



Abortion and Disability: Towards an Intersectional Human Rights-Based Approach

Women Enabled International



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Cover image depicts a crowd of women, including women with disabilities, marching for their rights. Protesters carry signs saying “Disability Justice Now!,” “Respect Autonomy,” “Safe and Legal Abortion!,” and “No Stigma.”

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Contents

Acknowledgments	ii
Executive Summary	iii
Introduction	1
I. Overview of WEI’s Abortion and Disability Consultations	4
II. Fetal Impairment, Abortion, and the Concerns of Key Stakeholders	5
Concerns of the Disability Rights Movement	6
Concerns of Women with Disabilities	8
Concerns of the Reproductive Rights Movement	12
III. International Human Rights Framework	15
The Right to Unbiased, Non-Discriminatory, and Evidence-Based Information during Pregnancy	15
The Right to Safe and Legal Abortion	17
Legalizing Abortion on Grounds of Fetal Impairment	17
Consolidating Human Rights Standards on Abortion	18
Dismantling Disability-Related Discrimination	19
IV. Reconciling Stakeholder Concerns: Towards an Intersectional Human Rights-Based Approach to Abortion	21
States must strengthen respect for legal decision-making in the area of sexual and reproductive health, rather than restrict it, to ensure reproductive autonomy	21
States must enact legal and policy measures to promote the rights of persons with disabilities	24
States must ensure that pregnant people have voluntary access to a range of unbiased, evidence-based information by trained providers to ensure they are able to make free and informed decisions	24
Conclusion and Key Takeaways	26
Endnotes	29

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Executive Summary

Ongoing debates around fetal impairment as a legal basis for abortion act as a wedge issue between the disability rights and reproductive rights movements. Disability rights advocates are concerned that laws that expressly permit abortion on grounds of fetal impairment codify the notion that disabled lives are worth less than non-disabled lives. Reproductive rights advocates are concerned that reforming abortion laws to remove fetal impairment grounds—or to expressly ban abortion in the case of a fetal impairment diagnosis—will result in less access to safe abortion and exacerbate the attendant human rights consequences. These tensions are fueled both by advocacy strategies to advance abortion rights that can reinforce harmful disability-related stereotypes and by opponents of abortion rights co-opting disability rights language to impose greater restrictions on abortion access.

Women with disabilities, who live at the intersection of these two movements, care deeply about both protecting reproductive autonomy, including the right to access safe abortion, and dismantling harmful disability-related stigma. Too often, however, their voices are left out of the debate. To remedy this lack of voice and representation in these ongoing debates, Women Enabled International (WEI) conducted a series of consultations with 40 persons with diverse disabilities, who have the biological capacity to become pregnant, and who advocate at the intersection of gender and disability. These consultations provided a safe space in which these advocates from around the globe could discuss specific concerns around this historic tension.

In this framing document, WEI identifies the primary concerns of the women with disabilities who participated in these consultations—as well as the primary concerns of the disability rights and the reproductive rights movements, analyzes the human rights standards that underpin this debate, and applies an intersectional human rights-based approach to posit a way forward.

Concerns Voiced at WEI Consultations

As advocates working at the intersection of gender and disability, participants in WEI's consultations consistently underscored that pregnant people—with and without disabilities—must be able to exercise reproductive autonomy and that laws, policies, and the medical community at large should respect their decisions. At the same time, there was consensus among the participants in WEI's consultations that it is impossible to address access to abortion, both in law and in practice, without addressing the broader barriers that women with disabilities encounter to sexual and reproductive health and rights, as well as the right to found a family if and when one chooses. WEI's consultations also surfaced the following key points about ensuring meaningful reproductive choice:

- ▶ Systemic disability discrimination plays a major role in reproductive decision-making.
- ▶ Both conscious and subconscious bias on the part of medical providers, including those imparting prenatal diagnoses, can unduly influence reproductive decision-making.
- ▶ Dismantling stigma and discrimination at the societal level—including by ensuring availability of and access to services and supports for persons with disabilities and their families, training medical providers on the rights of persons with disabilities, and ensuring an adequate standard of living and inclusion of persons with disabilities in society—is vital to ensuring meaningful reproductive decision-making.

International Human Rights Framework

International human rights standards affirm the right to reproductive autonomy and freedom, which includes the rights: to access timely, comprehensive, evidence-based and unbiased information related to sexual and reproductive health; to make autonomous, informed decisions about one's sexual and reproductive health; and to decide the number and spacing of one's children.¹ Human rights treaty bodies have increasingly called on States to fully decriminalize abortion and ensure access to safe abortion services.² International human rights law also obligates States to provide appropriate supports and services to persons with disabilities and their families and to dismantle harmful stereotypes around disability,³ measures that will have the effect of reducing the stigma surrounding giving birth to and parenting children with disabilities.

Reconciling Stakeholder Concerns: Towards an Intersectional Human Rights-Based Approach

Violations of the right to personal autonomy are often at the root of fundamental human rights violations faced by both people with disabilities and women, including women with disabilities.

Ensuring that all women are legally able to make decisions about their reproduction is essential for States to guarantee the full range of human rights implicated in this debate. To this end, States must decriminalize abortion generally and move toward a legal framework that respects the right to access safe abortion without restriction as to reason. Expanding access to safe abortion without specifically enumerated grounds for legal abortion would help eliminate the abortion-related stigma that pregnant people experience when abortion is criminalized and dismantle disability-related stigma that stems from laws that treat abortion on the basis of fetal impairment as “justified.”

States also must take comprehensive measures to address the underlying structural and social barriers that prevent persons with disabilities from exercising their rights and becoming full and equal participants in society. Taking steps to address the root causes of inequality for people with disabilities—and to challenge the medical model that pathologizes disability—will also help transform the environment in which pregnant people are making decisions about whether or not to carry a pregnancy to term and will enable meaningful decision-making, advancing rather than jeopardizing the fundamental rights of all women, including women with disabilities.

To truly ensure autonomy requires not just the legal right to make decisions, but the ability to make meaningful choices about reproduction. Laws and policies that respect decision-making over one’s body must be coupled with an enabling social protection program and access to the information necessary to make decisions free from undue legal, attitudinal, and financial coercion.

Recommendations and Key Takeaways

The disability rights and reproductive rights movements and women with disabilities share common experiences of stigma, discrimination, and denials of autonomy. Many actors within these movements also share common objectives: a society where people with disabilities are included and can participate as equal members of society, where people with disabilities and their families have access to the range of supports and services that they may need, where pregnant people have voluntary access to unbiased and evidence-based information, and where pregnant people are able to make autonomous and informed decisions both in law and in practice and are supported rather than stigmatized in that decision-making process.

Fostering a climate where the rights and dignity of people with disabilities and all women are respected is essential to ensuring meaningful reproductive choice for all. Working to overcome historic tensions between the disability and reproductive rights movements and to strengthen cross-movement collaboration will bolster efforts to transform the legal, policy, and social environments in which important life decisions, including sexual and reproductive health decisions, are made. This framing document includes a number of specific recommendations for the reproductive rights and disability rights movements and the funder community to strengthen such collaboration.

By approaching these issues with an open mind toward the views and experiences of each movement, advocates can foster greater understanding and bridge historic tensions to work together toward collective goals. Such efforts may not be easy, but they are essential to ensuring successful advocacy to advance the rights of all stakeholders in these debates.

Introduction

Ongoing debates around fetal impairment as a legal basis for abortion act as a wedge issue between the disability rights and reproductive rights movements. A history of disability-motivated eugenics programs,⁴ high rates of abortion where certain impairments have been diagnosed through pre-natal testing,⁵ and pervasive disability-related stigma⁶ trigger concerns among disability rights advocates that laws that expressly permit abortion on grounds of fetal impairment codify the notion that disabled lives are worth less than non-disabled lives. At the same time, restrictive laws and heavy opposition to abortion deny women access to safe abortions, fuel abortion-related stigma, and cause women to seek out unsafe abortions,⁷ which in turn leads to high rates of maternal mortality and morbidity.⁸ Reproductive rights advocates are concerned that reforming abortion laws to remove fetal impairment grounds—or to expressly ban abortion in the case of a fetal impairment diagnosis—will result in less access to safe and legal abortion for women and exacerbate the attendant human rights violations against women. Women with disabilities, who live at the intersection of these two movements, care deeply about both protecting reproductive autonomy, including the right to access safe abortion, and dismantling harmful disability-related stigma.

Targeted advocacy strategies to restrict or expand access to abortion fuel this divide. On the one hand, opponents of abortion rights often co-opt disability rights language—in particular, leveraging existential concerns linked to the history of eugenics—to advance an anti-abortion agenda.* Notably, these campaigns both perpetuate harmful stereotypes of persons with disabilities⁹ and reinforce the stigma surrounding abortion,¹⁰ and those behind such initiatives often oppose funding and policy measures to strengthen supports and services for people with disabilities.¹¹ On the other hand, proponents of abortion rights have used fetal impairment exceptions as a tool to advocate for greater access to legal abortion in otherwise highly restrictive settings,¹² in some cases reinforcing disability-related stigma.¹³

This tension has come to the forefront of international human rights debates, which has led to anti-rights organizations calling into question the integrity of the United Nations (UN) human rights system that is grounded in the notion that fundamental rights are universal, indivisible, and interdependent. The UN Committee on the Rights of Persons with Disabilities (CRPD Committee) has expressed concern that laws that explicitly list fetal impairment as a ground for abortion contribute to disability-related stigma and discrimination against existing people with disabilities. The CRPD Committee has accordingly made recommendations that States reform abortion laws to combat the potentially stigmatizing impact of fetal impairment grounds.¹⁴ At the same time, both the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee) and the UN Committee on Economic, Social, and Cultural Rights (ESCR Committee) have explained that gender equality in the provision of health care requires that women† have access to medical care that is specific to their biological capacity to become pregnant.¹⁵ The CEDAW Committee and the ESCR Committee, together with the UN Human Rights Committee, the UN Committee on the Rights of the Child (CRC Committee), and the UN Committee against Torture (CAT Committee), have emphasized that restricted access to safe and legal abortion, in particular, can expose women to a range of human rights violations, including violations of their rights to life and physical, mental,

* Several recent examples of this strategy are manifest in campaigns to either restrict access to abortion or to push back on attempts to liberalize abortion laws. For example, in the state of Ohio in the United States of America (U.S.), opponents of abortion rights enacted a law that banned abortion on the basis of a Down syndrome diagnosis. See, e.g., Tony Marco, “New Ohio law prevents abortion in Down syndrome cases,” CNN (Dec. 22, 2017), <https://www.cnn.com/2017/12/22/health/ohio-governor-signs-down-syndrome-abortion-ban/index.html>. In Ireland, opponents of a constitutional amendment to allow greater access to legal abortion utilized images of children with Down syndrome in their campaign against the amendment, to suggest that a liberal abortion law would lead to high rates of abortion in instances of a prenatal diagnosis of Down syndrome. See, e.g., Henry McDonald, “Irish abortion vote: ‘propagandistic’ use of children with Down’s syndrome condemned,” THE GUARDIAN (May 22, 2018), <https://www.theguardian.com/world/2018/may/22/irish-abortion-referendum-propagandistic-use-of-children-with-downs-syndrome-condemned>. In Poland, anti-abortion politicians sought to eliminate abortion on grounds of fetal impairment, a move that would effectively eliminate all legal abortions in a country with a highly restrictive abortion law. See, e.g., “Poland abortion: Protests against bill imposing new limits,” BBC News (March 26, 2018), <https://www.bbc.com/news/world-europe-43514965>.

† This paper primarily uses the term “women,” and the accompanying pronoun “her,” for brevity, though the analysis applies equally to all people—with and without disabilities—who have the biological capacity to become pregnant in the course of their lives and may need access to abortion care, including women, girls, intersex individuals, transgender men, and people who identify as nonbinary.

social, and emotional health,¹⁶ and the Human Rights Committee has found that denying women access to abortion where there is a high likelihood of fetal demise or death of an infant shortly after birth violates a right to be free from cruel, inhuman, or degrading treatment.¹⁷ An anti-rights organization has drawn attention to these diverging approaches to abortion, suggesting that it “exposes the absurd logic of the UN human rights system’s notion of non-discrimination,”¹⁸ underscoring how opponents of abortion rights are exploiting this lack of consensus to call the whole system into question. Notably, the CRPD and CEDAW Committees have sought recently to reconcile their diverging recommendations around abortion access to harmonize international standards on this issue.

This debate also has a unique impact on women with disabilities as both people who want to make autonomous decisions about their reproductive lives, including decisions about whether or not to continue a pregnancy to term, but who also bear the consequences of harmful stereotypes that undervalue the lives of people with disabilities. Too often, however, their voices are left out of the debate, as they are frequently marginalized in both the disability rights and reproductive rights movements and have limited access to relevant international fora. To remedy the lack of voice and representation that women with disabilities have had in these ongoing debates, Women Enabled International (WEI) conducted a series of consultations, as described below, to provide a safe space in which women with disabilities could discuss specific concerns around this historic tension.

This document puts forth an intersectional women’s rights and disability rights framing to posit a way forward in this debate. The perspectives developed in this paper draw extensively on WEI’s consultations with women with disabilities around the world, as well as WEI’s joint advocacy with—and engagement in ongoing conversations between—women with disabilities and the women’s rights movement[‡]. This framing document seeks to contribute to efforts to reconcile the rights at stake in this debate. **Section II** summarizes the consultative process that WEI undertook. **Section III** sets out the concerns of the disability rights movement, women with disabilities, and the reproductive rights movement with respect to laws that permit or restrict access to abortion on the ground of fetal impairment, as WEI understands the primary concerns. **Section IV** then outlines the international human rights standards that underpin this debate.

Recognizing that the principle of autonomy is of vital concern to all movements involved—and that meaningful reproductive choice is an essential component of autonomy—**Section V** of this framing document proposes a human rights-based approach that seeks to reconcile the perceived tensions. Specifically, this document argues that the following are essential to ensuring autonomous and meaningful decision-making and securing the fundamental rights of people with disabilities, women, and women with disabilities: **1)** fostering a legal and policy environment that respects reproductive decision-making and the capacity of women with and without disabilities to make autonomous decisions about their lives, **2)** ensuring an enabling environment that addresses the root causes of disability-related stigma and strengthens protections of the rights of persons with disabilities, including through greater access to supports and services for persons with disabilities and their families, and **3)** strengthening access to comprehensive, evidence-based, unbiased, and non-discriminatory information during pregnancy. This framing document concludes with key takeaways and recommendations for stakeholder movements to guide collective and complementary advocacy moving forward.

‡ For example, WEI developed intersectional talking points to inform ongoing debates related to the Zika epidemic (WEI, Talking Points: Zika, Microcephaly, Women’s Rights, and Disability Rights (April 2016), <https://www.womenenabled.org/pdfs/WEI%20Talking%20Points%20Zika,%20Microcephaly,%20Women's%20Rights,%20and%20Disability%20Rights%20ENGLISH%20June%202016.pdf>) and participated in CREA’s Global Dialogue on Abortion, Prenatal Testing and Disability, playing an active role in drafting the outcome document from that Global Dialogue (Nairobi Principles on Abortion, Prenatal Testing and Disability, <https://nairobiprinciples.creaworld.org>).

Terminology

Impairment and Disability: Impairment and disability are interrelated but distinct concepts. The UN Convention on the Rights of Persons with Disabilities (CRPD) defines disability as something that “results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society.”¹⁹ Impairment is not defined in the CRPD, but generally refers to a long-term condition that impacts physical, mental, intellectual or sensory capabilities.

Fetal Impairment: Fetal impairment refers to a diagnosis that a fetus is developing in a manner different from expected fetal development for any number of reasons. The term covers a range of conditions that may be diagnosed in utero, either through genetic testing and/or ultrasound screenings, including: **1)** diagnoses that may not manifest in a disability after birth, **2)** diagnoses that would result in the birth of a child with a disability if the pregnancy is carried to term, and **3)** diagnoses that are likely to result in miscarriage, stillbirth, or death shortly after birth.²⁰

In the disability rights context, the term impairment is typically seen as a corollary to disability; the connotations this term carries, then, leads to a perception within some segments of the disability rights movement that “abortion on grounds of fetal impairment” is the equivalent of “disability-selective abortion.” While fetal impairment includes diagnoses that will lead to a disability following birth, that is not the case for all such diagnoses.

While Women Enabled International acknowledges that “fetal impairment” is not a perfect term—recognizing both the connotations that the term fetal impairment carries within the disability rights community and the imprecision of applying a term that typically refers to a long-term condition to fetal development, WEI uses “fetal impairment” throughout this paper as the most neutral term in which to discuss diagnoses of atypical fetal development. Other terms that are often employed in this context, such as “anomaly,” connote “normal” versus “abnormal” fetal development, which WEI considers to reinforce disability-related stigma.

Fatal fetal impairment: Laws that legalize abortion on grounds of fetal impairment often limit such access to diagnoses of fetal impairments that make life outside of the uterus unviable. Fatal fetal impairment, as such diagnoses are often termed, refers to diagnoses of a condition, or complex conditions, that are likely to result in miscarriage, stillbirth, or death of a baby shortly after birth.²¹ While there is some debate as to the accuracy of fatal diagnoses in utero, the outcome of fetal impairment diagnoses is very case specific. The prospects for a live birth or infant survival after birth following a potentially fatal fetal diagnosis will depend on both the individual medical prognosis and the availability and quality of medical interventions. As technology advances, and as advanced technology becomes more widely available, the degree to which certain diagnoses are considered fatal will change, though it is worth noting that large portions of the global population may not have access to or be able to afford such technological advances.

Stigmatizing or derogatory terminology: Laws permitting abortion on grounds of fetal impairment use different terminology, much of which is outdated, perpetuates disability-related stigma, and fails to capture the range of prenatal diagnoses that may give rise to a claim for legal abortion. Such harmful terminology includes “handicapped,” “malformation,” “abnormalities,” “anomalies,” and “deformities.”²² Even such terms as a “healthy baby” are often meant to connote the opposite of these derogatory terms. This paper avoids the use of such terminology and strongly urges advocates pushing for greater access to abortion rights to avoid derogatory language that reinforces the idea that disabilities are somehow “abnormal.”

I. Overview of WEI's Abortion and Disability Consultations

To remedy the lack of spaces for women with disabilities to contribute to this discussion, WEI facilitated a series of consultations with people with disabilities with the biological capacity to become pregnant from across the world to discuss their perspectives on the perceived tensions between abortion rights and disability rights. To date, WEI has conducted formal and informal regional consultations—individually and in small groups, in person and through online platforms—with 40 women and nonbinary persons with disabilities from Africa, Europe, Latin America and the Caribbean, North America, South Asia, and Southeast Asia. WEI identified participants based on WEI's advocacy networks and online research into organizations and advocates in different countries that are working at the intersection of gender and disability. WEI selected participants with a demonstrated interest in sexual and reproductive health and rights and based on geographic and disability diversity. Consultation participants represented a range of disabilities, including several participants each with physical disabilities, psychosocial disabilities, Autism, and visual impairments, one Deaf participant, and one participant with an intellectual disability. Participants also represented countries across a range of legal frameworks—from countries with highly restrictive abortion laws to countries where abortion is readily accessible. With the exception of one of the consultations with participants from Latin America, which was facilitated in Spanish, consultations were facilitated in English with interpretation provided for individual participants as appropriate and with CART captioning.

WEI clarified at the outset that the consultations would be confidential to create a safe space in which participants could surface issues of concern; as such, no statements made during the consultations are attributed to the individual. Each consultation covered a range of topics related to abortion and disability, including personal perspectives on abortion and abortion on grounds of fetal impairment; ways in which this debate—and sexual and reproductive health issues more broadly—arise in participants' communities and across the focal region, including anecdotal information and personal experiences; concerns about exclusion of women with disabilities from the broader women's rights and disability rights movements; and viewpoints on how best States might address the perceived tensions that emerge in the context of this debate. These consultations inform WEI's analysis of the primary concerns of women with disabilities in **Section III** below, as well as our analysis of a human rights-based approach to resolving the perceived tensions between abortion rights and disability rights movements.

WEI, in consultation with organizations working on the rights of persons with intellectual disabilities, has further developed a concept note for conducting an in-person consultation with women with intellectual disabilities as essential constituents in this discussion. Women with intellectual disabilities and individuals working on the rights of persons with intellectual disabilities have further indicated that a separate consultation with mothers and sisters of persons with intellectual disabilities would be an important constituency to consult. However, WEI lacks necessary funding at this time to carry out these additional consultations. Recognizing this critical gap in the consultative process, WEI views this framing document as a work in progress and part of an ongoing dialogue with relevant stakeholders who, like WEI, seek to advocate for greater reproductive autonomy, including the right to safe abortion, without stigmatizing disability.

II. Fetal Impairment, Abortion, and the Concerns of Key Stakeholders

Underlying the tensions at play in this debate are a range of concerns held by key stakeholders—the disability rights movement, women with disabilities, and the reproductive rights movements. WEI’s understanding of the concerns of the disability and reproductive rights movements has been shaped by an extensive review of scholarly, media, and advocacy reports on the issue, while the discussion of the concerns of women with disabilities are informed primarily by WEI’s abortion and disability consultations. Lack of shared understanding of the terminology used in these debates—advocates within these movements can understand key concepts (such as fetal impairment and mental health implications) very differently—and lack of a deep understanding of the primary concerns of the other movement, rooted in the historic segregation of the two movements, comprise the primary barriers to overcoming historic tensions between the reproductive rights and disability rights movements.

To attempt to reconcile these concerns, it is first important to unpack these concerns and consider the legal, political, and historical contexts that trigger them. Accordingly, this section identifies primary concerns of the disability rights movement, participants in WEI’s abortion and disability consultations, and the reproductive rights movement, drawing from extensive research and discussions with key stakeholders. Recognizing both the historic exclusion of women with disabilities from mainstream disability rights and women’s rights movements and the unique space that people with disabilities with the biological capacity to become pregnant occupy at the intersection of these two movements, WEI separates out the concerns of women with disabilities from the other movements. In identifying the concerns of the disabled women who participated in WEI’s consultations, this framing document does not purport to represent the views of all disabled women, but rather the diverse group of disabled women and nonbinary persons who participated in WEI’s consultations. Similarly, in summarizing key concerns of the disability rights and women’s rights movements, WEI recognizes that these movements are not monoliths and does not purport to represent the full range of viewpoints of advocates within these movements. Rather, this section aims to unpack the most commonly expressed concerns that arise with respect to this issue to cultivate greater understanding across movements to begin to bridge this divide.

Legal Frameworks Relevant to this Discussion

There are different ways in which laws and policies bear on the abortion and disability debate.

In the 25 years since the International Conference on Population and Development articulated the need for States to take steps to reduce the incidence of maternal mortality and morbidity due to unsafe abortion,²³ a number of States have taken steps to liberalize their laws on abortion, including by allowing abortion on the ground of fetal impairment.²⁴ There are two primary ways in which laws governing access to abortion allow for legal access to abortion on the ground of fetal impairment:

As an exception to a restrictive law: A number of countries have extremely restrictive abortion laws, criminalizing abortion outside of a few narrow instances.²⁵ Fetal impairment grounds are often one of the few exceptions under which legal abortions are allowed in such restrictive environments.²⁶

Legal Frameworks, continued

As an exception after gestational limits have been reached: An increasing number of countries allow access to abortion on broad grounds or without restriction as to reason for a certain period of time—for instance, up to 12 weeks of gestation or through viability.²⁷ Legal abortion may be allowed beyond these gestational limits on certain narrow grounds, such as where continued pregnancy poses a risk to the life or health of the pregnant person and in cases of fetal impairment. Certain fetal impairments may not manifest or may not be diagnosable until later stages of pregnancy,²⁸ such that early gestational limits could effectively preclude access to abortion on such grounds; this is a primary rationale for these laws to impose different gestational limits in situations of fetal impairment.

At the same time, opponents of abortion rights regularly introduce measures aimed at restricting access to safe and legal abortion, including on the basis of fetal impairment. For instance, opponents of abortion rights have introduced **legislation to eliminate fetal impairment exceptions** to otherwise restrictive laws, like those described above.²⁹ Anti-abortion advocates in the U.S. have also introduced laws that would **impose criminal penalties in cases where the presumed ground for abortion is a diagnosis of a single specific condition**, such as Down syndrome (but not where abortion is based on a diagnosis of other types of fetal impairment).³⁰

Concerns of the Disability Rights Movement

People with disabilities regularly encounter pervasive stigma, suggesting their lives are of less value than people without disabilities. This devaluing of disabled lives, both historically and at present, manifests itself in egregious human rights violations, including State-sanctioned eugenics,³¹ unequal access to essential services for persons with disabilities,³² and a social and medical environment that seeks to “fix” people with disabilities³³ rather than treating people with disabilities as rights holders and their disabilities as a natural part of human diversity. In this context, the disability rights movement is concerned that laws that explicitly allow abortion on fetal impairment grounds reinforce disability-related stigma and foster an environment in which disability is something to be “eradicated.” The disability rights movement also takes issue with how some advocates in the abortion rights debate—including both opponents and supporters of abortion rights—instrumentalize disability to support their advocacy objectives.

Devaluing Disabled Lives

Some disability rights advocates are concerned that laws that treat abortion on grounds of fetal impairment differently from other types of abortion legitimize the idea that disabled lives are worth less than non-disabled lives, and as a result, that these laws contribute to a climate of disability-related stigma.³⁴ A number of States permit abortion on grounds of fetal impairment as one of several exceptions where abortion is otherwise criminalized;³⁵ fetal impairment exceptions often exist alongside exceptions for cases where continued pregnancy poses a risk to the pregnant person’s life or health or where pregnancy results from rape or incest.³⁶ By carving out these minimum circumstances in which abortion must be legal, such laws support the notion that some abortions are “justified,”³⁷ while others are not. The disability community is concerned that framing abortion on fetal impairment grounds as “justified” codifies the perception that disabled lives are not worth living,³⁸ recalling that some in the disability community consider that fetal impairment exceptions are effectively the same thing as disability-selective abortions³⁹ (see **Terminology** text box, above).

Moreover, the rationale for fetal impairment exceptions is often linked to the mental health of the pregnant person, and language concerning the mental health implications of prenatal diagnoses of fetal impairment are a major source of tension between the disability rights and reproductive rights movements. There is significant evidence that a pregnant person can experience anxiety and uncertainty about fetal health following a diagnosis of fetal impairment (see **Health of the Pregnant Person and Fetal Impairment** section below).⁴⁰ At the same time, messaging around the mental health implications of fetal impairment frequently carry stigmatizing connotations that having a child with a disability causes mental health risks for the parent. As such, some in the disability rights movement are concerned that rhetoric around “mental health consequences” reinforce the idea that people with disabilities are a burden on their families and communities, and in particular a burden to women who are seen as tasked with the caring for disabled people in our societies.⁴¹ In order to bridge the historic tensions between the movements, it is essential to recognize the way in which language around mental health implications is perceived by the disability rights community and ensure that advocacy messages are appropriately nuanced to avoid perpetuating such harmful stereotypes. (See **The So-Called Burden of Parenting a Child with a Disability** text box, below)

The Medical Model and Distrust of the Medical Community

Disability has long been treated as a medical issue that must be “fixed,” rather than as a social and human rights issue that requires society to adapt and include people with disabilities.⁴² This history of viewing disability through what is known as the “medical model” has led to assumptions that impairment is a legitimate ground for denying individuals their rights,⁴³ which in turn has led to extensive human rights abuses, including within health care settings. These abuses have included eugenics campaigns to eliminate disability from the gene pool,⁴⁴ the forced institutionalization of persons with disabilities for “medical” reasons;⁴⁵ forced medication and forced medical interventions, such as forced sterilization, forced abortion, forced contraception, and growth attenuation therapy;⁴⁶ and verbal and physical abuse and harassment by health care workers.⁴⁷

People with disabilities also encounter other health care-related violations, such as barriers to accessing health information, goods, and services, generally and in the context of sexual and reproductive health care.⁴⁸ These violations are frequently the result of discriminatory attitudes held by health care professionals towards persons with disabilities, including that they are “defective,” incapable of making decisions for themselves, cannot be “good parents,” and must be “protected” from the outside world.⁴⁹ At the same time, persons with disabilities are disproportionately underrepresented in the medical professions.⁵⁰ Despite the fact that, as of this writing, 180 countries have ratified the CRPD and accepted the human rights model of disability,⁵¹ these abuses in health care settings continue across the world and reinforce a distrust of the medical profession held by many persons with disabilities.

Disability rights advocates are concerned that pervasive disability-related stigma can impede autonomous decision-making where fetal impairment is diagnosed;⁵² when coupled with prenatal counseling by health care providers steeped in the medical model, pregnant people may experience even more pressure to terminate the pregnancy.⁵³ In particular, distrust of the medical profession raises concerns that health care workers do not understand disability or value the lives of persons with disabilities, that pregnant persons who receive a fetal impairment diagnosis may not receive information about local supports and services and/or may receive biased information about disability, or that health care providers will not offer to connect pregnant people with the community of people who have that disability and their families, if desired.⁵⁴

This distrust extends, in particular, to diagnoses of fatal fetal impairment; disability rights advocates, including the CRPD Committee, are concerned that it is impossible for medical providers to determine whether a fetal impairment diagnosis is likely to be fatal.⁵⁵ Some in the disability rights community also fear that laws that limit abortion access to situations of fatal fetal impairment will be implemented unevenly,⁵⁶ for instance, in Colombia, where abortion is permitted in circumstances where a fetal impairment diagnosis is “incompatible with life,” there is evidence that some medical providers interpret this exception to include situations where “quality of life” is perceived to be impacted by a fetal impairment diagnoses.⁵⁷

Prenatal Genetic Testing

Recent advancements in medical technology—particularly in the area of prenatal genetic testing—raise concerns for some in the disability rights movement, who see developments in these areas as facilitating the eradication of certain types of disability.⁵⁸ These concerns are particularly pronounced in the context of abortion following a diagnosis of Down syndrome, given that in a number of countries, particularly throughout Europe, a majority of prenatal diagnoses of Down syndrome lead to abortion.⁵⁹ Some in the disability rights movement are concerned that proliferation of prenatal testing for genetic differences and the manner in which the results of prenatal genetic tests are imparted prescribe a specific outcome—that is, abortion—where fetal impairment is diagnosed.⁶⁰ This is particularly the case where state policies actively promote prenatal genetic testing “without first making a major effort to re-educate the public, including prospective parents, about disabled people’s lives and improving financial and other support for disabled people and their families.”⁶¹

It is within this context that some disability rights advocates view abortion in cases of fetal impairment—an act perceived as pregnant people choosing (often on the advice of medical providers) to avoid giving birth to a child with a disability—as grounded in disability discrimination. It is also within this context that the CRPD Committee has called on States to address the potentially stigmatizing impact of laws that treat abortion on grounds of fetal impairment differently than abortion on other grounds,⁶² and that some disability rights advocates have called for States to prohibit abortion on these grounds⁶³ and to enact legal and policy reform related to prenatal genetic testing.⁶⁴

Instrumentalization and Misappropriation of Disability Rights Language

Many in the disability rights movement are further concerned that advocates for and against abortion rights use disability as a tool to advance their advocacy agendas without engaging the disability community and often while employing stigmatizing language around disability.⁶⁵ Moreover, vestiges of the medical model of disability permeate prenatal genetic testing and related rhetoric about “normal” and “abnormal” fetuses.⁶⁶ Advocacy campaigns to push for legal access to abortion on grounds of fetal impairment can perpetuate these harmful stereotypes, for instance by describing the “painful tragedy” of giving birth to a child with a disability⁶⁷ or reinforcing the perception of disability as a burden. These practices contribute to a sense of alienation from the reproductive rights movement by those members of the disability rights movement who otherwise generally support abortion rights and share the objective of bodily autonomy. Ignoring the impact of such rhetoric will only widen the gap between the movements.

Concerns of Women with Disabilities

Women with disabilities account for more than half of all persons with disabilities and almost one-fifth of women worldwide.⁶⁸ Women with disabilities face many of the same barriers to exercising their sexual and reproductive rights as women without disabilities; they also face unique barriers and human rights abuses due to the intersection of their gender and disability and pervasive stigma and stereotypes. Because women with disabilities exercise their sexuality and, in most cases, retain the ability to become pregnant, access to abortion is vital for ensuring their human rights. At the same time, women with disabilities are regularly denied their right to reproductive autonomy, including through legally sanctioned forced sterilizations, forced abortions, and forced contraception.⁶⁹ Women with disabilities, then, are concerned about denials of the right to reproductive autonomy (and sexual and reproductive rights more broadly), as well as with legal frameworks that perpetuate harmful stereotypes against persons with disabilities.

Sexual and Reproductive Health and Rights Information and Services

There was consensus among the participants in WEI’s consultations that it is impossible to address access to abortion, both in law and in practice, without addressing the broader barriers that women with disabilities encounter to sexual and reproductive health and rights. Virtually all participants further underscored that ensuring full realization of sexual and reproductive health and rights and broad protection of reproductive autonomy is a bigger concern for women with disabilities than access to abortion, specifically. Participants also

expressed concern that sidelining of women with disabilities from mainstream women’s rights and disability rights movements—coupled with lack of access to information about sexual and reproductive health and rights for women with disabilities—limit their active participation in conversations around these topics, as discussed in more depth in the **Concerns about Voice and Participation** text box below.

Reproductive Autonomy

Women with disabilities are regularly denied their right to reproductive autonomy. On the one hand, restrictions on access to abortion impact the rights of women with disabilities, including their right to make autonomous decisions about abortion. A recent paper by Inclusion Ireland—an organization working to promote the rights of persons with intellectual disabilities—found that Ireland’s then-existing restrictive abortion law, which forced women to travel abroad in order to access abortion services, “may be an insurmountable barrier” for women with disabilities.⁷⁰ This is because women with disabilities, due to societal discrimination, are more likely to have lower levels of education and less access to employment resulting in lower incomes, and so frequently cannot afford to travel abroad for abortion.⁷¹ Furthermore, women with mobility-related disabilities face additional barriers to travel, as the means of travel are often inaccessible.⁷² As such, a legal and de facto environment that ensures broad access to abortion—including abortion that is affordable and provided close to home—is a significant part of ensuring that women with disabilities can exercise their rights on an equal basis with others.

At the same time, women with disabilities experience heightened rates of legally sanctioned forced sterilizations, forced abortions, and forced contraception.⁷³ Moreover, stereotypes that women with disabilities are incapable of becoming mothers or are unfit to parent contribute to substandard and, in some cases, abusive healthcare, including during the perinatal period.⁷⁴ Consultation participants emphasized that these negative stereotypes are particularly pronounced for women with psychosocial and intellectual disabilities, as well as for women with disabilities with other intersecting characteristics that contribute to social exclusion (e.g. racial or ethnic minorities or people with disabilities who identify as non-binary or lesbian, gay, bisexual, trans, intersex, or queer (LGBTIQ)).

It is important to recognize a double standard when it comes to abortion access: while women with disabilities, like all women, experience barriers to accessing safe and legal abortion, women with disabilities are also more likely to be subjected to abortion without their consent—or may have an easier time accessing abortion, even in restrictive settings—due to the stigma of women with disabilities becoming mothers. Indeed, anecdotal reports of forced abortions arose in virtually every consultation that WEI conducted, and existing evidence reinforces this concern. For instance, in a 2015 study of motherhood for women with disabilities in Poland, a country with a highly restrictive abortion law, several women with disabilities reported that medical staff tried to convince them to have abortions or put their children up for adoption, rather than supporting them through their pregnancies and giving them information about assistance to raise their children.⁷⁵

As advocates working at the intersection of gender and disability, participants in WEI’s consultations consistently underscored that pregnant people—with and without disabilities—must be able to exercise reproductive autonomy and that laws, policies, and the medical community at large should respect their decisions. This includes the freedom to decide whether to terminate or continue to term a pregnancy where there is a prenatal diagnosis of fetal impairment, as well as the freedom of pregnant people with disabilities to decide to carry to term a pregnancy in general.

Perpetuating Harmful Stereotypes

Some women with disabilities in the consultations expressed concern that current legal frameworks around fetal impairment exceptions contribute to a climate of stigma against persons with disabilities, echoing the concerns surfaced in the **Disability Rights Movement** section above. Similarly, some participants expressed concern about the ways in which laws and policies treat prenatal sex determination and genetic testing differently; for example, a participant from India expressed concern that the State expressly prohibits testing to determine the sex of a fetus but has a policy of routinely offering prenatal genetic testing to test for fetal impairment.

Country context seemed to play a large role in perceptions about laws that permit fetal impairment as a ground for legal abortion. Participants from countries with highly restrictive abortion laws, for instance, tended to view such exceptions as something to tolerate to ensure that pregnant people have at least some access to legal abortion. In countries where laws governing access to abortion are less restrictive, participants were more likely to identify a stigmatizing effect where the law treats abortion on grounds of fetal impairment differently from other grounds for legal abortion. At the same time, several participants from countries with restrictive legal environments, including in both Europe and Latin America, expressed concern that abortion rights advocates often use “fetal impairment” as a wedge issue to broaden access to legal abortion, noting that the rhetoric used in these strategies can contribute to the devaluation of all persons with disabilities and hinders the ability of pregnant women to make voluntary choices to continue a pregnancy where there is a fetal impairment diagnosis.

There was no consensus among consultation participants as to whether laws limiting fetal impairment grounds to fatal fetal impairment would be more or less stigmatizing. Some participants, particularly those in the Latin America consultation, expressed that limiting abortion to fatal fetal impairment would be less stigmatizing, as abortion in this context focuses on fetuses that would not survive after birth. Other participants, particularly those in the European consultation, suggested that questions of viability frequently devolve into debates over “quality of life” and can, in practice, perpetuate stigma that disabled lives are not worth living.

At the same time, almost all participants indicated that irrespective of any potential stigmatizing effect of fetal impairment exceptions, they would not support laws that specifically restricted abortion on grounds of fetal impairment. Participants expressed concern that such restrictions would interfere with autonomy and informed decision-making and could contribute to higher rates of unsafe abortions or, in some instances, infanticide or abandonment of children with disabilities. Given this, consultation participants generally agreed that an ideal abortion law would be one that permits abortion without restriction as to reason and does not limit access to abortion on specific enumerated grounds, though many participants noted that, in the current political climate, this ideal law would be unlikely to gain traction in their countries.

Meaningful Reproductive Choice

Women with disabilities emphasized that meaningful reproductive choice is an essential component of exercising reproductive autonomy. Participants were particularly concerned about the current approach to genetic counselling, which is often carried out in a medical setting by individuals who have little to no training or understanding about the lived experiences of persons with disabilities. In this context, one participant emphasized that a diagnosis (identification of a condition or impairment) is not the same thing as prognosis (predicted outcome of that condition or impairment).

Recognizing that both conscious and subconscious bias on the part of medical providers can unduly influence reproductive decision-making, participants across the board underscored the need to evaluate the type of information available about prenatal diagnoses, how it is imparted, and by whom. Provider presumptions about a patient’s decision—for instance, a presumption that a prenatal diagnosis of fetal impairment will necessarily lead to a pregnancy termination—can unduly interfere with the patient’s reproductive autonomy. For example, a woman in Tasmania whose prenatal screening test revealed the possibility that her fetus had Down syndrome recalled her obstetrician saying “[I] would have liked to have seen you sooner as we only have a small window of opportunity for a termination.”⁷⁶ Another woman in Tasmania experienced more aggressive behavior after a similar prenatal screening result: “I was harassed and treated negatively by medical staff when I refused to terminate.”⁷⁷ An ethnographic study of a maternal-fetal unit in Colombia similarly documents the biases that can inform the delivery of prenatal diagnoses; the author of the study found that “when presenting a prognosis for a foetus with a chromosomal or developmental variation, such a prognosis is inflicted with medical values which have their own assumption of what a *normal life* entails,”⁷⁸ documenting one maternal fetal specialist as saying:

It is very difficult of course, the whole life plan changes, now you are stuck with something [a child with cognitive differences] that will last so many years. I mean the idea of having children, seeing them

grow and watching them finally leave home in search of their own life, that will never ever happen with a child like that. You are stuck your whole life with that, so you might as well consider not going through that situation.⁷⁹

Consultation participants underscored the importance of combating such biases to ensure that information about prenatal diagnoses are not provided in a manner that interferes with autonomous decision-making.

Related to concerns about pregnancy-related information and counselling, women with disabilities also expressed concern that systemic discrimination and harmful stereotypes are a major factor in reproductive decision-making. Dismantling stigma and discrimination at the societal level, including by ensuring availability of and access to services and supports for persons with disabilities and their families, training medical providers on the rights of persons with disabilities, and adopting public policies to ensure an adequate standard of living and inclusion of persons with disabilities in society, is vital to ensuring meaningful reproductive decision-making.

Concerns about Voice and Participation

In addition to concerns about the substance of this debate, the consultations with women with disabilities also surfaced concerns about the process through which this debate has taken place and the general exclusion of women with disabilities from mainstream women's rights and disability rights movements.

Participants noted that gender issues—and especially sexual and reproductive health and rights—are not a major priority for many disability rights organizations. Several participants, particularly in the Africa and Asia consultations, emphasized that they would like to see disability rights organizations place more emphasis on the issues impacting women with disabilities, but that lack of women with disabilities in leadership positions in these organizations hinders progress toward this objective.

At the same time, participants expressed concern that inclusion of women with disabilities in campaigns to liberalize abortion laws is often tokenistic and that such inclusion typically only occurs when convenient for those pushing for more liberal abortion laws. Participants from both Latin America and South Asia, in particular, expressed concern that the woman's rights movements in their regions are not actively engaging women with disabilities in discussions around abortion advocacy—including in advocacy that directly addresses issues around prenatal testing and abortion on grounds of fetal impairment—out of fear of having a difficult conversation.

Women with disability advocates emphasize that meaningful inclusion in these conversations is essential to ensuring an intersectional approach to sexual and reproductive health. There was broad consensus that the voices of women with disabilities must be brought into sexual and reproductive rights discussions (including, but not limited to, abortion access) in a more robust and holistic way. According to participants, this also means that women with disabilities need to push more actively to have their voices heard within the feminist movement and to push for an autonomy framing that is more inclusive of different bodies and different identities. Participants in the Africa consultation further emphasized that women with disabilities need to be empowered to participate more actively in these conversations, including by having more access to information about sexual and reproductive health and rights and the financial resources to engage in places where such conversations take place.

Concerns of the Reproductive Rights Movement

Abortion is one of, if not the, most stigmatized and punitively regulated issues across the globe.⁸⁰ In a number of countries, the termination of a pregnancy is treated as a criminal act.⁸¹ Criminalization of abortion—which can include criminal investigation, prosecution, and punishment for individuals who undergo abortion, those who perform a safe abortion procedure, and/or those who assist people to seek and obtain an abortion—promotes a climate of stigma and shame around abortion, with devastating consequences for women;⁸² criminalization of abortion also contributes to stigma, incarceration, and punishment for pregnant people who experience miscarriage, stillbirth, or other pregnancy-related complications.⁸³ Stigma related to abortion “plays a critical role in the social, medical and legal marginalization of abortion care around the world,” contributing to high rates of maternal mortality and morbidity.⁸⁴ Reproductive rights advocates are concerned that efforts to remove explicit fetal impairment grounds for abortion, to ban abortion on grounds of certain prenatal diagnoses, or to impose additional counseling requirements will further restrict women’s reproductive autonomy and choices about their lives, both in law and in practice, with attendant consequences for women’s lives and health.

Proliferation of Restrictions on Legal Abortion

In many countries and contexts across the world, there is currently a serious backlash against women’s rights and gender equality, including repeated harmful attempts to limit women’s reproductive autonomy by restricting access to safe abortion.⁸⁵ In recent years, opponents of abortion rights have co-opted disability rights language to advance their anti-abortion agenda,⁸⁶ including by introducing laws that ban abortion on the ground of specific prenatal diagnoses,⁸⁷ often while perpetuating harmful stereotypes of persons with disabilities.⁸⁸

Within this political climate, reproductive rights advocates are concerned that efforts to remove fetal impairment from among the limited grounds that allow women to access legal abortion—even where such efforts are coupled with calls to respect women’s reproductive autonomy or broaden the interpretation of other grounds for legal abortion, such as health grounds—will not result in positive legal reform that would guarantee women’s access to safe abortion in such circumstances. Instead, reproductive rights advocates think it likely that the effect of abortion law reform to remove fetal impairment exceptions would be regressive and would serve to introduce either *de facto* bans or even increased criminalization of abortion in such cases.⁸⁹

Harmful Impact of Restrictive Abortion Laws

The impact of restrictive abortion laws is both well documented and severe. Global data demonstrates that legal restrictions on access to abortion do not reduce the incidence of abortion; instead they lead to a greater number of unsafe and clandestine abortions.⁹⁰ Unsafe abortion, in turn, contributes to high rates of maternal mortality and morbidity; between 4.7% and 13.2% of all maternal deaths can be attributed to unsafe abortion.⁹¹ Laws banning abortion on any grounds typically have a chilling effect on access to legal abortion and can pose an insurmountable barrier to safe abortion services and post-abortion care.⁹² Evidence also demonstrates that restrictive abortion laws can compel women to travel abroad to access safe abortion care, which can carry significant emotional and economic costs for women and deprive them of necessary continuity of health care following their abortion.⁹³

Reproductive rights advocates are concerned that removal of fetal impairment from among the grounds on which abortion is legal will lead to less access to safe abortion for women who depend on such exceptions to restrictive abortion laws and that the net effect of such legal reforms will be to expose more women to risks of death, impairment, and abuse.⁹⁴

Health of the Pregnant Person and Fetal Impairment

A number of countries also permit access to abortion where the health of the pregnant person is at risk.⁹⁵ Some people across different movements have suggested that these health exceptions—with a broad interpretation of what constitutes “health risks”—could be a way to ensure access to abortion following a diagnosis of fetal impairment without specifically enumerating fetal impairment in abortion laws. Indeed, UN human rights treaty bodies have found that denying access to abortion in instances where continued pregnancy was likely to or did

lead to stillbirth or death of the infant shortly after birth carried such severe mental health consequences for the pregnant woman that it amounted to cruel, inhuman or degrading treatment.⁹⁶ There is significant evidence that diagnoses of fetal impairment can carry a range of physical, mental, and social health considerations for the pregnant person beyond the health risks associated with unsafe abortion. For instance:

- ▶ Certain prenatal diagnoses can increase the risk of miscarriage and stillbirth, which carries both physical and mental health implications—including anxiety and uncertainty about fetal health during pregnancy—for the pregnant person.⁹⁷
- ▶ Relatedly, there are mental health implications to giving birth to a child who may die within a few hours, days, or weeks of birth,⁹⁸ who may be in a lot of pain during that time, and/or whose survival may be incumbent on a series of intensive and expensive medical interventions that may or may not be available to the pregnant person or that the pregnant person may or may not be able to afford.
- ▶ The World Health Organization (WHO) defines health to include “social well-being,” recognizing that a range of social factors—referred to broadly as social determinants of health and encompassing, e.g., socioeconomic position, access to health systems, and employment and education opportunities—influence health outcomes.⁹⁹ Low-income women, in particular, are less likely to have access to quality health care,¹⁰⁰ which may impact health outcomes for both themselves and any children born with a disability. These social considerations—concerns that were echoed by a number of the participants in WEI’s consultations—are context specific and will vary depending on personal circumstances and the resources and supports available to pregnant persons and their families.¹⁰¹ (See **The So-Called Burden of Parenting a Child with a Disability** text box, below, for a more in-depth discussion of factors related to social well-being of caregivers.)

Although a small number of countries, such as Germany and Sweden, interpret the health ground for abortion access broadly, such that fetal impairment can fall within enumerated health grounds, rather than carving out a specific legal exception for fetal impairment,¹⁰² this is not the case in the vast majority of countries around the world. More often, laws permitting access to abortion on a health ground are typically interpreted very narrowly due to, among other factors, the abortion-related stigma and prevailing harmful gender stereotypes of women as “mothers” and “caregivers.”¹⁰³ In light of this fact, reproductive rights advocates feel that relying on health grounds would not be sufficient to guarantee access to abortion for women who may need it. Rather, reproductive rights advocates are concerned that reliance on health grounds as a way to expand access to legal abortion will have the effect, in practice, of limiting access to safe and legal abortion.

The So-Called Burden of Parenting a Child with a Disability

Harmful rhetoric around the so-called burden of parenting a child with a disability reinforces disability-related stigma. The perceived “burden” of parenting children with disabilities is not the effect of the disability, but rather the effect of disability-related stigma and discrimination, lack of inclusion and participation of persons with disabilities in society, and the lack of affordable and locally available supports and services for people with disabilities and their families.

As the WHO has noted, there are consequences for family members assisting persons with disabilities who are not provided with adequate support by the government, including stress and barriers to employment.¹⁰⁴ At the same time, the WHO underscores that “[c]aring, despite its demands, has many positive aspects that need to be brought out.”¹⁰⁵ Too often, however, the rights of persons with disabilities and family members assisting them compete with one another in policy agendas; it is essential to separate out, budget for, and accommodate the needed supports and services for both family members and persons with disabilities to ensure “that each person has independence, dignity, and quality of life.”¹⁰⁶

Biased and Coercive Counseling

Pervasive abortion-related stigma can limit access to safe abortion, even where it is legal, and influences both the information and the counseling that pregnant people receive about abortion. Inaccurate, mandatory, stigmatizing, or deliberately incomplete information about pregnancy and abortion can infringe the exercise of reproductive autonomy, and violations of the right to information in these contexts manifest in law, policy, and practice around the globe. Misinformation about the safety of the abortion procedure may be used to deter women from seeking abortions.¹⁰⁷ For example, when a minor in Mexico sought a lawful abortion on grounds of rape, the doctor treating her greatly exaggerated abortion-related risks, especially when compared with the health risks of a full-term pregnancy for a young minor. The doctor further “said that if [the minor] were to die, responsibility for that would fall to her mother alone.”¹⁰⁸ This scaremongering deterred the minor from following through with a planned legal abortion.

Laws and policies may similarly mandate the provision of inaccurate or stigmatizing information. The Russian Ministry of Health and Social Affairs’ 2010 Guidelines on Psychological Pre-Abortion Counseling “describe abortion as ‘murder of a living child’ and portray women with unwanted pregnancies as irresponsible. Counselors are instructed to ‘awaken [the woman’s] maternal feelings,’ convince her of ‘the immorality and cruelty of abortion,’ and ‘lead the woman to an independent conclusion that, if a baby is born, then the means to raise it can be found.’”¹⁰⁹ Some U.S. states similarly require that all women seeking abortion services receive medically inaccurate information about the abortion procedure, the impact of abortion on future fertility, and a link between abortion and increased risk of breast cancer.¹¹⁰ In some states, this mandatory counseling includes coercive and unsubstantiated information about a fetus’ ability to feel pain and assertions that personhood begins at conception.¹¹¹

In this context, reproductive rights advocates are concerned that the introduction of additional counseling requirements around prenatal testing and fetal impairment could result in additional biased counseling that has the effect of further stigmatizing women who choose to terminate a pregnancy on the ground of fetal impairment.

Collectively, these concerns have led reproductive rights advocates to recommend that States maintain fetal impairment exceptions to otherwise restrictive abortion laws, and, in some circumstances, to call on States to adopt new fetal impairment exceptions in order to expand access to safe and legal abortion in settings where a fetal impairment ground might be one of the only politically viable exceptions to an otherwise restrictive abortion law.

III. International Human Rights Framework

The concerns of key stakeholders are grounded in human rights protections for the rights of persons with disabilities, women, and women with disabilities, and advocates from each of these movements have sought to vindicate their rights with respect to this debate through advocacy within international and regional human rights mechanisms. In order to identify a cohesive rights-based approach to navigate the perceived tensions between these stakeholders, then, it is important to map the existing human rights standards that inform this debate.

International human rights standards affirm the right to reproductive autonomy and freedom, which includes the rights to decide the number and spacing of one's children and to autonomous, informed decision-making about one's sexual and reproductive health.¹¹² This, in turn, requires "access to the information, education and means to enable [people] to exercise these rights."¹¹³

Autonomy is also a core principle underpinning the CRPD,¹¹⁴ and the CRPD Committee has made clear that:

Like all women, women with disabilities have the right to choose the number and spacing of their children, as well as the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.¹¹⁵

International human rights standards recognize that reproductive autonomy necessarily entails voluntary access to timely, comprehensive, evidence-based and unbiased information related to sexual and reproductive health.¹¹⁶ Essential information for pregnant people includes information about their health and the health of their pregnancy, prenatal diagnostic screenings, and the potential impact of a fetal impairment on their health and the health of their pregnancy. UN treaty bodies and human rights experts also confirm that pregnant people must also have access to information about available services for children born with disabilities and their families¹¹⁷ and information about abortion services.¹¹⁸

Human rights standards further affirm that enabling women to make autonomous decisions about their sexual and reproductive health includes access to safe and legal abortion.¹¹⁹ Human rights treaty bodies have increasingly called on States to fully decriminalize abortion and ensure access to safe abortion services.¹²⁰

Alongside guarantees of reproductive autonomy, international human rights law also obligates States to provide appropriate supports and services to persons with disabilities and their families and to dismantle harmful stereotypes around disability, measures that will have the effect of reducing the stigma surrounding giving birth to and parenting children with disabilities. The CRPD, in particular, specifies that States must combat stereotypes, prejudices, and harmful practices relating to persons with disabilities and promote positive perceptions and greater social awareness towards persons with disabilities.¹²¹ States also have an obligation to ensure the availability of, and raise awareness about, support services for persons with disabilities and their families.¹²²

It is important to note that, under international law, rights vest at birth.¹²³ While there are some who would invoke the alleged rights of the fetus in this debate, a fetus is not a rights holder under international human rights law. Accordingly, this section refers to states' obligations to respect, protect, and fulfil the rights of persons with the biological capacity to become pregnant and born persons with disabilities.

The Right to Unbiased, Non-Discriminatory, and Evidence-Based Information during Pregnancy

The right to reproductive autonomy and decision-making necessitates that a pregnant woman have access to the information she needs to make an informed decision about whether to continue her pregnancy.¹²⁴ In a recent statement on sexual and reproductive health and rights for all women, the CRPD and CEDAW Committees jointly affirmed that "States should adopt effective measures to enable women, including women with disabilities, to make autonomous decisions about their sexual and reproductive health and should ensure that women have access to evidence-based and unbiased information in this regard."¹²⁵

UN treaty bodies have not expressly addressed the issue of unbiased or non-directive information and counseling for women who may give birth to a child with a disability. However, existing standards provide some clarity on how the right to sexual and reproductive health-related information must be implemented in the context of a prenatal diagnosis of a fetal impairment.

To guarantee the right to health, the ESCR Committee has emphasized that States must ensure “access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behavior.”¹²⁶ Indeed, the ESCR Committee emphasized in its General Comment 22 that non-discriminatory and unbiased information on sexual and reproductive health is a core obligation of the right to sexual and reproductive health.¹²⁷ This Committee has further underscored that States must refrain from the “deliberate withholding or misrepresentation of information vital to health protection or treatment,”¹²⁸ noting that such restrictions “can fuel stigma and discrimination.”¹²⁹

Related to these obligations, States must ensure that women have access to unbiased, non-directive and evidence-based information about abortion.¹³⁰ Women also must have access to objective and non-coercive information about the risks associated with their pregnancy as a result of any fetal impairment and voluntary access to timely diagnostic screenings for potential disabilities, as needed, for them to develop an informed opinion.¹³¹ This information and counseling must be provided in a form and format that is accessible and understandable to the pregnant woman.¹³² The CEDAW Committee has affirmed that the information health care professionals provide to women seeking abortion must be based in evidence and science to ensure that women can make an autonomous and informed decision.¹³³

At the regional level, the European Court of Human Rights has reinforced these standards. In the case of *R.R. v. Poland*, which concerned a woman who was denied access to prenatal genetic testing and counseling after an ultrasound revealed possible fetal impairment, the Court recognized that “in the context of pregnancy, the effective access to relevant information on the mother’s and foetus’ health, where legislation allows for abortion in certain situations, is directly relevant for the exercise of personal autonomy.”¹³⁴ In finding a violation of the prohibition on inhuman and degrading treatment, the Court noted that the “lack of proper counselling and information”¹³⁵ by health care providers—specifically the lack of information about the health of the fetus and “the options available to her”—meant that “she had to endure weeks of painful uncertainty concerning the health of the foetus, her own and her family’s future. . . . She suffered acute anguish through having to think about how she and her family would be able to ensure the child’s welfare, happiness and appropriate long-term medical care.”¹³⁶

Pregnant women who have received a diagnosis of fetal impairment also have the right to information about available support services if they choose to give birth to and raise a child with a specific disability. International human rights standards affirm that parents and other caregivers must have access to information about available interventions and services for children in their care.¹³⁷ The Special Rapporteur on the right to health has emphasized that such information is essential “for [parents] to develop an informed opinion about the child’s health status and potential interventions and to participate thoroughly in decision-making processes that affect their children’s health, survival and development.”¹³⁸ As information about available treatment options and services is essential to informed decision-making, it follows that this right extends to women who may give birth to a child with a disability, including as they decide whether or not to continue with their pregnancy.

Information both about the potential impact of a fetal impairment on one’s pregnancy and information about available services for children born with disabilities and their families must be provided in an unbiased, non-discriminatory and disability-sensitive manner¹³⁹ that does not perpetuate stereotypes about persons with disabilities.¹⁴⁰ This requires that health professionals be trained on the human rights and lived experiences of people with disabilities.¹⁴¹ Similar to the requirement that professionals be trained on gender bias and stereotypes,¹⁴² professionals should be trained to recognize disability biases in counselling pregnant women about prenatal diagnoses.

The Right to Safe and Legal Abortion

International human rights standards recognize that access to safe and legal abortion is critical to the exercise of reproductive autonomy. Human rights bodies have consistently affirmed the right to reproductive autonomy and have increasingly called for the full decriminalization of abortion,¹⁴³ which refers to the elimination of criminal investigation, prosecution, and punishment for individuals who undergo abortion, those who perform a safe abortion procedure, and those who assist people to seek and obtain an abortion.¹⁴⁴

Treaty bodies have consistently found that restrictive abortion laws violate numerous rights, including the rights to life, health, freedom from torture and ill treatment, equality before the law and freedom from discrimination, privacy, and liberty and security of the person.¹⁴⁵ In general comments providing authoritative interpretations of corresponding human rights treaties, UN treaty bodies have called upon States to remove or refrain from applying punitive sanctions against women who obtain abortions¹⁴⁶ and ensure access to safe abortion, regardless of the legal environment.¹⁴⁷ They have also called upon States to liberalize restrictive abortion laws¹⁴⁸ and to decriminalize abortion under all circumstances.¹⁴⁹ In at least one concluding observation, the Human Rights Committee has also connected the need to address a restrictive abortion law with a recommendation that the State “take all measures necessary to combat the stigma associated with abortion.”¹⁵⁰

Although the CRPD Committee’s jurisprudence has focused on reproductive autonomy in the context of forced reproductive health interventions, including forced abortion, its 2018 joint statement with the CEDAW Committee on guaranteeing sexual and reproductive health and rights for all women calls on States to fully decriminalize abortion, recognizing that:

Access to safe and legal abortion, as well as related services and information are essential aspects of women’s reproductive health and a prerequisite for safeguarding their human rights to life, health, equality before the law and equal protection of the law, non-discrimination, information, privacy, bodily integrity and freedom from torture and ill treatment.¹⁵¹

Legalizing Abortion on Grounds of Fetal Impairment

Despite recognizing the centrality of safe abortion to reproductive autonomy, no treaty body has yet expressly articulated a right to unrestricted access to abortion. On occasion, human rights bodies have called for the legalization of abortion, which, in contrast to decriminalization, requires affirmative legislation prescribing the circumstances in which abortion is legal.

In their general comments, UN treaty bodies have almost universally refrained from enumerating specific grounds on which abortion should be legal. The one exception is the Human Rights Committee, which issued a general comment on the right to life in 2018 that specifically stated abortion must be legally permitted on certain grounds, including where the pregnancy “is not viable.”^{152§} The Human Rights Committee’s case law and concluding observations are consistent with this approach: recommending that States ensure access to abortion, at a minimum, in cases involving fatal fetal impairment.¹⁵³ The Human Rights Committee has not addressed fetal impairment exceptions in cases where the pregnancy is viable. Notably, both the UN Working Group on the Issue of Discrimination against Women in Law and in Practice (Working Group) and the CRPD Committee have disagreed with the Human Rights Committee’s approach. During discussions around the development of the Human Rights Committee’s General Comment 36, the CRPD Committee expressed concern that the focus on “fatal” fetal impairment “perpetuates notions of stereotyping disability as incompatible with a good life.”¹⁵⁴

§ This position is also the one taken by the African Human Rights System. The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women (Maputo Protocol), the only human rights treaty to explicitly mention abortion, calls on States to authorize abortion “where the continued pregnancy endangers the . . . life of . . . the fetus,” among other grounds. [Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, adopted July 11, 2003, art. 14(2)(c).] The African Commission has issued a general comment interpreting this provision, explaining that this refers to cases where the “foetus . . . suffers from deformities that are incompatible with survival” or where women need treatment for “heart disease, cancer, or other diseases which may endanger the survival of the foetus.” [African Commission on Human and Peoples’ Rights. General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, ¶ 40 (2014).]

The Working Group also expressed concern that the narrow list of grounds is “too restrictive,”¹⁵⁵ asserting that “where objective grounds are required, they should be expansive,” and has called for States to permit “women to terminate a pregnancy on request during the first trimester,” rather than restrict legalization to “exceptional grounds.”¹⁵⁶

Various UN treaty bodies have articulated certain minimum grounds for legalizing abortion in their recommendations to individual States. In that regard, treaty bodies have called for legalization of abortion, at a minimum, on one or more of the following grounds, on a case-by-case basis: where the pregnancy poses a risk to the woman’s life or health—including therapeutic grounds,¹⁵⁷ rape,¹⁵⁸ incest,¹⁵⁹ severe fetal impairment¹⁶⁰ and/or fatal fetal impairment.¹⁶¹ Notably, when addressing specific grounds, including fetal impairment, these recommendations often respond to proposed legislative or policy initiatives within the country under review.¹⁶²

In contrast, the CRPD Committee, while explicitly “recogniz[ing] women’s right to reproductive autonomy,”¹⁶³ has recommended that a few individual States “abolish any distinction, allowed by law, in the period within which a pregnancy can be terminated based solely on disability.”¹⁶⁴ These concluding observations took issue with laws in which abortion on fetal impairment grounds is permitted as an exception to gestational limits (as opposed to fetal impairment exceptions to otherwise restrictive abortion laws (see **Legal Frameworks Relevant to this Discussion** text box above)). In one outlying concluding observation, the CRPD Committee expressed concern “about the termination of pregnancy at any stage on the basis of fetal impairment,”¹⁶⁵ recommending that “[w]omen’s rights to reproductive and sexual autonomy should be respected without legalizing selective abortion on the ground of fetal deficiency.”¹⁶⁶ However, more recently and in a particularly noteworthy development, the CRPD Committee’s concluding observations to Poland in 2018, a country where the fetal impairment ground is virtually the only ground on which abortion can be legally accessed, the Committee did not address the fetal impairment exception in its recommendations to the State; the concluding observations instead called on the State to “[t]ake the measures necessary to ensure that the autonomy and decisions of women with disabilities are respected, [including] access to safe abortion.”¹⁶⁷

Consolidating Human Rights Standards on Abortion

In recent years, the CEDAW Committee and the CRPD Committee have sought to identify areas of common ground in addressing issues impacting abortion and disability. In particular, both Committees have emphasized the need to recognize women’s right to reproductive autonomy while also acknowledging the importance of combating negative stereotypes against persons with disabilities. In February 2018, the CEDAW Committee issued a report on its inquiry on access to abortion in Northern Ireland. In the most comprehensive statement on access to abortion in the context of fetal impairment by any UN treaty body, the CEDAW Committee stated:

In cases of severe foetal impairment, the Committee aligns itself with the Committee on the Rights of Persons with Disabilities in the condemnation of sex-selective and disability-selective abortions, both stemming from the need to combat negative stereotypes and prejudices towards women and persons with disabilities. While the Committee consistently recommends that abortion on the ground of severe foetal impairment be available to facilitate reproductive choice and autonomy, States parties are obligated to ensure that women’s decisions to terminate pregnancies on this ground do not perpetuate stereotypes towards persons with disabilities. Such measures should include the provision of appropriate social and financial support for women who choose to carry such pregnancies to term.”¹⁶⁸

Implicit in this statement is a recognition that reproductive autonomy requires legal access to abortion services, including on grounds of fetal impairment, measures to dismantle harmful stereotypes about persons with disabilities, and the availability of appropriate services and financial supports for children with disabilities and their families.

Moreover, as mentioned above, the CEDAW and CRPD Committees issued a joint statement in August 2018, emphasizing that States must “legalize [abortion] in a manner that fully respects the autonomy of women, including women with disabilities.”¹⁶⁹

These steps have not necessarily harmonized the Committees' different stances on fetal impairment exceptions: the CEDAW Committee has indicated that it will continue to recommend fetal impairment grounds as an exception to otherwise restrictive abortion laws, and it remains to be seen how the CRPD Committee's stated commitment to legalizing abortion in a manner that fully respects the autonomy of the pregnant person will impact its recommendations to States that have or are considering adopting fetal impairment exceptions. However, these developments mark an important first step for the Committees to ensure that human rights standards develop in a way that better reflects the intersectional concerns at play.

Dismantling Disability-Related Discrimination

International human rights law requires States to take active measures to address the underlying causes of inequality for persons with disabilities. This requires, on the one hand, taking measures to dismantle pervasive disability-related stigma and, on the other hand, ensuring access to the essential services and supports that persons with disabilities need to be able to enjoy their fundamental rights on an equal basis with people without disabilities. Addressing the root causes of discrimination against women and persons with disabilities is essential to the enjoyment of fundamental rights for both women and persons with disabilities. Meeting these obligations is necessary to ensuring meaningful reproductive choice.

In their joint statement on sexual and reproductive rights, the CRPD and CEDAW Committees call upon States to “fulfill their obligations under articles 5 and 8 of CEDAW and CRPD Conventions respectively by addressing the root causes of discrimination against women and persons with disabilities. This includes challenging discriminatory attitudes and fostering respect for the rights and dignity of persons with disabilities, in particular women with disabilities, as well as providing support to parents of children with disabilities in this regard.”¹⁷⁰ Article 8 of the CRPD obligates States to take “immediate, effective and appropriate measures” to combat stereotypes, prejudices and harmful practices relating to persons with disabilities and to promote positive perceptions and greater social awareness towards persons with disabilities.¹⁷¹ States should use public awareness campaigns, the media, and awareness training programs to realize this obligation,¹⁷² and must allocate a specific budget line towards such goals.¹⁷³ Training programs should target health professionals, who should be trained on the human rights and health care needs of people with disabilities, including pregnant women with disabilities.¹⁷⁴

Campaigns should be developed with close participation of people with disabilities¹⁷⁵ and should explicitly counter harmful stereotypes about children with disabilities,¹⁷⁶ seeking to sensitize the public about the rights of children with disabilities and the barriers they experience.¹⁷⁷ For example, the CRC Committee has urged one State to take immediate steps to address the stigma associated with having a child with a disability by reforming the State's family planning policy, addressing “the root causes of the abandonment of girls and children with disabilities,” and offering training to professionals by allocation of training funds.¹⁷⁸ Campaigns should also include information about the prohibition on discrimination against people with disabilities.¹⁷⁹

Greater access to supports and services for persons with disabilities and their families is also essential to securing the fundamental rights of people with disabilities, women, and women with disabilities and to promoting autonomous decision-making.¹⁸⁰ A child born with disabilities is entitled to a range of services and supports,¹⁸¹ as is the child's family.¹⁸² The rights of children with disabilities are enumerated in Article 7 of the CRPD, which outlines the obligation of States to “take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.”¹⁸³ States should establish and raise awareness about a comprehensive system of support services available to persons with disabilities and their families, to ensure that children and adults with disabilities are included and able to participate in public life, access inclusive education, and exercise their broad range of rights on an equal basis with others, as required by the CRPD.¹⁸⁴

Failure to guarantee supports and services for children and adults with disabilities can have a coercive impact on individual decision-making in the context of pregnancy by “limit[ing] the choices that individuals can exercise

with respect to their sexual and reproductive health.”¹⁸⁵ As discussed above, both personal and systemic social considerations play a significant role in autonomous decision-making around carrying a pregnancy to term; in acknowledging that the “right to sexual and reproductive health is also deeply affected by ‘social determinants of health,’” the ESCR Committee has affirmed that “States parties must tackle underlying “systemic discrimination and marginalization.”¹⁸⁶ The CEDAW Committee has relatedly underscored States’ obligations to provide “appropriate and ongoing support, social and financial, for women who decide to carry such pregnancies to term,”¹⁸⁷ recognizing the considerable impact that structural barriers can have on a woman’s decision to continue her pregnancy in a case of fetal impairment.

IV. Reconciling Stakeholder Concerns: Towards an Intersectional Human Rights-Based Approach to Abortion

Although all people have the right to make autonomous decisions about their lives, including their sexual and reproductive lives, violations of the right to personal autonomy are often at the root of fundamental human rights violations faced by both people with disabilities and women, including women with disabilities. For instance:

- ▶ **Both women and persons with disabilities may have their decision-making authority substituted by that of someone else.** Persons with disabilities may be formally or informally deprived of legal capacity, allowing guardians, medical personnel, parents, spouses, partners, judges, or others to make decisions on their behalf.¹⁸⁸ Non-disabled women can have their decision-making power stripped through laws, policies, or cultural practices that prevent women from making important life decisions, including laws requiring spousal or parental consent for reproductive health-related decisions.¹⁸⁹
- ▶ **Both women with disabilities and non-disabled women face violations of their reproductive autonomy.** Women with disabilities are regularly denied their right to reproductive autonomy, including through legally-sanctioned forced sterilizations, forced abortions, and forced contraception.¹⁹⁰ Women, with and without disabilities, face a range of legal and practical barriers to accessing sexual and reproductive health information, goods, and services and are therefore also deprived of the ability to make important decisions about their reproductive lives.¹⁹¹
- ▶ **Women, including women with disabilities, are denied reproductive autonomy due to restrictive abortion laws that prevent them from making their own informed decisions about whether and when to reproduce.** Given the barriers that women with disabilities already encounter in trying to access health care and exercise their reproductive rights, the barriers imposed by restrictive abortion laws are particularly onerous for women with disabilities, as noted above.¹⁹²

Given these realities, the protection of autonomy is a core human rights principle that unites the disability rights and women's rights movements.¹⁹³ To truly ensure autonomy, however, requires not just the legal right to make decisions, but the ability to make meaningful choices about reproduction. This requires laws and policies that respect decision-making over one's body coupled with an enabling social protection program and access to the full range of information necessary to make informed and voluntary decisions. The ability to make a voluntary and informed decision free from undue legal, attitudinal, and financial coercion is essential to ensuring meaningful reproductive choice.

In order to protect personal autonomy for both groups, States must remove legal restrictions on that autonomy and provide accessible information and any necessary supports to facilitate making important life decisions, including decisions surrounding sexuality and reproduction.¹⁹⁴ States must also work to combat the impact of abortion-related stigma on women's ability to make autonomous decisions about pregnancy termination.¹⁹⁵

At the same time, pervasive stigma and discrimination against people with disabilities can influence women's decisions about whether to carry a pregnancy to term in both subtle and overt ways. As discussed in **The So-Called Burden of Parenting a Child with a Disability** text box, above, the perceived "burden" of parenting children with disabilities is not the effect of the disability, but rather a result of disability-related stigma and discrimination, lack of inclusion and participation in society, and the lack of affordable and locally available supports and services. States must actively combat this climate of stigma to create a legal, policy, and social environment that enables people with disabilities to live their lives with dignity, while also allowing women and their families to feel supported in whatever decision they make about their pregnancies.

States must strengthen respect for legal decision-making in the area of sexual and reproductive health, rather than restrict it, to ensure reproductive autonomy.

Ensuring that all women are legally able to make decisions about their reproduction is essential for States to guarantee the full range of human rights implicated in this debate. This approach allows women, who are the

experts in their own lives and who are best equipped to make the personal and private decision of whether they can continue a pregnancy or not, to exercise the fullest possible agency concerning their bodies and their lives.

Fostering a legal and policy environment that respects reproductive decision-making and the capacity of women with and without disabilities to make decisions about their reproductive health requires:

- ▶ Recognition of and respect for the **legal capacity** of all women, including women with disabilities, to make decisions about whether and when to reproduce;
- ▶ Access to any supports necessary to make informed reproductive decisions, fostering **supported decision-making**, as required under the CRPD, instead of substituted decision-making;
- ▶ Campaigns and other communication strategies to dismantle both **disability and abortion stigma**; and
- ▶ Greater access to **safe and legal abortion**.

Expanding access to safe abortion without specifically enumerated grounds for legal abortion would help eliminate the abortion-related stigma that pregnant people experience when abortion is criminalized. Full decriminalization of abortion also would help dismantle disability-related stigma that is fueled by legal frameworks that treat abortion on the basis of fetal impairment as “justified.” This approach would address the disability community’s concerns while strengthening, rather than undermining, reproductive autonomy.

Some advocates have posited that a broad interpretation of the risk to the health of the pregnant person could allow pregnant people to access legal abortion without requiring a separate exception for fetal impairment. In practice, however, many countries interpret the health ground for legal abortion very narrowly,¹⁹⁶ and the chilling effect of criminalization of abortion can pose a significant barrier to accessing abortion even where it is legal.¹⁹⁷ Moreover, in light of the current backlash against gender equality that seeks to restrict access to safe and legal abortion, asking States to revise existing abortion laws to eliminate fetal impairment grounds for legal abortion and instead ensure access through broad interpretations of health grounds would have the practical effect of deteriorating rather than safeguarding women’s reproductive autonomy.

Unfortunately, the current political environment in many countries will not allow changes to laws and policies to ensure access to abortion without restriction as to reason, nor will the political climate lead to a broad interpretation of health grounds. As such, removing an explicit legal ground for abortion based on fetal impairment without simultaneous legislative action to ensure abortion access would likely limit access to safe and legal abortion, with attendant consequences for women’s lives, health, and other fundamental rights.

Imposing greater restrictions on reproductive autonomy in the area of abortion law—whether by removing explicit grounds for fetal impairment or banning abortion on the basis of specific prenatal diagnoses—can foster a climate of restrictions on reproductive autonomy writ broadly. As one disability scholar explained:

[W]hile we demand that medicine rethink its pathologisation of ... forms of difference, we need to be careful not to build a disability stance that vilifies all women whose exercise of their reproductive agency leads to termination. This ... is important because logically, we cannot grant agency to exercise a right of autonomy if we insist that only one outcome is correct. Ultimately, the rights we recognize for one person inform the terrain on which we recognize rights for others.¹⁹⁸

As such, it is imperative that States do not remove existing legal grounds for abortion—including fetal impairment grounds—at this time, unless it is to fully remove the decision to have an abortion from the criminal codes or unless the outcome is an expanded right to exercise reproductive autonomy. To do so would be to legitimize restrictions on autonomy for one group that reverberate to the fundamental rights of others. Instead, States must decriminalize abortion generally and move toward a legal framework that respects the right to access safe abortion without restriction as to reason. To the extent that States maintain gestational limits on abortion access, they must ensure that any gestational limits allow for legal abortion within the timeframe during which pregnant people are able to access essential information about their health and the health of their pregnancy.

Lessons Learned from Responses to Sex-Selective Abortion

Sex selection in favor of male fetuses is a symptom of broader social, cultural, political, and economic inequalities experienced by women that lead to boy children being valued more highly than girl children.¹⁹⁹ Outrage over son preference and high rates of sex-selective abortion of female fetuses has prompted some states to ban abortion on grounds of sex selection. Some States have also prohibited prenatal testing to determine the sex of a fetus, and criminalized revealing the sex of the fetus, in an effort to prevent this practice.²⁰⁰

Abortion on grounds of fetal impairment is occasionally referred to as “disability-selective abortion,” likening it to “sex-selective abortion.”²⁰¹ This comparison has prompted some disability rights advocates to suggest that disability-selective abortion and/or prenatal genetic testing should similarly be banned.

However, there are valuable lessons to be drawn from the legislative and policy approaches to sex selective abortion. In particular, evidence shows that restrictive laws and policies are ineffective in preventing sex-selective abortions because they fail to address the underlying gender discrimination and stigma that drive son preference.²⁰² Moreover, these prohibitions on access to essential health care have harmful consequences for women’s lives and health, restrict women’s reproductive autonomy, and violate women’s human rights.²⁰³ Experts agree that awareness-raising measures to change social norms and measures to develop an enabling legislative and policy environment that promotes the rights of women and girls—measures that seek to dismantle the root causes of sex-selective abortion—are far more effective.²⁰⁴

A 2011 UN interagency statement on “Preventing gender-biased sex selection” assessed legal and policy interventions around sex-ratio imbalances and distilled a number of lessons learned:

- ▶ **Legal restrictions on access to sex-selective abortion and technologies to determine the sex of the fetus are ineffective, almost impossible to implement in practice, have significant health consequences for women, and violate women’s rights.** They do little to address the underlying stigma and gender discrimination that fuels this practice.²⁰⁵ Further, implementing legal prohibitions in isolation, without addressing larger societal and structural factors that shape decision-making, can lead to higher rates of unsafe abortion, with the attendant risks to women’s lives and health.²⁰⁶ Prohibiting sex-selective abortion can also have a significant chilling effect on all access to safe and legal abortion services in that country.²⁰⁷
- ▶ **Effective approaches to reducing sex-selective abortion focus on the root causes of the practice: gender discrimination and inequality.** Successful interventions employ a combination of “integrated and systematic” measures, by a “broad range of actors,” to effect structural change and transform the social, cultural, political, and economic environment in which sex selection occurs.²⁰⁸ In particular:
 - **Legal and policy measures that promote the rights of women and girls can reduce the prevalence of sex-selective abortion.** For example, legislative reform that permits daughters to inherit property or recognizes women-headed households can “send out a clear message that the legal rights of men and women are to be recognized as equal.”²⁰⁹ Similarly, financial incentives or subsidies to the parents of daughters have been found to positively influence sex ratios, particularly in the short-term²¹⁰ “while longer-term efforts to change deep-rooted thinking and attitudes take effect.”²¹¹
 - **Advocacy and awareness-raising programs that “increase recognition of the value of girls and women in society” are essential.**²¹² These initiatives “are particularly successful when they provide correct information from trusted sources, stimulate debate at local and national level, and lead to an explicit endorsement of attitudes that are supportive of greater equality.”²¹³ It is also critical that these programs and campaigns “involve the participation of people from the communities that are affected or being targeted.”²¹⁴

States must enact legal and policy measures to promote the rights of persons with disabilities.

Regardless of the status of laws on abortion, States must take comprehensive measures to address the underlying structural and social barriers that prevent persons with disabilities from exercising their rights and becoming full and equal participants in society. Taking steps to address the root causes of inequality for people with disabilities—and to challenge the medical model that pathologizes disability—will also help transform the environment in which women are making decisions about whether or not to carry a pregnancy to term and will enable meaningful decision-making, advancing rather than jeopardizing the fundamental rights of all women, including women with disabilities.

To this end, States must take legislative and policy measures to address root causes of inequalities of people with disabilities and raise public awareness about the rights of people with disabilities to eliminate stigma associated with disability and to promote an inclusive society.²¹⁵ This includes ensuring that children with disabilities and their families have access to appropriate information, supports, and services within their local community, in line with States' obligations under the CRPD, to ensure that people with disabilities can live with dignity and exercise their rights. This, in turn, requires:

- ▶ Ensuring that children with disabilities have access to necessary health services in general and specific to their disability, “including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities.”²¹⁶ Necessary health services must be as close as possible to people's own communities, including in rural areas.²¹⁷ States must also provide habilitation and rehabilitation services aimed at enabling individuals with disabilities to attain full physical, mental, and social ability.²¹⁸
- ▶ Ensuring an inclusive, accessible, and affordable education system, available in the local community.²¹⁹
- ▶ Taking steps to safeguard the right to an adequate standard of living for persons with disabilities and their families, including through the provision of social protection and poverty reduction programs.²²⁰ For families of persons with disabilities living in poverty, States must provide financial assistance with disability-related expenses, as well as adequate training, counselling, and respite care.²²¹

States must allocate sufficient resources to ensure that these supports and services are adequately funded to the maximum of available resources.²²² States must also invest in the research necessary to provide assistance and services, including new technologies to promote information and communication, accessibility, inclusion, and participation by people with disabilities.²²³

Importantly, States must also ensure that medical providers and support staff are trained on the rights of people with disabilities, on how to provide them with human-rights based medical care and support,²²⁴ and to recognize disability biases in counselling women who may give birth to a child with a disability. Training and education on the rights of people with disabilities must begin in medical school and other health care training programs. Ongoing training and education should be implemented through mandatory continuing medical education programs to ensure that established medical providers are sensitized to the rights of persons with disabilities.

States must ensure that pregnant people have voluntary access to a range of unbiased, evidence-based information by trained providers to ensure they are able to make free and informed decisions.

Access to unbiased, evidence-based information is vital to ensuring reproductive autonomy. The manner in which information about a prenatal diagnosis of fetal impairment is imparted to a pregnant person can have a profound impact on her decision-making, particularly where such information is coupled with either disability-related and/or abortion-related stigma; counseling must be non-directive and avoid suggesting a presumption either in favor of or against abortion.

At the same time, as discussed above, onerous counseling requirements can infringe women's rights to make autonomous decisions about whether or not to terminate a pregnancy.²²⁵ Burdensome counseling requirements—for instance, mandatory waiting periods that require women to receive counseling up to several days before they can obtain a legal abortion—may be coupled with biased, stigmatizing, and scientifically unsound information designed to discourage women from terminating a pregnancy for any reason.²²⁶

To balance the need for full information on the one hand and concerns about biased and directive counseling on the other, States must ensure that pregnant people are offered voluntary access to information, including:

- ▶ Unbiased, evidence-based information and non-directive counseling about their pregnancies, including prenatal diagnostic tests to ensure access to all information about their pregnancy;
- ▶ Unbiased, evidence-based information and non-directive counseling about what the diagnosis means for their pregnancy and their health, including, e.g., risks of miscarriage or stillbirth;
- ▶ Unbiased, evidence-based information and non-directive counseling about what the diagnosis could mean if the pregnancy is carried to term, including information about the lived experiences of people with similar disabilities, information about what it could mean to parent a child with such a disability, information about available supports and services in the local community for children with disabilities and their families, and referrals upon request to professional organizations and/or disabled people's organizations (DPOs) that could provide additional information and resources, including about family or parent support networks;
- ▶ Information about access to abortion, including its legal status and where to access safe and legal abortions, and any financial supports to cover the costs of an abortion; and
- ▶ Referrals upon request for counseling and other supports to process the information received, including referrals to support groups for women who have received similar prenatal diagnoses.

To combat stigma and bias in the provision of information, medical providers and their staff must be trained to discuss pregnancy-related diagnoses in a disability-sensitive manner²²⁷ and in a way that respects women's autonomous decision-making. States must ensure that the information is accessible to the pregnant person, including by providing information in a range of alternative formats (e.g., Braille, Easy Read, plain language, etc.) and providing alternative forms of communication, such as Sign Language interpretation.

Conclusion and Key Takeaways

The disability rights and reproductive rights movements and women with disabilities share common experiences of stigma, discrimination, and denials of autonomy. These movements also share common objectives: a society where people with disabilities are included and can participate as equal members of society, where people with disabilities and their families have access to the range of supports and services that they may need, where pregnant people have voluntary access to unbiased and evidence-based information, and where pregnant people are able to make autonomous and informed decisions both in law and in practice and are supported rather than stigmatized in that decision-making process.

Fostering a climate where the rights and dignity of people with disabilities and all women are respected is essential to ensuring meaningful reproductive choice for all. Working to overcome historic tensions between the disability and reproductive rights movements and to strengthen cross-movement collaboration will bolster efforts to transform the legal, policy, and social environments in which important life decisions, including sexual and reproductive health decisions, are made. Here are a few takeaways and recommendations for key stakeholders to strengthen such collaboration:

To all advocates:

- ▶ Ensure meaningful inclusion of women with disabilities in this debate as the stakeholders that straddle this divide and bear the consequences of both restrictive abortion laws and disability-related stigma.
- ▶ Recognize that the key stakeholders in this debate share more commonalities than differences.
- ▶ The fight for personal autonomy cuts across both the disability rights and reproductive rights movements; working together to strengthen protections of this right will make both movements stronger.
- ▶ Moving past historic tensions around abortion to bridge the gap between the disability rights movement and the women's rights movement will strengthen both movements' advocacy efforts.
- ▶ Language matters. Be willing to engage the other movements to solicit feedback on messaging to ensure that advocacy messages are nuanced and carefully crafted to navigate the historic, political, and social contexts in which these dialogues take place.
- ▶ Be willing to engage respectfully in difficult conversations and listen to the concerns of other movements, even or especially if those perspectives do not fit within your understood narrative. Recognize that this can be an emotionally charged debate that triggers personal concerns for all involved.

To the reproductive rights movement:

- ▶ Where politically feasible, advocate for either fully decriminalized abortion or legal abortion without restriction as to reason as the ideal legal framework on abortion, rather than focusing on minimum grounds on which abortion should be legal.
- ▶ Avoid using language in advocacy campaigns that perpetuates disability-related stigma, such as the notion that having a child with a disability is “tragic” or “traumatic,” language that conflates disability with pain and suffering, or language that suggests that children born with disabilities are “abnormal” or “defective.”
- ▶ Recognize that distinguishing between “fetal impairment” and “severe or fatal fetal impairment” is not necessarily a meaningful distinction for the disability rights movement and carries the risk of reinforcing stigma about the “quality of life” of people with disabilities. Keep these considerations in mind when crafting advocacy messages related to this issue to avoid perpetuating disability-related stigma.
- ▶ Avoid language that reinforces the perceived “burden” of parenting a child with a disability; where advocacy relates to the social well-being of the pregnant person, focus instead on the personal circumstances of the pregnant person and on the failure of the State to provide appropriate and locally-available supports for children with disabilities and their families.

- ▶ Ensure meaningful, not tokenistic, engagement of women with disabilities in discussions around sexual and reproductive health broadly. This includes:
 - Budgeting for participation of women with disabilities in reproductive rights spaces, including costs related to a personal assistant and other accessibility measures as applicable;
 - Ensuring accessibility of materials related to sexual and reproductive health and rights (including in alternative formats, such as screen-reader accessible electronic formats, large print for women with visual impairments, and plain language or Easy Read for women with intellectual disabilities), given that women with disabilities often experience significant barriers to accessing information about sexual and reproductive health and rights; and
 - Integrating priority sexual and reproductive health concerns of women with disabilities into broader sexual and reproductive rights advocacy agendas.
- ▶ Engage the disability rights community to better understand the intersecting disability rights issues relating to autonomy—such as forced abortion and issues around legal capacity. Be an ally to the disability rights movement in their advocacy on corollary rights issues.
- ▶ Recognize the pervasive harms of the medical model of disability. In advocacy related to abortion counseling, reflect the need for:
 - anti-disability bias training for healthcare providers,
 - information about the lived experiences of people with similar disabilities,
 - information about available supports and services in the local community for children with disabilities and their families, and
 - referrals upon request to professional organizations and/or DPOs that could provide additional information and resources, including about family or parent support networks.
- ▶ Assess both personal and organizational biases against disability and take steps to dismantle internalized prejudices and stereotypes about people with disabilities and the disability rights movement.

To the disability rights movement:

- ▶ Recognize that reproductive autonomy is an issue of major concern to women with disabilities and should be a priority of the disability rights movement.
- ▶ Recognize that not all fetal impairment diagnoses will lead to a disability following birth, that there are some conditions, or complex conditions, that will result in miscarriage or stillbirth. Recognize, too, that miscarriage, stillbirth, and the death of an infant within hours or days of birth can be traumatic events for the person who carried that pregnancy.
- ▶ Engage the reproductive rights community to better understand intersecting reproductive rights issues relating to autonomy—such as informed consent and supported decision-making. Be an ally to the reproductive rights movement in their advocacy on corollary rights issues.
- ▶ Advocate for either fully decriminalized abortion or legal abortion without restriction as to reason as the ideal legal framework on abortion.
- ▶ Recognize the political environment in which abortion is regulated. In advocacy related to fetal impairment:
 - Avoid advocating for disability-selective abortion bans or bans on prenatal genetic testing—the experience of sex-selective bans²²⁸ demonstrates that such restrictions are likely to be both ineffective and counterproductive to advancing the rights of people with disabilities, including women with disabilities.
 - Focus on advocating for measures that will address the root causes of disability-related stigma.
- ▶ Assess both personal and organizational gender biases and take steps to dismantle internalized prejudices and stereotypes about gender and the reproductive health and rights movement.

To the funder community:

- ▶ Recognize that funding silos—whether disability rights, women’s rights, or reproductive rights—can widen rather than bridge the divide between movements, weakening overall efficacy. Fund collaboration between movements.
- ▶ Fund programs and strategies that recognize that autonomy and reproductive justice encompass not just the legal right to make decisions, but the ability to make meaningful choices about reproduction, including the ability to make a voluntary and informed decision to either terminate or continue a pregnancy free from undue legal, attitudinal, and financial coercion.
- ▶ Consider a twin-track funding strategy that:
 - encourages the inclusion of women with disabilities in mainstream women’s rights, reproductive rights, disability rights programs and strategies, and
 - recognizes work led by disabled women and focused specifically on the rights of disabled women and girls.
- ▶ Promote—through invitations, scholarships, and grants—active participation of women with disabilities in women’s rights, reproductive rights, and disability rights spaces to intentionally amplify these historically excluded voices; allocate sufficient resources for accessibility and inclusion to ensure that such participation is not tokenistic.

By approaching these issues with an open mind toward the views and experiences of each movement, advocates can foster greater understanding and bridge historic tensions to work together toward collective goals. Such efforts may not be easy, but they are essential to ensuring successful advocacy to advance the rights of all stakeholders in these debates.

Endnotes

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- 120 CRC Committee, General Comment No. 20, *supra* note 1, ¶ 60; CEDAW Committee, General Recommendation No. 35, *supra* note 2, ¶ 31(a); ESCR Committee, General Comment No. 22, *supra* note 1, ¶28. See also, CEDAW Committee, General Recommendation No. 24, *supra* note 2, ¶ 31(c); CRPD Committee & CEDAW Committee, *Joint statement on guaranteeing sexual and reproductive health and rights*, *supra* note 1.
- 121 CRPD, art. 8.
- 122 CRPD, art. 7.
- 123 Article 1 of the Universal Declaration of Human Rights states that “[a]ll human beings are born free and equal in dignity

and rights” [Universal Declaration of Human Rights, *adopted*, Dec. 10, 1948, G.A. Res. 217a (III), Art. 1, U.N. Doc. A/810 (1948)], and the history of negotiations over the Declaration indicate that “born” was used intentionally to preclude application of the protected rights prenatally [U.N. GAOR 3rd Comm., 99th Mtg., ¶¶ 110-124, U.N. Doc. A/PV/99 (1948)]. See also, Rhonda Copelon et al., *Human Rights Begin at Birth: International Law and the Claim of Fetal Rights*, 13 REPRO. HEALTH MATTERS 120 (Nov. 2005).

- 124 CEDAW, art. 16(1).
- 125 CRPD Committee & CEDAW Committee, *Joint statement on guaranteeing sexual and reproductive health and rights*, *supra* note 1.
- 126 ESCR Committee, General Comment No. 22, *supra* note 1, ¶¶ 6, 49(f).
- 127 *Id.*
- 128 ESCR Committee, General Comment No. 14, *supra* note 116, ¶ 50.
- 129 *Id.*, ¶ 41.
- 130 See, e.g., CEDAW Committee, *Concluding Observations: Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); P. & S. v. Poland, No. 57375/08 Eur. Ct. H.R. (2008); ESCR Committee, General Comment No. 22, *supra* note 1, ¶ 18; Human Rights Committee, *Concluding Observations: Ireland*, ¶ 9, U.N. Doc. CCPR/C/IRL/CO/4 (2014); Special Rapporteur on Health, *Criminalization of Sexual and Reproductive Health*, *supra* note 118, ¶¶ 24, 31.
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- 142 See R.P.B. v. Philippines, CEDAW Committee, Commc’n No. 34/2011, ¶ 9, U.N. Doc. CEDAW/C/57/D/34/2011 (2014).
- 143 CRC Committee, General Comment No. 20, *supra* note 1, ¶ 60; CEDAW Committee, General Recommendation No. 35, *supra* note 2, ¶ 31(a). See also, CEDAW Committee, General Recommendation No. 24, *supra* note 2, ¶ 31(c); CRPD Committee & CEDAW Committee, *Joint statement on guaranteeing sexual and reproductive health and rights*, *supra* note 1.
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- 147 CRC Committee, General Comment No. 15, *supra* note 1, ¶ 70. See also ESCR Committee, General Comment No. 22, *supra* note 1, ¶ 28; CRPD Committee, *Concluding Observations: Poland*, ¶ 44(e), U.N. Doc. CRPD/C/POL/CO/1 (2018).
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- 155 Working Group on the issue of discrimination against women in law and in practice, *Inputs on the Human Rights Committee draft general comment No. 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life* (Oct. 2017).
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- 160 See, e.g., CEDAW Committee, *Concluding Observations: Peru*, ¶ 36(a), U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); CEDAW Committee, *Concluding Observations: Chile*, ¶ 34, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012); CAT Committee, *Concluding Observations: Peru*, ¶ 41, U.N. Doc. CAT/C/PER/CO/7 (2018); CRC Committee, *Concluding Observations: Peru*, ¶ 56, U.N. Doc. CRC/C/PER/CO/4-5 (2016); ESCR Committee, *Concluding Observations: United Kingdom*, ¶ 25, U.N. Doc. E/C.12/GBR/CO/5 (2009); CEDAW Committee, *Summary of the Philippines inquiry*, *supra* note 157, ¶ 51(v).
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- 163 CRPD Committee), *Concluding Observations: Austria*, ¶ 14, U.N. Doc. CRPD/C/AUT/CO/1 (2013).
- 164 *Id.*; CRPD Committee, *Concluding Observations: Spain*, ¶ 18, U.N. Doc. CRPD/C/ESP/CO/1 (2011); CRPD Committee, *Concluding Observations: Hungary*, ¶ 18, U.N. Doc. CRPD/C/HUN/CO/1 (2012).
- 165 CRPD Committee, *Concluding Observations: United Kingdom*, ¶ 12, U.N. Doc. CRPD/C/GBR/CO/1 (2017).
- 166 *Id.*, ¶ 13.
- 167 CRPD Committee, *Concluding Observations: Poland*, ¶ 44, U.N. Doc. CRPD/C/POL/CO/1 (2018).
- 168 CEDAW Committee, Report of the UK and Northern Ireland Inquiry, *supra* note 140, ¶ 62. The Committee further called upon the state to: "(b) Adopt legislation to provide for expanded grounds to legalise abortion at least in the following cases: (i) Threat to the pregnant woman's physical or mental health without conditionality of "long-term or permanent" effects; (ii) Rape and incest; and (iii) Severe foetal impairment, including FFA, without perpetuating stereotypes towards

- persons with disabilities and ensuring appropriate and ongoing support, social and financial, for women who decide to carry such pregnancies to term.” *Id.*, ¶ 85(b).
- 169 CRPD Committee & CEDAW Committee, *Joint statement on guaranteeing sexual and reproductive health and rights*, *supra* note 1.
- 170 *Id.*
- 171 CRPD, art. 8. See also CRPD, arts. 24, 27 & 29.
- 172 CRPD, art. 8(2); CRPD Committee, General Comment No. 5, *supra* note 117, ¶ 77.
- 173 CRPD Committee, *Concluding Observations: Mexico*, ¶ 10, U.N. Doc. CRPD/C/MEX/CO/1 (2014).
- 174 CRPD, art. 25; CRPD Committee, *Concluding Observations: Qatar*, ¶ 12, U.N. Doc. CRPD/C/QAT/CO/1 (2015); Special Rapporteur on Health, *Health Workforce Education*, *supra* note 141, ¶ 38; ESCR Committee, General Comment No. 14, *supra* note 116, ¶ 37; ESCR Committee, General Comment No. 22, *supra* note 1, ¶¶ 13, 24.
- 175 CRPD Committee, General Comment No. 5, *supra* note 117, ¶ 77.
- 176 CRC Committee, *Concluding Observations: Albania*, ¶ 59, U.N. Doc. CRC/C/ALB/CO/2-4 (2012).
- 177 CRC Committee, *Concluding Observations: Andorra*, ¶ 40, U.N. Doc. CRC/C/AND/CO/2 (2012).
- 178 CRC Committee, *Concluding Observations: China*, ¶ 54, U.N. Doc. CRC/C/CHN/CO/3-4 (2013).
- 179 CEDAW Committee, *Concluding Observations: Finland*, ¶ 33, U.N. Doc. CEDAW/C/FIN/CO/7 (2014).
- 180 See CEDAW Committee, Report of the UK and Northern Ireland Inquiry, *supra* note 140, ¶¶ 62, 85(b).
- 181 CRC Committee, General Comment No. 9, *supra* note 117; Catalina Devandas Aguilar, Special Rapporteur on the Rights of Persons with Disabilities, *Report of the Special Rapporteur on the rights of persons with disabilities: Access to Rights-Based Support*, ¶¶ 29-41, 44, U.N. Doc. A/HRC/34/58 (Dec. 20, 2016) [hereinafter Special Rapporteur on Disability, *Access to Rights-Based Support*].
- 182 See Convention on the Rights of the Child, art. 20(2)-(3), G.A. Res. 44/25, U.N. Doc. A/44/49 (1989) (entered into force Sept. 2, 1990). See CRC Committee, *Concluding Observations: Bosnia and Herzegovina*, ¶ 53(b), U.N. Doc. CRC/C/BIH/CO/2-4; CRPD Committee, *Concluding Observations: Ukraine*, ¶¶ 23, 29, U.N. Doc. CRPD/C/UKR/CO/1 (2015); CRPD Committee, *Concluding Observations: Gabon*, ¶ 45, U.N. Doc. CRPD/C/GAB/CO/1 (2015); CRPD Committee, *Concluding Observations: Kenya*, ¶ 42, U.N. Doc. CRPD/C/KEN/CO/1 (2015); CRPD Committee, General Comment No. 5, *supra* note 117, ¶ 76; Special Rapporteur on Health, *Prevention of Child Mortality*, *supra* note 117, ¶ 83; CRC Committee, General Comment No. 9, *supra* note 117, ¶ 32; CRC Committee, *General Comment No. 7 (2005): Implementing child rights in early childhood*, ¶ 20, U.N. Doc. CRC/C/GC/7/Rev.120 (Sept. 2006); Special Rapporteur on Disability, *Access to Rights-Based Support*, *supra* note 181, ¶ 44.
- 183 CRPD, art 7.
- 184 CRPD, arts. 7, 24 & 29.
- 185 ESCR Committee, General Comment No. 22, *supra* note 1, ¶ 8.
- 186 *Id.*
- 187 CEDAW Committee, Report of the UK and Northern Ireland Inquiry, *supra* note 140, ¶ 85(b).
- 188 See, e.g., CRPD Committee, General Comment No. 1, *supra* note 45, ¶¶ 7, 9.
- 189 See, e.g., CRR, Law and Policy Guide: Third-Party Authorization, <https://reproductiverights.org/law-and-policy-guide-third-party-authorization>.
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- 191 See, e.g., ESCR Committee, General Comment No. 22, *supra* note 1, ¶ 27.
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- 193 David Perry, “My Body, My Choice: Why the Principle of Bodily Autonomy Can Unite the Left,” THE NATION (Sept. 13, 2017), <https://www.thenation.com/article/my-body-my-choice-why-the-principle-of-bodily-autonomy-can-unite-the-left/>.
- 194 See, e.g., CRPD Committee, General Comment No. 1, *supra* note 45, ¶¶ 26, 29.
- 195 Human Rights Committee, *Concluding Observations: Pakistan*, ¶ 16 U.N. Doc. CCPR/C/PAK/CO/1 (2017); CRPD Committee & CEDAW Committee, *Joint statement on guaranteeing sexual and reproductive health and rights*, *supra* note 1.
- 196 For example, the manner in which the health grounds are interpreted in Poland is so restrictive that virtually no legal abortions take place under these grounds. See, e.g., Christian Davies, “Polish MPs back even tougher restrictions on abortion,” THE GUARDIAN (Jan. 11, 2018), <https://www.theguardian.com/world/2018/jan/11/polish-mps-reject-liberalised-abortion-laws-but-back-new-restrictions>.
- 197 See, e.g., Amnesty International, *Key Facts on Abortion*, *supra* note 7.

- 198 Morgan Holms, *Mind the Gaps: Intersex and (Re-productive) Spaces in Disability Studies and Bioethics*, 5 J. BIOETHICAL INQUIRY 169 (2008).
- 199 See, e.g., Sneha Barot, *A Problem-and-Solution Mismatch: Son Preference and Sex-Selective Abortion Bans*, 18 GUTTMACHER Pol. Rev. 15, at 18 (2012), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/gpr/15/2/gpr150218.pdf>.
- 200 Bela Ganatra, *Maintaining access to safe abortion and reducing sex ratio imbalances in Asia*, 16 REPRO. HEALTH MATTERS 90, 91 (2008).
- 201 CEDAW Committee, Report of the UK and Northern Ireland Inquiry, *supra* note 140, ¶ 62.
- 202 Bela Ganatra, *supra* note 200, at 96.
- 203 *Id.* at 90-98; WHO et al., *Preventing Gender-Biased Sex Selection: An Interagency Statement OHCHR, UNFPA, UNICEF, UN Women and WHO* (2011), http://whqlibdoc.who.int/publications/2011/9789241501460_eng.pdf.
- 204 Sneha Barot, *supra* note 199, at 19-20.
- 205 WHO, *Preventing Gender-Biased Sex Selection*, *supra* note 203, at 7.
- 206 *Id.* at 6, 12.
- 207 Bela Ganatra, *supra* note 200, at 93.
- 208 WHO, *Preventing Gender-Biased Sex Selection*, *supra* note 203, 8, 12.
- 209 *Id.* at 7-8.
- 210 *Id.* at 7.
- 211 *Id.* at 10.
- 212 *Id.* at 7.
- 213 *Id.* at 7.
- 214 *Id.* at 8.
- 215 CRPD, art. 8.
- 216 CRPD, art. 25(b).
- 217 CRPD, art. 25(c).
- 218 CRPD, art. 26.
- 219 CRPD, art. 24.
- 220 CRPD, arts. 28(1), 28(2)(b).
- 221 CRPD, art. 28(2)(c).
- 222 CRPD, arts. 4(1)(i); 25(d).
- 223 CRPD, art. 4(1)(g).
- 224 CRPD, art. 4(2).
- 225 See, e.g., Guttmacher Institute, *Counseling and Waiting Periods for Abortion*, *supra* note 110; CRR, *Mandatory Waiting Periods*, *supra* note 109.
- 226 CRR, *Mandatory Waiting Periods*, *supra* note 109.
- 227 CRPD, art. 4(2).
- 228 Bela Ganatra, *supra* note 200, at 90-98. WHO, *Preventing Gender-Biased Sex Selection*, *supra* note 203.

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Women Enabled International advances human rights at the intersection of gender and disability to: respond to the lived experiences of women and girls with disabilities; promote inclusion and participation; and achieve transformative equality. Women Enabled International envisions a world where women and girls with disabilities claim human rights, act in solidarity and lead self-determined lives.



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