that failure to provide testing equipment, medications, or proper diet for persons with disabilities deprived of their liberty may violate the rights to personal integrity, humane treatment, and life.¹⁶⁴ The Inter-American Court further indicated that a failure to provide prenatal health care or postnatal medical care to pregnant prisoners also constitutes a violation of the right to humane treatment, and for all women prisoners, the state has an obligation to provide for women’s physiological needs.¹⁶⁵

5. Women with disabilities often lack recourse to justice for violations committed against them while deprived of liberty.¹⁶⁶

The issue of non-consensual and, thus arbitrary, deprivation of liberty is intrinsically related to the lack of access to justice that persons with disabilities experience in general, and it has a specific impact on women with disabilities in particular. As discussed above, women are at higher risk than men of being denied legal capacity by the imposition of a substitute decision maker,¹⁶⁷ and denial of legal capacity can, in turn, make it virtually impossible for an individual to access the justice system or to challenge institutionalization.

In **India**, for example, current state laws, policies, and practices reinforce the potential for violence against women with disabilities in Indian institutions. Under the Mental Health Act 1987, women with psychosocial disabilities can be forcibly institutionalized by family members or guardians without a court order and effectively without the opportunity to appeal these decisions.¹⁶⁸ Once institutionalized, they are in practice, if not by law, deprived of the ability to make decisions for themselves, with family members, guardians, or the heads of institutions instead deciding on treatment, leading to abusive forced treatment.¹⁶⁹ If women with disabilities do suffer violence in institutions, they have little access to redress. As Human Rights Watch reported, of 128 instances of abuse documented in Indian institutions in 2014, none of the women had been able to access redress mechanisms to address their forced institutionalization or the verbal, physical, or sexual abuse they suffered.¹⁷⁰

Even when women are not deprived of legal capacity, they still face significant barriers to accessing justice once they are institutionalized. The Working Group on Deprivation of Liberty has stated that “[p]ersons with disabilities are entitled to request individualized and appropriate accommodations and

support, if needed, to exercise the right to challenge the arbitrariness and lawfulness of their detention in accessible ways.”¹⁷¹ With regard to women in general, which includes women with disabilities, it stated that

[a]ppropriate and tailored measures shall be taken into account in the provision of accessibility and reasonable accommodation to ensure the ability of women and girls to exercise their right to bring proceedings before a court to challenge the arbitrariness and lawfulness of detention and to receive without delay appropriate and accessible remedies. This includes introducing an active policy of incorporating a gender equality perspective into all policies, laws, procedures, programmes and practices relating to the deprivation of liberty to ensure equal and fair access to justice.¹⁷²

Women with disabilities who are deprived of liberty in the context of isolation or segregation, particularly due to abusive relationships, also face hurdles to accessing justice to escape these settings. Two of the most obvious and egregious barriers to access to justice for women with disabilities are the physical and communication barriers to courthouses and other institutions of the justice system. Stairs leading to a building, inaccessible witness chairs, lack of technology to enable persons with disabilities to understand or participate in proceedings, and failure to provide materials in alternative formats for women who are blind or sign language interpreters for Deaf women all create substantial barriers to justice for women with disabilities. Information may not be available in Braille or other alternative formats, making it more difficult for women with a visual disability to pursue their complaints to the fullest extent of the law. Information about legal rights is not often provided in clear, easy-to-understand formats, which can prevent women with intellectual disabilities from understanding their rights. Women with intellectual disabilities can also have trouble remembering the sequence of events, which can make them seem less credible as witnesses.¹⁷³ Such communication limitations pose enormous barriers to navigating the justice system.

Stigma and stereotypes play a significant role in limiting access to justice for women with disabilities subjected to violence. The court system systematically fails to acknowledge women with disabilities as competent witnesses or give sufficient credence to their testimony, which is particularly problematic in cases involving sexual assault or other forms of gender-based violence where the complaining witness’s testimony may provide the only evidence against the assailant.¹⁷⁴ Because society generally fails to see women with disabilities as sexual beings, for example, such stereotypes may lead judges and juries to discount their testimony.¹⁷⁵ Because barriers to access to justice can limit women’s ability to seek protection or redress, such barriers can functionally perpetuate violence against women with disabilities by compelling women to remain in the abusive situation and emboldening abusers who know that the justice system is unlikely to take complaints seriously.¹⁷⁶ As the CRPD Committee noted in its General Comment No. 3 on women with disabilities, “Perpetrators [of violations against women with disabilities in institutions] may act with impunity because they perceive little risk of discovery or punishment given that 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.”¹⁷⁷

The CRPD Committee has routinely expressed concern about barriers to access to justice for women with disabilities,¹⁷⁸ and has emphasized that recognition of legal capacity is essential to access to justice for persons with disabilities. In its General Comment No. 1, the CRPD Committee explained that “[p]olice officers, social workers and other first responders must be trained to recognize persons with disabilities as full persons before the law and to give the same weight to complaints and statements from persons with disabilities as they would to nondisabled persons.”¹⁷⁹ To give full effect to this principle of legal capacity, States must provide training and awareness-raising to the police, judiciary, and other professions that may come into contact with victims of violence and abuse with disabilities. The CRPD Committee also explains that States may need to provide support in various forms—“including recognition of diverse communication methods, allowing video testimony in certain situations, procedural accommodation, the

provision of professional sign language interpretation and other assistive methods”—in order to ensure that persons with disabilities are able to testify on an equal basis with nondisabled persons.¹⁸⁰

The CEDAW Committee has also recognized that women with disabilities may face compounded discrimination and unique barriers to access to justice, and recommends that States pay particular attention to access to justice systems for women with disabilities.¹⁸¹ In its General Recommendation No. 33, the CEDAW Committee emphasizes that States should provide training to law enforcement, the judiciary, law students, health care providers, social workers, and others who might play an important role in cases of gender-based violence to eliminate gender stereotyping¹⁸² and calls on States to review rules of evidence in cases of violence against women and to improve the criminal justice response to domestic violence.¹⁸³

III. Conclusions and Recommendations

As the Working Group develops its thematic report examining the gender-related dimensions of deprivation of liberty, we encourage the Working Group to consider the unique ways in which gender and disability intersect to lead to high rates of deprivation of liberty of—and the specific consequences of such deprivation of liberty for—women and girls with disabilities. Specifically, we encourage the Working Group to:

- Examine how women with disabilities experience particular forms of deprivation of liberty, including due to stigma, harmful stereotypes on the basis of both gender and disability, and lack of services to live independently and being included in the community as well as accessible gender-based violence services.
- Recognize isolation at home and segregation from their communities as forms of deprivation of liberty experienced disproportionately by women with disabilities.
- Call on states to address the root causes of deprivation of liberty of women with disabilities, and in particular women with psychosocial and intellectual disabilities, including by:
 - Eliminating laws, policies, and practices that strip women with disabilities of their legal capacity, and replace substituted decision-making regimes with supported decision-making models that respect the right of women with disabilities to equal protection of the law.
 - Adopting concrete measures to dismantle harmful stereotypes that portray women with disabilities as “burdens” for their families and communities and that contribute to institutionalization or isolation.
 - Ensuring that women with disabilities that are victims of gender-based violence do not remain in abusive relationships due to the lack of accessible gender-based violence services in their communities.
 - Ensuring that the educational system does not discriminate against girls with disabilities by excluding them from access to school or segregating them in special education settings, leaving their families no option but to institutionalize them or isolate them at home.
- Call on states to address the disproportionate representation of women with psychosocial disabilities in detention settings, including prisons, psychiatric hospitals and long-term residential care institutions, including by:
 - Ensuring that women with disabilities in conflict with law are provided with reasonable accommodations to stand trial and are prosecuted with due process of law guarantees on an equal basis with others.¹⁸⁴
 - Eliminating the practice of forced institutionalizations of persons with disabilities in psychiatric institutions, including women and girls with disabilities.¹⁸⁵
 - Moving expeditiously toward the adoption of a deinstitutionalization strategy that includes the closure of psychiatric institutions¹⁸⁶ and the creation of services in the local

community, both to facilitate living in the community and to mitigate the risk of incarceration and forced institutionalization of women with psychosocial disabilities. This strategy should include the adoption of measures to provide accessible housing, health care, access to work, social security, and accessible gender-based violence services.¹⁸⁷

- Clarify state obligations to protect the rights of women with disabilities who are deprived of their liberty, including by:
 - Providing women with disabilities in prison with reasonable accommodations.
 - Eliminating security measures that involve force medical and psychiatric treatment.
 - Adopting specific measures to target sexual abuse and sexual based violence against women and girls with disabilities placed in prisons and institutions. This includes the obligation to ensure independent monitoring of prisons and institutions.
 - Raising awareness and conducting trainings with law enforcement and health care professionals to reduce stigma against women and girls with psychosocial disabilities.
 - Eliminating forced treatment, including forced reproductive health interventions such as forced sterilization, forced abortion, and forced contraception.¹⁸⁸

Thank you again for the opportunity to contribute to the Working Group’s work on women’s rights in the context of deprivations of liberty. For any further inquiries on this matter, please contact Stephanie Ortoleva, President and Executive Director, at president@womenenabled.org, Suzannah Phillips, Deputy Director at S.Phillips@WomenEnabled.org, Amanda McRae, Director of U.N. Advocacy, at a.mcrae@womenenabled.org, or Mariela Galeazzi, Legal Fellow, at m.galeazzi@womenenabled.org.

¹ See Universal Declaration of Human Rights, Art. 3; International Convention on Civil and Political Rights, Art. 9.

² For purposes of this submission, WEI will use the term “women” to refer to all women and girls of all ages, unless otherwise noted.

³ WORLD HEALTH ORGANIZATION (WHO) AND WORLD BANK, WORLD REPORT ON DISABILITY 28-29 (2011).

⁴ PRISON REFORM TRUST, BROMLEY BRIEFINGS PRISON FACTFILE 32 (Dec. 2011), available at <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefing%20December%202011.pdf>.

⁵ Janet I. Warren et al., *Personality Disorders and Violence Among Female Prison Inmates*, 30 J. Am. Acad. Psychiatry Law 502-503 (2002), <http://www.jaapl.org/cgi/reprint/30/4/502.pdf>.

⁶ See, e.g., CRPD Committee, *General Comment No. 5: Article 19: Living independently and being included in the community* [hereinafter General Comment No. 5], ¶ 33, U.N. Doc. CRPD/C/GC/5 (2017).

⁷ See, e.g., CRPD Committee, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities* [hereinafter Guidelines on Art. 14], ¶¶ 13-14 (Sept. 2015), <https://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc>.

⁸ HUMAN RIGHTS WATCH, DOUBLE PUNISHMENT INADEQUATE CONDITIONS FOR PRISONERS WITH PSYCHOSOCIAL DISABILITIES IN FRANCE, 15 (2016) [internal citation omitted] available at https://www.hrw.org/sites/default/files/report_pdf/france0416web.pdf.

⁹ Prison Rape Elimination Act of 2003, Pub. L. No. 108-79, 117 Stat. 972 (2003)

¹⁰ U.S. Department of Justice Bureau of Justice Statistics, *Disabilities Among Prison and Jail Inmates*, 2011–12, 2015, Figure 1, (Dec 2015), available at <https://www.bjs.gov/content/pub/pdf/dpji1112.pdf>.

¹¹ Kenyan Network Advocating for the Rights of Women and Girls with Disabilities, Submission on Kenya to the Committee on the Convention on Elimination of Discrimination Against Women (CEDAW) for the 68th session 23rd October to 7th November 2017.

¹² Commission on Human Rights, *Women and adequate housing: Study by the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living*, Miloon Kothari, ¶ 64, U.N. Doc. E/CN.4/2005/43 (2005), http://www.un.org/womenwatch/enable/E-CN4-2005-43_Housing.pdf.

¹³ UNICEF, *Factsheet: Children and Young People with Disabilities* 19 (May 2013), https://www.unicef.org/disabilities/files/Factsheet_A5_Web_NEW.pdf.

¹⁴ See Universal Declaration of Human Rights, Art. 3; International Convention on Civil and Political Rights, Art. 9.

¹⁵ CRPD, art. 14 (emphasis added).

¹⁶ CRPD Committee, Guidelines on Article 14, *supra* note 8, ¶18.

- ¹⁷ *Id.*, ¶13.
- ¹⁸ *Id.* ¶14.
- ¹⁹ *Id.*, ¶ 20.
- ²⁰ UN General Assembly, *Report of the Working Group on Arbitrary Detention, Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court* [hereinafter Report of the Working Group on Arbitrary Detention], ¶ 103, U.N.Doc., A/HRC/20/37 (2015).
- ²¹ *Id.*, ¶106 b).
- ²² U.N. Office of the High Commissioner on Human Rights, *Mental health and human rights*, ¶ 29, U.N.Doc, A/HRC/34/32 (2017), available at http://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/34/32.
- ²³ UN General Assembly, *Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Novak*, ¶ 65, U.N. Doc. A/63/175 (2008).
- ²⁴ CRPD, art. 12. CRPD Committee, *General Comment No. 1: Article 12: Equal Recognition Before the Law* [hereinafter General Comment No.1] ¶ 41, U.N. Doc. CRPD/C/GC/1 (2015).
- ²⁵ *Id.*
- ²⁶ See, e.g., CRPD Committee, *General Comment No. 3: Article 6: Women and girls with disabilities*, ¶¶ 33 & 36, U.N. Doc. CRPD/C/GC/3 (2016).
- ²⁷ See, e.g., *id.*, ¶ 31 (“Examples of violence, exploitation and/or abuse against women with disabilities that violate article 16 include ... the exercise of control, for example by restricting face-to-face or virtual access to family, friends or others.”).
- ²⁸ For instance, in Nigeria, women with disabilities are perceived as having less value to a family than do men with disabilities, because men with disabilities are perceived as being more able to fulfill their gendered role by working and supporting a family, and they are also able to inherit familial property (See Advocacy for Women with Disability Initiative, Legal Defence and Assistance Project, Women Enabled International, *Submission to the Human Rights Committee for its Development of Nigeria’s List of Issues in the Absence of a State Report*, April 30, 2018, available at <https://www.womenenabled.org/pdfs/WEI%20AWWDI%20LEDAP%20letter%20to%20HRC%20Nigeria%20List%20of%20Issues%20Submission%20FINAL.pdf> p. 5-6).
- ²⁹ Non-governmental organizations in India report that the disempowerment of women and girls within in families is one reason behind the higher rates of institutionalization of women and girls with disabilities in that country (See Women Enabled International, Women with Disabilities India Network, *Joint Submission to the United Nations Universal Periodic Review: India Third Cycle*, ¶ 20, available at <https://www.womenenabled.org/pdfs/WEI%20WWDIN%20India%20UPR%20Submission%20September%202016.pdf>).
- ³⁰ CRPD Committee, *General Comment No. 5*, *supra* note 6, ¶ 74.
- ³¹ See, e.g., CREA, *count me IN!: Violence against disabled, lesbian, in sex-working women in Bangladesh, India, and Nepal* (2012), available at <http://www.creaworld.org/sites/default/files/The%20Count%20Me%20In!%20Research%20Report.pdf>.
- ³² Centro de Estudios Legales y Sociales, *La situación de las mujeres en El Hospital Psiquiátrico Dr. Alejandro Korn “Melchor Romero* [hereinafter CELS, *The situation of women in the Dr. Alejandro Korn “Melchor Romero” Psychiatric Hospital*], p. 2. [unofficial translation from Spanish] <https://www.cels.org.ar/web/wp-content/uploads/2017/11/2017-Mujeres-en-Melchor-Romero.pdf>
- ³³ *Id.*, at p. 4.
- ³⁴ Ministry of Women and Social Development, National Policy on Rehabilitation of Persons with Disabilities, § 2.3.3 (date unknown), available at <http://www.womenaffairs.gov.ng/index.php/85-quick/127-policies>.
- ³⁵ NRSP, Inclusive Friends, *What violence means to us: women with disabilities speak*, at p. 19, <http://www.nsrp-nigeria.org/wp-content/uploads/2015/09/What-Violence-Means-to-us-Women-with-Disabilities-Speak.pdf>
- ³⁶ ENHANCING NIGERIA’S HIV/AIDS RESPONSE (ENR) PROGRAMME, HIV/AIDS AND SEXUAL BEHAVIOURS OF PERSONS WITH DISABILITIES IN NIGERIA 23 (2015) [hereinafter ENR, HIV/AIDS AND PERSONS WITH DISABILITIES IN NIGERIA].
- ³⁷ *Id.* at 16.
- ³⁸ *Id.* at 12.
- ³⁹ *Id.* at 11.
- ⁴⁰ *Id.*
- ⁴¹ Talia Meer & Helene Combrinck, *Help, harm or hinder? Nongovernmental Service Providers’ Perspectives on Families and Gender-Based Violence against Women with Intellectual Disabilities in South Africa* [hereinafter Talia Meer & Helene Combrinck, *Help, harm or hinder?*] 32, 46 *DISABILITY & SOCIETY* 1, 37-55 (2017).

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- ⁴² See *Id.*; CRPD Committee, *General Comment No. 3*, *supra* note 26, ¶ 53; CRPD Committee, *General Comment No. 5*, *supra* note 6 ¶ 72. See also Nation Nyoka, *Life Esidimeni Hearings Told of Rape at the Facility*, NEWS 24 (Nov. 22, 2017), available at <https://www.news24.com/SouthAfrica/News/life-esidimeni-hearings-told-of-rape-at-facility-20171122>.
- ⁴³ CRPD Committee, *General Comment No. 3*, *supra* note 26, ¶ 36.
- ⁴⁴ CRPD Committee, *General Comment No. 4 on the right to inclusive education*, ¶ 46, U.N. Doc. CRPD/C/GC/4 (2016).
- ⁴⁵ Anna Nowak, *Zagrożenie wykluczeniem społecznym kobiet niepełnosprawnych* [A Danger of Social Exclusion of Disabled Women] at 271 (2012) (unofficial English translation) [hereinafter Anna Nowak, *A Danger of Social Exclusion of Disabled Women*], at 10.
- ⁴⁶ *Id.*, at 301.
- ⁴⁷ Magdalena Gałczyńska, *Dzieci niepełnosprawne znikną ze szkół? "Decyzja MEN niehumanitarna. Domowe ghettos"*, ONET.pl (July 5, 2018), available at <https://lodz.onet.pl/dzieci-niepelnosprawne-znikna-ze-szkol-decyzja-men-nieludzka-domowe-getta/k3008xi>
- ⁴⁸ MINISTERIO DE EDUCACIÓN, EDUCACIÓN PARA TODOS, ALTABLERO, 2007 <http://www.mineducacion.gov.co/1621/article-141881.html>.
- ⁴⁹ Colectiva Polimorfás, Profamilia, Women Enabled International, Submission to the Committee on Economic, Social and Cultural Rights Working Group for Colombia, August 27, 2017, p. 10, available at <https://www.womenenabled.org/pdfs/WEI,%20Colectiva%20Polimorfas%20&%20Profamilia%20CESCR%20Submission%20Colombia%20August%2027,%202017%20FINAL.pdf>
- ⁵⁰ *Id.*
- ⁵¹ As the former UN Special Rapporteur on Violence against Women, Radhika Coomaraswamy, found in a report from 1994, “[d]enying women economic power and economic independence is a major cause of violence against women because it prolongs their vulnerability and dependence. Unless economic relations in a society are more equitable towards women, the problem of violence against women will continue” (Commission on Human Rights, *Preliminary report submitted by the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1994/45*, ¶ 53, U.N. Doc. E/CN.4/1995/32 (1994)). In its General Recommendation No. 19 on violence against women, the CEDAW Committee also recognized that “[l]ack of economic independence forces many women to stay in violent relationships” (CEDAW, *Gen. Recommendation No. 19*, *supra* note 35, ¶ 23). Concerning women with disabilities in particular, economic constraints can also lead to violence, and the CRPD Committee has recognized in its General Comment No. 3 that women with disabilities face multiple and intersecting forms of discrimination in access to education and economic opportunities and may be more susceptible to economic coercion and exploitation (CRPD Committee, *Gen. Comment No. 3*, *supra* note 9, ¶¶ 2, 31 & 34.).
- ⁵² See, e.g., CRPD Committee, *General Comment No. 3*, *supra* note 26, ¶ 59.
- ⁵³ For instance, in South Africa, as a result of lack of community-based support services and the prevalence of resentment towards women with disabilities (as burdens to their family), families sometimes choose to institutionalize women with disabilities to enable these families to “just get on with their lives.” (Talia Meer & Helene Combrinck, *Help, Harm or Hinder?* *Supra* note 41, 37-55.
- ⁵⁴ Comité CDPD, *Observaciones finales sobre el informe inicial de Argentina*, CRPD/C/ARG/CO/1 (2012), ¶ 23
- ⁵⁵ *Id.* ¶ 24.
- ⁵⁶ CELS, *The situation of women in the Dr. Alejandro Korn “Melchor Romero” Psychiatric Hospital*, *supra* note 32, p. 4.
- ⁵⁷ *Id.*, at p. 5.
- ⁵⁸ *Id.*
- ⁵⁹ Talia Meer & Helene Combrinck, *Help, harm or hinder?*, *supra* note 41, at 41, 45.
- ⁶⁰ *Id.*, at 41.
- ⁶¹ *Id.*
- ⁶² CRPD Committee, *General Comment No. 3*, *supra* note 26, para. 31.
- ⁶³ HUMAN RIGHTS WATCH, “TREATED WORSE THAN ANIMALS”: ABUSES AGAINST WOMEN AND GIRLS WITH PSYCHOSOCIAL OR INTELLECTUAL DISABILITIES IN INSTITUTIONS IN INDIA 40 (2014) [hereinafter HRW, *INSTITUTIONS IN INDIA*] at 38-40.
- ⁶⁴ Part VI of the Mental Health Act.
- ⁶⁵ CRPD, Art. 19.
- ⁶⁶ CRPD Committee, *General Comment No. 5*, *supra* note 6, ¶ 48.
- ⁶⁷ *Id.* ¶ 57.

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- ⁶⁸ *Id.*
- ⁶⁹ CRPD Committee, *General Comment No. 3*, *supra* note 26, ¶ 55, U.N. Doc. CRPD/C/GC/3 (2016).
- ⁷⁰ *Id.* ¶¶ 74-75.
- ⁷¹ UN 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*, (2017), A/HRC/35/21, ¶ 64, 66.
- ⁷² *Id.* ¶ 98 d).
- ⁷³ Report of the Working Group on Arbitrary Detention, *supra* note 20, ¶ 107 d).
- ⁷⁴ *Id.*
- ⁷⁵ Inter-American Commission on Human Rights, *Situation of Human Rights in Guatemala*, Approved by the Inter-American Commission on Human Rights on December 31, 2017, OEA/Ser,L/V/II), ¶ 465.
- ⁷⁶ *Id.*, ¶ 467.
- ⁷⁷ *Id.*, ¶ 468.
- ⁷⁸ *Id.*, ¶ 469.
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July 31, 2018, available at

<https://www.womenenabled.org/pdfs/WEI%20et%20al%20South%20Africa%20CRPD%20Committee%20Shadow%20Report%20Submission%20-%20July%202018,%202018%20Final.pdf>

⁹⁷ Stanisław Trociuk (ed.), *Przeciwdziałanie przemocy wobec kobiet, w tym kobiet starszych i z niepełnosprawnościami* [Counteracting Violence Against Women including Older Women and Women with Disabilities], at 88.

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¹⁰⁷ CEDAW Committee, *General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, ¶ 31(a)(ii), U.N. Doc. CEDAW/C/GC/35 (2017).

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