

**Center for Reproductive Rights:  
Submission to the Committee on the Rights of Persons with Disabilities  
Half Day of General Discussion on Women with Disabilities**

**I. Introduction and Foundational Principles**

The Center for Reproductive Rights (“the Center”), an international non-governmental legal advocacy organization dedicated to the advancement of reproductive freedom as a fundamental human right, submits this paper to the Committee on the Rights of Persons with Disabilities (CRPD Committee) in order to call attention to the overlap between reproductive rights and disability rights, particularly as these issues affect women with disabilities. The Center is an ECOSOC-accredited non-governmental organization and has worked with treaty monitoring bodies at the UN for over 20 years, submitting shadow reports and letters during state reviews, using complaint mechanisms to bring individual cases to the committees, and helping to develop general recommendations that address reproductive rights. The Center also undertakes fact-finding missions and legal casework at the national and regional levels across the globe. The Center is based in New York and has offices in Geneva, Kathmandu, Nairobi, and Bogota.

The exercise of reproductive rights, including the right to decide freely on the number and spacing of one’s children, is essential to ensuring that women can achieve equality and overcome discrimination by exercising their autonomy and self-determination. Too often, however, women face restrictions, in law and/or in practice, on the exercise of their reproductive rights, and state failure to take positive measures to ensure access to reproductive health services and to prevent and punish violations contribute to the barriers women face in exercising their reproductive rights.

Autonomy is also one of the foundational principles and core legal obligations outlined in the Convention on the Rights of Persons with Disabilities (CRPD). And although all women and girls face barriers to accessing reproductive health information and services, women and girls with disabilities may have particular difficulty ensuring their reproductive rights, though the ways in which barriers to access affect women with disabilities have not yet been widely studied.

As the CRPD recognizes, women with disabilities are subject to multiple discrimination because of both their gender and disability statuses.<sup>1</sup> The CRPD requires states to take measures to address this multiple discrimination, which also manifests itself in the exercise of reproductive rights and poses additional barriers for women with disabilities in exercising their autonomy, including through the provision of information and services that support that autonomy. The CRPD recognizes the importance of fulfilling reproductive rights for persons with disabilities, particularly women and girls, and includes the most expansive language on reproductive rights of any UN human rights convention. The reproductive rights specifically enumerated in the CRPD include the rights “to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education,”<sup>2</sup> to retain fertility on an equal basis with others, including for children with disabilities,<sup>3</sup> and to health on an equal basis with others, “including in the area of sexual and reproductive health and population-based public health programs.”<sup>4</sup>

These obligations imposed by the CRPD give the CRPD Committee the opportunity and the imperative to set important and progressive standards in the field of reproductive rights. Additionally, the CRPD Committee can encourage states to document, gather disaggregated data, and report on barriers to accessing reproductive health information and services for women and girls with disabilities, which the CRPD has done for collecting general data on women with disabilities,<sup>5</sup> thereby filling an important gap in the understanding of reproductive rights for this population.

This submission explores some of the reproductive rights issues affecting women and girls with disabilities, including access to information in healthcare settings and through sexuality education, and access to services such as contraception and abortion on the basis of free and informed consent. The submission addresses how the CRPD

can be used to address many of these violations, including examples of how other UN treaty bodies and human rights mechanisms have addressed reproductive rights issues. Finally, the submission includes recommendations to the CRPD Committee about how to strengthen its comments on reproductive rights to ensure autonomy, equality, and non-discrimination for women and girls with disabilities.

## **II. Access to Sexual and Reproductive Health Information for Women and Girls with Disabilities**

In order for women with disabilities to fully exercise their reproductive autonomy, they must have access to the accurate and timely information they need to make important life decisions. This information, however, is often not provided to women with disabilities because they are unable to physically access healthcare facilities, the information provided to them is biased by a perception that they are unable to take care of children,<sup>6</sup> or the information they receive is not in accessible formats.<sup>7</sup> And although sexuality education, both in and out of schools, is an important part of ensuring that women and girls are empowered to protect their reproductive rights, sexuality education is often effectively denied to women and girls with disabilities because of stereotypes about their sexuality, lack of accessibility of information, and exclusion from mainstream schools.<sup>8</sup>

### **A. Access to reproductive health information in healthcare settings**

Access to information in healthcare settings is an issue that affects all women, as laws often restrict what information is available or require healthcare professionals to provide unnecessary or misleading information to women about their health. In some circumstances, the information that is provided reflects biases and prejudices about the role of women and the health services that should be available to them.<sup>9</sup> Accurate and timely information is essential to exercising autonomy and making an informed choice to undergo medical procedures. When accurate and evidence-based information, free from biases and prejudices, is denied to individuals in healthcare settings, including reproductive healthcare, it is a human rights violation.

Women with disabilities may face barriers to accessing information about their reproductive health distinct from other women, because of physical barriers to entry into healthcare facilities or to the use of transportation,<sup>10</sup> and communication barriers or lack of reproductive health information in accessible formats.<sup>11</sup> For example, two women with physical disabilities in Northern Uganda reported that they were not able to seek reproductive health information and services following rape because the facilities were too far away, and they had no accessible means to get to them.<sup>12</sup>

The information that is provided to women with disabilities about reproductive healthcare and parenting may undermine their rights, exposing a bias in the community that persons with disabilities are not able to care for their children.<sup>13</sup> Social science research has documented that women with disabilities face skepticism about their ability to care for children from family members and healthcare professionals.<sup>14</sup> Parents of children with intellectual disabilities in particular may be biased against the ability of their children to become parents, sometimes resulting in abusive practices such as forced sterilization.<sup>15</sup>

### **B. Access to Sexuality Education**

Comprehensive and accurate sexuality education is a key component of ensuring that reproductive rights are fulfilled, by providing needed information at an early age so that people can make decisions about their reproductive health. Sexuality education is also important as a means to empower women and girls to protect themselves from unwanted pregnancies and STIs, such as HIV/AIDS, as well as to access reproductive health services.<sup>16</sup> However, according to the World Health Organization, adolescents with disabilities are more likely to be excluded from sexuality education programs than other children.<sup>17</sup>

According to the UNESCO technical guidelines on sexuality education, sexuality education should be comprehensive and at minimum include information about anatomy and physiology, puberty, pregnancy, and STIs, including HIV/AIDS.<sup>18</sup> Additionally, these programs should address the relationships and emotions

involved in sexual experiences, promote self-esteem, respect for the rights of others, gender equality,<sup>19</sup> and avoid “reinforcing demeaning stereotypes and perpetuating forms of prejudice.”<sup>20</sup> Inadequate sexuality education, including abstinence-only programs, creates barriers to youth exercising their reproductive rights because these programs provide adolescents with neither accurate nor sufficient information to make decisions about preventing STIs and to determine the timing and spacing of their children.<sup>21</sup> Sexuality education should also be available to women and girls both in school and outside of formal school settings in order to reach the widest possible audience.<sup>22</sup>

Sexuality education for all is not only a means to empower women and girls with disabilities to understand their reproductive health but also to educate the public about the sexuality of persons with disabilities. For instance, accurate sexuality education can help dispel myths that pervade communities about women and girls with disabilities, such as that they are asexual, or in some instances over-sexual.<sup>23</sup> On the other hand, lack of information on sexuality may in turn make persons with disabilities more susceptible to sexual abuse.<sup>24</sup>

Children with disabilities, particularly girls, are often shut out of education, including sexuality education. The World Bank estimates that as many as 97 percent of all individuals with disabilities – and 99 percent of women with disabilities – are illiterate.<sup>25</sup> Thus, it is imperative that sexuality education not only begin at the earliest stages in school, but that governments initiate programs to reach the large number of young people outside the school system.<sup>26</sup>

### C. International Human Rights Standards for Access to Sexual and Reproductive Health Education and Information

UN human rights bodies have recognized that states have a legal obligation to provide sexual and reproductive health information to women and girls in an accessible manner.<sup>27</sup> Indeed, the Committee on Economic, Social, and Cultural Rights (ESCR Committee) has considered that the right to health includes “access to health-related education and information, including on sexual and reproductive health.”<sup>28</sup> According to this Committee, accessibility of health information includes “the right to seek, receive and impart information and ideas concerning health issues” and the provision of this information without discrimination.<sup>29</sup> In order to ensure that women do not face discrimination in accessing health information, the ESCR Committee has required “the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.”<sup>30</sup>

The Committee on the Elimination of all forms of Discrimination against Women (CEDAW Committee) has recognized the importance of reproductive health information in the exercise of decision-making autonomy, noting that “women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services” to be able to make informed decisions regarding their reproductive health.<sup>31</sup> Additionally, the Committee on the Rights of the Child (CRC Committee) has emphasized the importance of such information for adolescents, indicating that “States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs).”<sup>32</sup> In his most recent report to the Human Rights Council, the UN Special Rapporteur on Torture classified denial of reproductive health information as a potential form of cruel, inhuman or degrading treatment (CIDT), stating that “[a]ccess to information about reproductive health is imperative to a woman’s ability to exercise reproductive autonomy, and the rights to health and to physical integrity.”<sup>33</sup>

Several UN treaty monitoring bodies have acknowledged the importance of sexuality education to fulfilling basic human rights. These bodies have recognized the importance of accurate and objective sexuality education as a means to reduce maternal mortality, abortion rates, adolescent pregnancies, and HIV/AIDS prevalence and to promote gender equality in education, generally.<sup>34</sup> In its General Comment No. 4 on adolescent health and development, the CRC Committee states that countries must ensure that “all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their

health and development and practice healthy behaviors.”<sup>35</sup> The UN Special Rapporteur on the Right to Education has stated that sexuality education “is especially important in ensuring the enjoyment of women’s right to live free of violence and gender discrimination...”<sup>36</sup> and has highlighted that sexual education should be accurate and comprehensive and provided on a non-discriminatory basis.<sup>37</sup>

According to the CRC Committee, part of the obligation to ensure access to sexuality education is training of teachers to provide accurate information.<sup>38</sup> As part of ensuring women’s health, the CEDAW Committee has also recommended that “States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality.”<sup>39</sup>

In addition to the rights in the CRPD to access reproductive and sexual health information described above, the CRPD also provides a right for persons with disabilities “to seek, receive, and impart information and ideas on an equal basis with others” through the provision of information in accessible formats.<sup>40</sup> States are obligated under the CRPD to ensure that facilities and transportation, including medical facilities and emergency services, are accessible to persons with disabilities,<sup>41</sup> an important part of ensuring access to needed health information.

Although the CRPD Committee has yet to comment on the need for sexuality education or reproductive health information for persons with disabilities, the Committee has taken some steps to ensure that the rights to health and information in the CRPD are fulfilled. The Committee has commented on “systemic barriers that make it impossible for persons with disabilities to access health services...,” including “physical barriers, a dearth of accessible materials, a lack of health-care professionals trained in the human rights model of disability ...”<sup>42</sup> The CRPD Committee has also expressed concern about lack of available health services, particularly in rural areas, and its effect on access for persons with disabilities.<sup>43</sup>

### **III. Access to Reproductive Health Services**

As noted above, one of the foundational principles of both reproductive rights and disability rights is the idea that individuals should be able to exercise their autonomy and make important decisions about their lives for themselves. But in reproductive healthcare settings, restrictions on reproductive health services in law and in practice often undermine women’s autonomy. Women and girls with disabilities face particular barriers to accessing services because they are too often denied the opportunity to decide for themselves whether to have children or face stereotypes about their capabilities that undermine the exercise of their reproductive rights. This section explores the discrimination women and girls, including those with disabilities, face when trying to access contraception and abortion, as well as the violence perpetrated against them in the forms of forced sterilization or forced abortion, and the international human rights and medical standards surrounding access to these services.

#### **A. Access to Contraception**

Lack of access to modern contraceptive information and services means that women and adolescents are often unable to protect themselves from HIV and other sexually transmitted infections (STIs) or to control their fertility and reproduction, with attendant negative consequences for their health and lives.<sup>44</sup> Of the approximately 80 million women who annually experience unintended pregnancies, 45 million have abortions.<sup>45</sup> Many of those are clandestine and unsafe due to laws that restrict or ban abortions, making unsafe abortion a leading cause of maternal mortality and morbidity.<sup>46</sup> Satisfying the current unmet need for contraceptives—for women who are sexually active and do not want children but do not use modern contraceptives<sup>47</sup>—could prevent roughly 150,000 maternal deaths and 25 million induced abortions worldwide annually.<sup>48</sup>

Because of limited data, it is unclear how women with disabilities are affected by lack of access to contraception; however, given the barriers to healthcare that they experience, it is likely that women with disabilities have serious challenges in accessing contraceptive information and services. Contraceptive information and services may be unavailable to individuals with disabilities due to physical barriers, lack of accessible information, stigma

and discrimination.<sup>49</sup> It is commonly assumed that individuals with disabilities are not sexually active, and so not in need of contraception, but research shows that they are as likely to be sexually active as their non-disabled peers.<sup>50</sup> However, they are less likely to receive information about HIV prevention and safe sex, and are less likely to have access to prevention methods such as condoms.<sup>51</sup>

Lack of access to and information about contraception, including emergency contraception, can have particularly severe physical and mental consequences for women who are victims of sexual violence.<sup>52</sup> Women with disabilities experience violence, including sexual violence, at higher rates than other women,<sup>53</sup> making access to contraception essential for the exercise of their reproductive rights. But as the Center for Reproductive Rights has documented, women are often unable to access these services, because of legal restrictions on access to emergency contraception in some countries<sup>54</sup> or, for women with disabilities, lack of accessible services.<sup>55</sup> Emergency contraceptive services must be reached as quickly as possible, and generally no later than 120 hours after unprotected intercourse, in order for them to be effective at preventing pregnancy,<sup>56</sup> which may be particularly difficult for women with disabilities that impact their mobility.<sup>57</sup>

### 1. International Human Rights Standards for Access to Contraception

Women's and adolescents' right to modern contraceptives and information about contraceptives is grounded in basic human rights protections. These human rights include the rights to equality and non-discrimination, to privacy, to determine the number, timing, and spacing of children, to life and health, to education and information, to be free from torture or CIDT, and to benefit from scientific progress.<sup>58</sup> Contraceptives are also included on the World Health Organization's (WHO) Model List of Essential Medicines, medicines the WHO considers necessary for a basic healthcare system.<sup>59</sup>

The ESCR Committee has stated that lack of access to contraception is a violation of the right to health.<sup>60</sup> States thus have an obligation to provide all women with access to affordable, acceptable, accessible, and good quality contraceptives. To this end, the ESCR Committee has called upon states parties to ensure that all drugs on the WHO Model List of Essential Medicines, which include a range of contraceptives, be made accessible<sup>61</sup> and has noted that access to drugs on this list is a core state obligation under the right to health.<sup>62</sup> In addition, states have core obligations to ensure minimum essential levels of the right to health,<sup>63</sup> and this includes the duty to ensure access to contraceptive information and services "on a non-discriminatory basis, especially for vulnerable or marginalized groups" and "[t]o provide essential drugs, as . . . defined [under the WHO Action Programme on Essential Drugs],"<sup>64</sup> which includes contraceptives.

The CEDAW Committee has also affirmed that, to avoid discrimination against women, states need to ensure family planning services, which include contraception.<sup>65</sup> As part of this obligation, states should themselves provide family planning services, not obstruct women in accessing those services, and ensure that those who attempt to obstruct access face legal sanctions.<sup>66</sup> In addition, the CEDAW Committee has recommended that states take special measures to ensure that women with disabilities have equal access to healthcare, including reproductive health services.<sup>67</sup>

Treaty bodies have also acknowledged that lack of access to contraception, particularly emergency contraception, may cause severe physical or mental suffering for women and girls and put their lives and health at risk. The CRC Committee raised the issue of access to emergency contraception in Ecuador, where some forms of emergency contraception are illegal, stating that access to emergency contraception is an important part of preventing unsafe abortions or suicides and recommending that the state make all forms of emergency contraception available to adolescents.<sup>68</sup> Treaty bodies have also recognized the additional traumatization of being forced to carry unwanted pregnancies for victims of sexual violence. In its 2012 concluding observations for Peru, the Committee against Torture expressed concern at the lack of access to oral emergency contraception to victims of rape, classifying the practice as potential torture or CIDT.<sup>69</sup> The Committee against Torture then called on Peru to remove legal restrictions on the distribution of emergency contraception to rape victims in order to protect its citizens from torture or CIDT.<sup>70</sup>

Under the CRPD, people with disabilities have the right to health, with specifications that health services should be “gender sensitive” and that persons with disabilities should have equal access to services “in the area of sexual and reproductive health and population-based public health programs.”<sup>71</sup> People with disabilities also have the right to found a family and “decide freely and responsibly on the number and spacing of their children,” including through access to “reproductive and family planning education ... and the means necessary to enable them to exercise these rights...”<sup>72</sup> These rights strongly indicate that women with disabilities should have access to modern contraceptives, though the CRPD Committee has not yet addressed the issue of access to elective contraceptive services for women with disabilities.

## B. Forced Sterilization and Forced Abortion

In many parts of the world, women rely on access to a range of methods to control their fertility, including voluntary sterilization. Sterilization is defined as “a process or act that renders an individual incapable of sexual reproduction.”<sup>73</sup> Voluntary sterilization is an important part of ensuring that a wide range of contraceptive methods are available to women, including women with disabilities, who do not want children or do not want more children and is a widely-used form of voluntary contraception throughout the world.<sup>74</sup>

Too often, however, sterilization is not a choice. Forced and coerced sterilization,<sup>75</sup> which takes away reproductive capacity without free and informed consent, is often targeted at women with disabilities. Additionally, women with disabilities are often subject to forced abortion as a result of discriminatory beliefs about who should have children or unjustifiable state policies.

Forced or coerced sterilization of women and girls with disabilities is often undertaken as a way to control menstrual cycles<sup>76</sup> or because of misconceptions and discriminatory attitudes about the ability of women with disabilities to take care of children.<sup>77</sup> Women with disabilities are particularly vulnerable to forced sterilizations performed under the auspices of legitimate medical care or as the result of decisions made by their parents, guardians, or doctors without the individual woman’s consent. The Special Rapporteur on Violence against Women in her most recent report called forced sterilization of women with disabilities a form of violence and classified it as a “global problem.”<sup>78</sup> The UN Special Rapporteur on the Right to Health recognized that “[f]orced sterilizations, rape and other forms of sexual violence, which women with mental disabilities are vulnerable to, are inherently inconsistent with their sexual and reproductive health rights and freedoms.”<sup>79</sup>

Research has indicated that parents of children with intellectual disabilities may consider sterilization for their children because of perceptions that their children would not be good parents themselves, that other means of contraception would not be effective at preventing unwanted pregnancies, or that pregnancy may result from sexual abuse.<sup>80</sup> In reality, however, parents may feel they need to sterilize their children because the parents lack support in caring for children with disabilities undergoing menstruation,<sup>81</sup> or because supports are not available in the community for persons with disabilities who decide to have children. And contrary to parents’ reasoning concerning sexual abuse, forced sterilization is itself a form of abuse.<sup>82</sup>

Although the issue of forced abortion for women with disabilities is not yet widely studied, news reports indicate that when women and girls, particularly with intellectual or mental disabilities, become pregnant, they are sometimes forced or coerced into undergoing an abortion.<sup>83</sup> The European Disability Forum (EDF) noted in a submission to OHCHR on sexual and reproductive rights that “[i]n some countries where therapeutic sterilization of women with disabilities has become illegal, the practice of coerced abortion of women with intellectual or psychosocial disabilities or women and girls with intensive support needs has become even more common....”<sup>84</sup> EDF explains that, because of the widespread societal notion that women with disabilities should not become mothers,<sup>85</sup> “women with disabilities sometimes have to argue with the medical personnel that they actually want to keep their baby [and] often feel pushed by their own families, or persons close to them/personnel in the institutional setting where they live to undergo an abortion.”<sup>86</sup> Women with disabilities who live in institutional settings may be particularly vulnerable to forced abortion.<sup>87</sup>

## 1. International Human Rights and Medical Standards on Forced Sterilization and Forced Abortion

Numerous reports from UN bodies and medical associations indicate that the only valid form of informed consent is that which stems from the patients themselves. The International Federation for Gynecology and Obstetrics (FIGO), a global organization of professionals in these fields seeking to promote the wellbeing of women and improve practice standards,<sup>88</sup> recently released guidelines on female contraceptive sterilization that stress that surgical sterilization must be preceded by “the patient’s informed and freely given consent.”<sup>89</sup> The guidelines note that “[m]edical practitioners must recognize that, under human rights provisions and their own professional codes of conduct, it is unethical and in violation of human rights for them to perform procedures for prevention of future pregnancy on women who have not freely requested such procedures or who have not previously given their free and informed consent.”<sup>90</sup>

According to the UN Special Rapporteur on Health’s report on informed consent and the right to health, informed consent is “not mere acceptance of a medical intervention but a voluntary and sufficiently informed decision protecting the right of the patient to be involved in medical decision-making, and assigning associate duties and obligations to health-care providers, its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being.”<sup>91</sup> For women and girls with disabilities, however, “informed consent” for sterilization or abortion often comes from parents, guardians, or medical professionals rather than themselves. This practice is the result of the widespread and worldwide practice of depriving them of legal capacity and thus the right to make important life decisions, or because individuals assume that women with disabilities lack capacity to make choices about their reproductive health.<sup>92</sup>

The CRPD Committee has interpreted Article 12, which includes the right to full exercise of legal capacity on an equal basis with others, to mean that persons with disabilities should not be deprived of legal capacity and that states should replace current regimes of substituted decision-making, such as guardianship, with systems to support persons with disabilities in making decisions.<sup>93</sup> The Committee has explicitly stated that “a substitute decision-making model that overrides the wishes of the persons concerned ... runs counter to article 12 of the Convention.”<sup>94</sup>

The CRPD Committee has considered forced sterilization and forced abortion as violations of the rights to bodily integrity, family and fertility, health, or legal capacity.<sup>95</sup> Although the CRPD protects persons with disabilities from torture or ill-treatment,<sup>96</sup> the CRPD Committee has not yet addressed forced or coerced sterilization or abortion of women and girls with disabilities as a form of torture or ill-treatment. Other UN human rights bodies have taken this step. The Committee against Torture in its 2012 concluding observations for Peru condemned the practice of forced sterilization of persons with intellectual or mental disabilities as potentially amounting to torture or CIDT and called for the repeal of administrative decrees that allowed the practice.<sup>97</sup> The Special Rapporteur on Torture, in his recent report on torture and ill-treatment in healthcare settings, specifically set out that forced sterilization or abortion of vulnerable or marginalized groups, including persons with disabilities, may amount to torture or ill-treatment, and called for the repeal of laws allowing this practice.<sup>98</sup>

### C. Access to Abortion

Lack of access to safe and legal abortion services has a devastating impact on women’s health and lives. Historically, women have been denied the right to choose to terminate a pregnancy and as such, the ability to make decisions about their lives and bodies. Moreover, gaps in the implementation of abortion laws or procedural barriers placed in the way of abortion services have undermined women’s access to this reproductive health service.<sup>99</sup>

Evidence has shown that women who wish to terminate their pregnancies will do so regardless of the legality of this service.<sup>100</sup> However, the legal status of abortion will largely determine whether they can access abortion services in safe or unsafe conditions.<sup>101</sup> In circumstances in which abortion is legally restricted, women are more likely to seek out clandestine and unsafe abortions, which are associated with increased rates of maternal

mortality and morbidity.<sup>102</sup> Moreover, in countries in which women are unable to access the abortion services to which they are legally entitled, they may also be forced to seek clandestine and unsafe abortions. An estimated 22 million women undergo unsafe abortions each year and 47,000 women die from unsafe abortions annually,<sup>103</sup> accounting for up to 13 percent of maternal deaths worldwide.<sup>104</sup>

Human rights bodies have increasingly recognized women's access to safe and legal abortion as a human rights issue,<sup>105</sup> calling on states to remove legal restrictions on abortion and ensure women's access to safe abortion services.<sup>106</sup> Since the adoption of the International Conference on Population and Development Programme of Action, which called on governments to support a woman's right to make decisions about her reproductive capacity and her body,<sup>107</sup> thirty countries worldwide have liberalized their abortion laws.<sup>108</sup> They have generally done so by amending penal code provisions criminalizing women who seek or healthcare providers who offer abortions in order to decriminalize this service in certain circumstances.<sup>109</sup> During this time, only a few countries have legally restricted abortion.<sup>110</sup> This trend toward the liberalization of abortion laws and increasing women's access to abortion services has been a major victory in recognizing women's, including women with disabilities', right to have their decisions and autonomy respected.

The abortion laws in 60 countries throughout the world permit a woman to terminate her pregnancy without restriction as to reason within certain gestational limits, thereby recognizing a woman's capacity to make decisions about her body and reproduction.<sup>111</sup> Beyond the gestational limit for which a woman can terminate her pregnancy without restriction as to reason, abortion is normally permitted on specific grounds, such as in circumstances in which the pregnancy poses a risk to the woman's life or health or in cases of rape, incest or fetal impairment.<sup>112</sup> Conversely, approximately 125 countries maintain restrictive abortion laws, banning this service altogether or only authorizing it in limited circumstances, such as to protect a woman's life or health or in cases of rape, incest or fetal impairment.<sup>113</sup> These abortion laws not only deprive women of their autonomy concerning decisions about their reproductive lives; they also pose significant risks to women's health and lives.

Women choose to continue or terminate their pregnancies for myriad reasons that are personal to them. These decisions vary immensely and depend on a variety of factors that affect women's health and well-being, such as their health, family relationships, economic resources, and the availability of medical care. Given the complexity of this decision, the only person equipped to make it is the pregnant woman herself, with support provided by people of her choice if she requests it.

All women, including women with disabilities, have difficulty navigating through restrictive environments to ensure the full exercise of their reproductive rights,<sup>114</sup> but women with disabilities are placed at a particular disadvantage because of barriers to accessing reproductive health services, as described above. In countries with restrictive abortion laws, women are often unable to access abortion services in the limited circumstances for which they are permitted due to a variety of factors including lack of clarity about the legal grounds for abortion, lack of training for health care workers, lack of information about legal abortion services, stigma around performing abortion, criminal penalties attached to performing illegal abortions, and health care workers' fear of prosecution for performing even legal abortions.<sup>115</sup> Coupled with the barriers already experienced by women with disabilities in accessing reproductive health services, including barriers to physical access, the absence of alternative formats of information and communication, lack of disability-related support services, and stigma,<sup>116</sup> abortion services may be virtually inaccessible for women with disabilities in practice.

Moreover, restrictive abortion laws affect the rights of women with disabilities in other ways. For example, many countries with restrictive abortion laws do not permit women to terminate pregnancies that result from sexual violence, leaving them with a choice between carrying the pregnancy to term or undergoing a clandestine, unsafe abortion. Since women with disabilities experience sexual violence at higher rates than other women,<sup>117</sup> they may more often be subjected to carrying a pregnancy resulting from rape.

## 1. International Human Rights Standards for Access to Abortion



As noted above, the CRPD contains the strongest and most explicit language of any UN human rights treaty on reproductive rights, providing the CRPD Committee with an opportunity to advance the commentary in this important area for ensuring the rights of women, including women with disabilities. An important aspect of ensuring reproductive rights is providing access to safe and legal abortion services to ensure that women have control over their lives and bodies.

Nearly all of the UN treaty monitoring bodies have framed maternal deaths due to unsafe abortion as a violation of women's rights and recognized the detrimental consequences of criminalizing abortion on women's lives, health, and well-being.<sup>118</sup> As such, they have called on states to review and repeal laws that criminalize abortion.<sup>119</sup> Among other rights, they have analyzed this issue in the context of the right to non-discrimination, noting that the problem of maternal mortality due to unsafe abortion is evidence of discrimination against women.<sup>120</sup> Moreover, they have called on states to ensure women's access to safe abortion services where legal, recognizing that the failure to do so constitutes discrimination.<sup>121</sup> Notably, the CEDAW Committee has also indicated that, in certain circumstances, forcing a woman to continue a pregnancy constitutes discrimination.<sup>122</sup>

As per above, no UN treaty monitoring body has ever recommended that a state party eliminate a legal grounds for abortion, recognizing that women will procure abortions regardless of its legal status, with attendant risks to their health and lives. Instead, as described above, UN treaty monitoring bodies have called on States to liberalize their abortion laws in order to support women's reproductive rights. The recent concluding observations from the CRPD Committee on Hungary and Spain could be interpreted to contravene these well-established human rights standards. In these concluding observations, the CRPD Committee recommended that each state party eliminate the fetal impairment ground for abortion,<sup>123</sup> characterizing the law that explicitly allows for abortion on this ground as a form of discrimination "on the basis of disability" with respect to Hungary.<sup>124</sup> As previously discussed, restricting women's access to legal abortion services will not prevent them from seeking to terminate a pregnancy if they wish to do so; such restrictions will only force them to resort to clandestine and unsafe abortions, which may place their lives and health at risk. Furthermore, seeking to restrict the fundamental rights of women by limiting their access to abortion does not address the core problem of discrimination against persons with disabilities.

Persons with disabilities have historically been, and continue to be, subjected to discrimination that has devalued their lives, and laws that list fetal impairment as a grounds for abortion may reinforce feelings of exclusion.<sup>125</sup> The CRPD Committee has sought to address this subject in its concluding observations by recommending that states eliminate specific reference to fetal impairment as a ground for abortion. However, eliminating grounds for abortion will not resolve this problem. The most effective ways to promote the rights of individuals with disabilities and to combat discrimination against them is to implement policies and practices that support the autonomy and rights of all persons, as outlined in the CRPD and other human rights instruments. This includes providing families the support they need to raise children with disabilities and ensuring that persons with disabilities are included in their communities, instead of restricting reproductive autonomy for women, including women with disabilities

Moreover, framing abortion on the ground of fetal impairment as a form of discrimination also opens the door to the recognition of prenatal legal personhood. The histories of the negotiations of the major human rights treaties and the jurisprudence of the UN treaty monitoring bodies clarify that human rights protections do not apply before birth and recognize that bestowing rights before birth could contradict human rights protections for women.<sup>126</sup> Recognizing rights for a fetus, such as the right to non-discrimination, could jeopardize many women's rights, including their rights to life, health, non-discrimination, privacy, and freedom from cruel, inhuman or degrading treatment, among others. For example, it could prevent doctors from administering emergency medical treatment to pregnant women for fear of harming the fetus, or lead to the prohibition of abortion in all circumstances, which, as discussed above, poses grave risks to women's health and lives.

## **IV. Conclusions**

Women cannot fully exercise their human rights without reproductive autonomy. State obligations to ensure reproductive autonomy are particularly important for women and girls with disabilities, who have historically faced, and continue to face, discrimination in forming families, including in deciding the number and spacing of children, and making important decisions about their own lives.

The CRPD provides a framework for tackling many of the reproductive rights violations facing women and girls with disabilities. The CRPD Committee could strengthen its jurisprudence promoting the rights of women and girls with disabilities by ensuring that these important issues, including access to information and essential services such as contraception and abortion, are part of its analysis of state compliance with the CRPD, and by condemning these violations using the strongest means possible.

## **V. Recommendations to the CRPD Committee**

### **A. Foundational Principles**

- Include in lists of issues provided to states questions about access to reproductive health information and services for women with disabilities, including concerns about accessibility of information and services, legal restrictions on access to abortion and contraception, and restrictions on the exercise of autonomy and legal capacity in healthcare settings.

### **B. Access to Information**

- Recommend that states ensure that healthcare facilities are accessible to persons with disabilities, including by providing facilities in rural locations, so that persons with disabilities can access essential reproductive health services in a timely manner.
- Recommend that states train and sensitize doctors and other healthcare providers and staff on disability rights and the reproductive rights requirements of the CRPD to ensure that women with disabilities receive unbiased and accurate information about their reproductive health.
- Recommend that states produce reproductive health materials in accessible formats and provide assistance to women with disabilities who are seeking reproductive health information so that they can more effectively communicate with healthcare professionals and staff.
- Recommend that states provide comprehensive, accurate, and accessible sexuality education to all young women and girls with disabilities, inside and outside of school, in order to ensure that women can exercise their rights to health and life, to found a family, and to be free from violence, exploitation, or abuse.

### **C. Access to Services**

- Recommend that states ensure access to all forms of contraception, including emergency contraception, to women with disabilities without restrictions. Recommend that states overcome barriers to accessibility by ensuring that contraceptives are available in locations close to all communities, including rural communities.
- Recognize that women with disabilities are more often victims of sexual violence, and recommend that states remove restrictions on access to reproductive health services such as emergency contraception and abortion in order to avoid further violations of their human rights. Classify denial of these services in cases of sexual violence as a violation of the rights to health, to decide on the number and spacing of children, and to be free from torture or CIDT.
- Strengthen jurisprudence on forced sterilization and forced abortion by recognizing these acts as torture or CIDT under Article 15 of the CRPD.
- Refrain from recommending that states restrict women's access to legal abortion services on grounds of fetal impairment and instead encourage states to fulfill their obligations by taking measures to ensure that individuals, women and families have the support they need to raise children with disabilities.

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<sup>1</sup> Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, art. 6, G.A. Res. A/RES/61/106, U.N. GAOR, 61<sup>st</sup> Sess., U.N. Doc. A/61/611, (*entered into force* May, 3 2008) [hereinafter CRPD].

<sup>2</sup> CRPD, *supra* note 1, art. 23 (b).

<sup>3</sup> *Id.* art. 23 (c).

<sup>4</sup> *Id.* art. 25 (a).

<sup>5</sup> *See, e.g.*, CRPD Committee, *Concluding Observations: Tunisia*, para. 15(c), U.N. Doc. CRPD/C/TUN/CO/1 (2011).

<sup>6</sup> OPEN SOCIETY FOUNDATIONS, *AGAINST HER WILL: FORCED AND COERCED STERILIZATION OF WOMEN WORLDWIDE*, 6 (2011) [hereinafter *AGAINST HER WILL*].

<sup>7</sup> WORLD HEALTH ORGANIZATION, *WORLD REPORT ON DISABILITY 205-206* (2011) [hereinafter *WORLD REPORT ON DISABILITY*].

<sup>8</sup> *Id.*

<sup>9</sup> *See Mandatory Delays and Biased Counseling for Women Seeking Abortions*, CENTER FOR REPRODUCTIVE RIGHTS (Sept. 30, 2010), <http://reproductiverights.org/en/project/mandatory-delays-and-biased-counseling-for-women-seeking-abortions>.

<sup>10</sup> *WORLD REPORT ON DISABILITY*, *supra* note 7, at 70-71.

<sup>11</sup> *Id.* at 77-79.

<sup>12</sup> HUMAN RIGHTS WATCH, “AS IF WE WEREN’T HUMAN”: DISCRIMINATION AND VIOLENCE AGAINST WOMEN WITH DISABILITIES IN NORTHERN UGANDA 47 (2010) [hereinafter “AS IF WE WEREN’T HUMAN”].

<sup>13</sup> *AGAINST HER WILL*, *supra* note 6, at 6.

<sup>14</sup> Suzanne Smeltzer, *Pregnancy in Women With Physical Disabilities*, 36 *JOURNAL OF OBSTETRIC, GYNAECOLOGIC, AND NEONATAL NURSING* 88, 88-96 (2007).

<sup>15</sup> M. Aunos & M.A. Feldman, *Attitudes towards Sexuality, Sterilization and Parenting Rights of Persons with Intellectual Disabilities*, 15 *JOURNAL OF APPLIED RESEARCH IN INTELLECTUAL DISABILITIES* 285, 289 (2002). On the other hand, as Women with Disabilities Australia has noted, women with disabilities who ask for support services to help them parent often see that request used as proof that they are not capable of being parents. *WOMEN WITH DISABILITIES AUSTRALIA, PARENTING ISSUES FOR WOMEN WITH DISABILITIES IN AUSTRALIA 2009*, 12 (2009).

<sup>16</sup> UNITED NATIONS EDUCATIONAL, SCIENTIFIC, AND CULTURAL ORGANIZATION, *THE RATIONALE FOR SEXUALITY EDUCATION: INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION 20* (2009) [hereinafter *RATIONALE FOR SEXUALITY EDUCATION*].

<sup>17</sup> *WORLD REPORT ON DISABILITY*, *supra* note 7, at 61.

<sup>18</sup> *RATIONALE FOR SEXUALITY EDUCATION*, *supra* note 16, at 22.

<sup>19</sup> CENTER FOR REPRODUCTIVE RIGHTS, *THE REPRODUCTIVE RIGHTS OF ADOLESCENTS: A TOOL FOR HEALTH AND EMPOWERMENT 6* (2008) [hereinafter *REPRODUCTIVE RIGHTS OF ADOLESCENTS*].

<sup>20</sup> European Committee of Social Rights, *Interights v. Croatia*, para. 48, Complaint No. 45/2007 (2009).

<sup>21</sup> *See REPRODUCTIVE RIGHTS OF ADOLESCENTS*, *supra* note 19, at 6-7.

<sup>22</sup> *Id.* at 7.

<sup>23</sup> For instance, many northern Ugandans believe that women with disabilities are asexual and thus do not have HIV/AIDS, or even that sex with a woman with disability can cure AIDS. This made women with disabilities especially vulnerable to HIV infection. HRW, “AS IF WE WEREN’T HUMAN”, *supra* note 12, at 46-47. Women with disabilities are also sometimes perceived as being over-sexual, leading to many human rights abuses. *See* Desjardin M. The sexualized body of the child, parents and the politics of ‘voluntary’ sterilization of people labelled intellectually disabled in R McRuer and A Mollow (editors) *Sex and Disability*, Durham [N.C.]; Duke University Press (2012).

<sup>24</sup> F.A. Owen, et al., *Perceptions of acceptable boundaries of persons with developmental disabilities and their care-providers*, 7 *JOURNAL ON DEVELOPMENTAL DISABILITIES* 34-49 (2000).

<sup>25</sup> *WORLD REPORT ON DISABILITY*, *supra* note 7, at 205-206; HUMAN RIGHTS WATCH, *HIV AND DISABILITY 8* (2012) [hereinafter *HIV AND DISABILITY*]; *see also* *REPRODUCTIVE RIGHTS OF ADOLESCENTS*, *supra* note 19, at 7.

<sup>26</sup> Susheela Singh et al., *Evaluating the need for sex education in developing countries: sexual behaviour, knowledge of preventing sexually transmitted infections/HIV and unplanned pregnancy*, 5(4) *SEX EDUCATION* 307, 310 (2005).

<sup>27</sup> *See* CENTER FOR REPRODUCTIVE RIGHTS, *The Human Right to Information on Sexual and Reproductive Health: Government Duties to Ensure Comprehensive Sexuality Education*, in *BRINGING RIGHTS TO BEAR* (2008); *see also, e.g.*, Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33<sup>rd</sup> Sess., 2003), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 418, para. 28, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter *Committee on the Rights of the Child, Gen. Comment No. 4*]; Special Rapporteur on the right to education, *Rep. of the United Nations Special Rapporteur on the right to education*, paras. 19, 24-37, U.N. Doc. A/65/162 (July 23, 2010) (by Vernon Muñoz) [hereinafter *Rep. of the Special Rapporteur on the right to education*]; CEDAW Committee, *Concluding*

*Observations: Antigua and Barbuda*, para. 267, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Belize*, paras. 56–57, U.N. Doc. A/54/38 (1999); *Bosnia and Herzegovina*, para. 36, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); *Chile*, para. 227, U.N. Doc. A/54/38 (1999); *Dominican Republic*, para. 349, U.N. Doc. A/53/38 (1998); *Greece*, para. 208, U.N. Doc. A/54/38 (1999); *Peru*, para. 342, U.N. Doc. A/53/38 (1998); *Slovakia*, para. 92, U.N. Doc. A/53/38/Rev.1 (1998); *Slovenia*, para. 119, U.N. Doc. A/52/38/Rev.1 (1997); *Zimbabwe*, para. 161, U.N. Doc. A/53/38 (1998).

<sup>28</sup> Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22<sup>nd</sup> Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 80, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter *ESCR Committee, Gen. Comment No. 14*].

<sup>29</sup> *Id.* para. 12(b).

<sup>30</sup> *Id.* para. 21.

<sup>31</sup> Committee on the Elimination of Discrimination against Women, *General Recommendation No. 21: Equality in marriage and family relations*, (13th Sess., 1994), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 337, para. 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).

<sup>32</sup> Committee on the Rights of the Child, *Gen. Comment No. 4, supra* note 27, para. 28.

<sup>33</sup> Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, para. 47, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan E. Méndez) [hereinafter *Rep. of the Special Rapporteur on torture*].

<sup>34</sup> See, e.g., CEDAW Committee, *Concluding Observations: Belize*, paras. 56-57, U.N. Doc. A/54/38 (1999); *Burundi*, para. 62, U.N. Doc. A/56/38 (2001); *Chile*, paras. 226–27, U.N. Doc. A/54/38 (1999); *Dominican Republic*, para. 349, U.N. Doc. A/53/38 (1998); *Lithuania*, para. 25, U.N. Doc. CEDAW/C/LTU/CO/4 (2008); *Nigeria*, para. 33, U.N. Doc. CEDAW/C/NGA/CO/6 (2008); *Slovakia*, para. 32-33, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); CRC Committee, *Concluding Observations: Cambodia*, para. 52, U.N. Doc. CRC/C/15/Add.128 (2000); *Colombia*, para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); *Dominican Republic*, para. 37, U.N. Doc. CRC/C/15/Add.150 (2001); *Ethiopia*, para. 61, U.N. Doc. CRC/C/15/Add.144 (2001); *ESCR Committee, Concluding Observations: Bolivia*, para. 43, U.N. Doc. E/C.12/1/Add.60 (2001); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Libyan Arab Jamahiriya*, para. 36, U.N. Doc. E/C.12/LYB/CO/2 (2006); *Senegal*, para. 47, U.N. Doc. E/C.12/1/Add.62 (2001); *Ukraine*, para. 31, U.N. Doc. E/C.12/1/Add.65 (2001).

<sup>35</sup> Committee on the Rights of the Child, *Gen. Comment No. 4, supra* note 27, para. 26.

<sup>36</sup> *Rep. of the Special Rapporteur on the right to education, supra* note 27, para. 32.

<sup>37</sup> *Id.* para. 39.

<sup>38</sup> CRC Committee, *Concluding Observations: Benin*, para. 58(h), U.N. Doc. CRC/C/BEN/CO/2 (2006); *Thailand*, para. 58(e), U.N. Doc. CRC/C/THA/CO/2 (2006); *Tanzania*, para. 49(b), U.N. Doc. CRC/C/TZA/CO/2 (2006).

<sup>39</sup> Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20<sup>th</sup> Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 362, para. 18, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter *CEDAW Committee, Gen. Recommendation No. 24*]. UNESCO has also highlighted the need to adequately train teachers as a means of building their comfort and confidence in the material and thus ensuring access to comprehensive and accurate sexuality education. See *RATIONALE FOR SEXUALITY EDUCATION, supra* note 16, at 11.

<sup>40</sup> CRPD, *supra* note 1, art. 21.

<sup>41</sup> *Id.* at art. 9.

<sup>42</sup> CRPD Committee, *Concluding Observations: Argentina*, para. 39, U.N. Doc. CRPD/C/ARG/CO/1 (2012).

<sup>43</sup> CRPD Committee, *Concluding Observations: Peru*, para. 39, U.N. Doc. CRPD/C/PER/1 (2012).

<sup>44</sup> See *CENTER FOR REPRODUCTIVE RIGHTS, ACCESS TO CONTRACEPTIVES: THE SOCIAL AND ECONOMIC BENEFITS AND ROLE IN ACHIEVING GENDER EQUALITY 1* (2009).

<sup>45</sup> Anna Glasier et al., *Sexual and reproductive health: a matter of life and death*, 368 *LANCET* 1595, 1597 (2006).

<sup>46</sup> *Id.* at 1598.

<sup>47</sup> Women who use traditional methods of contraception are included in the number with the an unmet need, because traditional methods of contraception are more likely to fail. Susheela Singh & Jacqueline E. Darroch, *GUTTMACHER INSTITUTE & UNFPA, ADDING IT UP: COSTS AND BENEFITS OF CONTRACEPTIVE SERVICES, ESTIMATES FOR 2012* 4, 14 (2012).

<sup>48</sup> SUSHEELA SINGH ET AL., *GUTTMACHER INSTITUTE & UNITED NATIONS POPULATION FUND (UNFPA), ADDING IT UP: THE COSTS AND BENEFITS OF INVESTING IN FAMILY PLANNING AND MATERNAL AND NEWBORN HEALTH 19-20* (2009).

<sup>49</sup> See *WORLD HEALTH ORGANIZATION & UNFPA, PROMOTING SEXUAL AND REPRODUCTIVE HEALTH FOR PERSONS WITH DISABILITIES: WHO/UNFPA GUIDANCE NOTE 6–7* (2009) [hereinafter *PROMOTING SEXUAL AND REPRODUCTIVE HEALTH: WHO/UNFPA GUIDANCE*].

<sup>50</sup> *Id.* at 3; *HIV AND DISABILITY, supra* note 25 at 8.

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- <sup>51</sup> HIV AND DISABILITY, *supra* note 25 at 8.
- <sup>52</sup> See CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013).
- <sup>53</sup> Special Rapporteur on violence against women, its causes and consequences, *Rep. of the Special Rapporteur on violence against women, its causes and consequences*, para. 60, U.N. Doc. A/67/227 (Aug. 3, 2012) (by Rashida Manjoo) [hereinafter SRVAW, *Rep. of the Special Rapporteur* (2012)]; see also STEPHANIE ORTOLEVA & HOPE LEWIS, FORGOTTEN SISTERS: A REPORT ON VIOLENCE AGAINST WOMEN WITH DISABILITIES: AN OVERVIEW OF ITS NATURE, SCOPE, CAUSES AND CONSEQUENCES (2012) [hereinafter FORGOTTEN SISTERS].
- <sup>54</sup> The Philippines, for example, has the most egregious form of denial: a Manila City Executive Order effectively bans all modern contraception. See CENTER FOR REPRODUCTIVE RIGHTS, IMPOSING MISERY: THE IMPACT OF MANILA'S CONTRACEPTION BAN ON WOMEN AND FAMILIES (2007); see also ESCR Committee, *Concluding Observations: Philippines*, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008).
- <sup>55</sup> CENTER FOR REPRODUCTIVE RIGHTS & UNFPA, BRIEFING PAPER: THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES FOR WOMEN AND ADOLESCENTS 10-11 (2010) [hereinafter RIGHT TO CONTRACEPTIVE INFORMATION].
- <sup>56</sup> World Health Organization, Emergency Contraception: Fact Sheet No. 244 (2012).
- <sup>57</sup> Two rape survivors with physical disabilities in Northern Uganda reported that they could not travel the long distances to health centers to get post-exposure prophylaxis for HIV or emergency contraception. "AS IF WE WEREN'T HUMAN," *supra* note 12, at 48.
- <sup>58</sup> RIGHT TO CONTRACEPTIVE INFORMATION, *supra* note 55, at 12-14.
- <sup>59</sup> World Health Organization, Model Lists of Essential Medicines, 17<sup>th</sup> ed., Explanatory Notes and Section 18.3 (2011).
- <sup>60</sup> See ESCR Committee, *Concluding Observations: Poland*, para. 27, U.N. Doc. E/C.12/POL/CO/5 (2009); *Lithuania*, para. 50, U.N. Doc. E/C.12/1/Add.96 (2004); *Republic of Moldova*, para.49, U.N. Doc. E/C.12/1/Add.91 (2003); *Russian Federation*, paras. 62-63, U.N. Doc. E/C.12/1/Add.94 (2003).
- <sup>61</sup> ESCR Committee, *Gen. Comment No. 14*, *supra* note 28, paras. 12(a), 43 (d), 44 (a).
- <sup>62</sup> *Id.* para. 43(d).
- <sup>63</sup> *Id.* para. 43.
- <sup>64</sup> *Id.* paras. 43(a), (d).
- <sup>65</sup> CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 39, para. 2.
- <sup>66</sup> *Id.* paras. 14-15, 17.
- <sup>67</sup> "Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation. States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity." *Id.* para. 25.
- <sup>68</sup> CRC Committee, *Concluding Observations: Ecuador*, paras. 60-61, U.N. Doc. CRC/C/ECU/CO/4 (2010).
- <sup>69</sup> CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/C/5-6 (2013).
- <sup>70</sup> *Id.* para. 15(b).
- <sup>71</sup> CRPD, *supra* note 1, art. 25(1)(a).
- <sup>72</sup> *Id.* art. 23(1)(b).
- <sup>73</sup> MOSBY'S MEDICAL DICTIONARY, (8th ed., 2009). Voluntary sterilization refers to the process or act being undertaken with the individual's free and informed consent. Conversely, involuntary sterilization refers to the process or act being undertaken without the free and informed consent of the individual, such as when a person is forced or coerced into submitting to a sterilization procedure.
- <sup>74</sup> International Federation of Obstetrics and Gynecology, Guidelines on Female Contraceptive Sterilization, para. 2 (2011) [hereinafter FIGO, Female Contraceptive Sterilization].
- <sup>75</sup> For purposes of this paper, forced sterilization refers to the situation in which a person is sterilized after expressly refusing the procedure, without her knowledge or is not given an opportunity to provide consent. Coerced sterilization occurs when financial or other incentives, misinformation, or intimidation tactics are used to compel an individual to undergo the procedure.
- <sup>76</sup> See, e.g., SUSAN BRADY ET AL., HUMAN RIGHTS AND EQUAL OPPORTUNITY COMMISSION, THE STERILISATION OF GIRLS AND YOUNG WOMEN IN AUSTRALIA: ISSUES AND PROGRESS, A report commissioned by the Federal Sex Discrimination Commissioner and the Disability Discrimination Commissioner (2001) [hereinafter STERILISATION OF GIRLS AND YOUNG WOMEN IN AUSTRALIA].
- <sup>77</sup> AGAINST HER WILL, *supra* note 6, at 6.
- <sup>78</sup> SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 53, para. 28.

<sup>79</sup> Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, *Advancement of Women*, para. 38, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005) (by Paul Hunt).

<sup>80</sup> Hougmai H. Pham, *In the patient's best interest? Revisiting sexual autonomy and sterilization of the developmentally disabled*, 175 WORLD JOURNAL OF MEDICINE 283 (2001).

<sup>81</sup> Although parents may have concerns handling girls with disabilities who are undergoing menstruation, many requests for sterilization of girls with disabilities actually occur before menstruation even begins. See, e.g., *STERILISATION OF GIRLS AND YOUNG WOMEN IN AUSTRALIA*, *supra* note 76.

<sup>82</sup> See, e.g., *id.* Additionally, interviews with parents of children with disabilities in Nepal found that parents chose to have their children undergo forced sterilization as a means of addressing menstruation or fears of unwanted pregnancy, but others reported that they decided against sterilization since the surgery could also cause trauma and because their daughters may be at even greater risk of rape and sexual violence once family members know that they cannot have children. HUMAN RIGHTS WATCH, *FUTURES STOLEN: BARRIERS TO EDUCATION FOR CHILDREN WITH DISABILITIES IN NEPAL* 37 n. 147 (2011).

<sup>83</sup> See *Mentally disabled woman escapes forced abortion*, THE TELEGRAPH, Jan. 10, 2013,

<http://www.telegraph.co.uk/health/healthnews/9793790/Mentally-disabled-woman-escapes-forced-abortion.html>; Robin Marty, *Court Battle Ensues Over Pregnant Mentally-Disabled Woman in Nevada*, RH REALITY CHECK, Nov. 5, 2012, <http://rhrealitycheck.org/article/2012/11/05/court-battle-ensues-over-disabled-woman-abortion/>.

<sup>84</sup> EUROPEAN DISABILITY FORUM, EDF INPUT TO THE GENERAL DISCUSSION OF THE CESCRC ON SEXUAL AND REPRODUCTIVE RIGHTS 6 (2010) [hereinafter EDF INPUT].

<sup>85</sup> *Id.* at 6; See also Melissa Masden, *Pre-Natal Testing and Selective Abortion: The Development of a Feminist Disability Rights Perspective* (1992), available at <http://www.wvda.org.au/masden1.htm> (“There are...strong social sanctions against women with a disability as parents”).

<sup>86</sup> EDF INPUT, *supra* note 84, at 6.

<sup>87</sup> See JANE MAXWELL ET AL., HESPERIAN FOUNDATION, A HEALTH HANDBOOK FOR WOMEN WITH DISABILITIES 306 (2007).

<sup>88</sup> *Mission & Vision Statement*, INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS, <http://www.figo.org/about/mission>.

<sup>89</sup> FIGO, *Female Contraceptive Sterilization*, *supra* note 73, para. 2.

<sup>90</sup> *Id.* para. 6.

<sup>91</sup> Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, para. 9, U.N. Doc. A/64/272 (August 10, 2009) (by Anand Grover); See also *A.S. v. Hungary*, CEDAW Committee, Comm’n No. 4/2004, para. 22, U.N. Doc. CEDAW/C/36/D/4/2004 (2006) (quoting CEDAW Committee, General Recommendation No. 21, para. 22 (1994)) (in the context of case about forced sterilization, “informed decision-making about safe and reliable contraceptive measures depends upon a women having ‘information about contraceptive measures and their use, and guaranteed access to sex education and family planning services.’”).

<sup>92</sup> AGAINST HER WILL, *supra* note 6, at 6; SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 53, para. 28.

<sup>93</sup> CRPD Committee, *Concluding Observations: Tunisia*, paras. 22-23, U.N. Doc. CRPD/C/TUN/CO/1 (2011); *Spain*, paras. 33-34, U.N. Doc. CRPD/C/ESP/CO/1 (2011); *Peru*, paras. 24-25, U.N. Doc. CRPD/C/PER/CO/1 (2012); *Argentina*, paras. 19-20, U.N. Doc. CRPD/C/ARG/CO/1 (2012); *China*, para. 21-22, U.N. Doc. CRPD/C/CHN/CO/1 (2012); *Hungary*, paras. 25-26, CRPD/C/HUN/CO/1 (2012).

<sup>94</sup> CRPD Committee, *Concluding Observations: Argentina*, para. 19, U.N. Doc. CRPD/C/ARG/CO/1 (2012).

<sup>95</sup> CRPD Committee, *Concluding Observations: Spain*, paras. 37-38, U.N. Doc. CRPD/C/ESP/CO/1 (2011); para. 34, U.N. Doc. CRPD/C/CHN/CO/1 (2012); *Argentina*, paras. 31-32, U.N. Doc. CRPD/C/ARG/CO/1 (2012); *Peru*, para. 35, U.N. Doc. CRPD/C/PER/CO/1 (2012).

<sup>96</sup> CRPD, *supra* note 1, art. 15.

<sup>97</sup> CAT Committee, *Concluding Observations: Peru*, para. 19, U.N. Doc. CAT/C/PER/CO/6, (2012). The Committee against Torture has also recognized forced sterilization schemes that were targeted at other marginalized groups, such as indigenous women or women from the Roma minority, as a form of torture or CIDT. See CAT Committee Peru 2006 and 2012; *Czech Republic*, para. 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012).

<sup>98</sup> *Rep. of the Special Rapporteur on torture*, *supra* note 33, paras. 48, 88.

<sup>99</sup> Procedural barriers include mandatory and biased counseling requirements, waiting periods, third-party consent and notification requirements, limitations on the range of abortion options (such as restrictions on medical abortion), conscience clauses, limitations on abortion funding, and abortion advertising restrictions. These burdensome procedural barriers impede access to safe and legal abortions, demean women, and undermine their autonomy in making decisions about their lives.

Reed Boland & Laura Katzive, *Developments in Laws on Induced Abortion: 1998-2007*, 34 INTERNATIONAL FAMILY PLANNING PERSPECTIVES (2008) [hereinafter *Developments in Laws on Induced Abortion*]; WORLD HEALTH ORGANIZATION,

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SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 96-97 (2<sup>nd</sup> ed., 2012) [hereinafter WHO SAFE ABORTION GUIDANCE].

<sup>100</sup> See WHO SAFE ABORTION GUIDANCE, *supra* note 99, at 23.

<sup>101</sup> See *id.* at 23; Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, 379 *The Lancet* 625 (2012).

<sup>102</sup> See WHO SAFE ABORTION GUIDANCE, *supra* note 99, at 23.

<sup>103</sup> *Id.*

<sup>104</sup> GUTTMACHER INSTITUTE, *FACTS ON INDUCED ABORTION WORLDWIDE – IN BRIEF: FACT SHEET 2* (2012).

<sup>105</sup> *Developments in Laws on Induced Abortion*, *supra* note 99, at 116.

<sup>106</sup> CENTER FOR REPRODUCTIVE RIGHTS, *Abortion and Human Rights: Government Duties to Ease Restrictions and Ensure Access to Safe Services*, in *BRINGING RIGHTS TO BEAR* (2008).

<sup>107</sup> Programme of Action of the International Conference on Population and Development, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc.A/CONF.171/13/Rev.1 (1995).

<sup>108</sup> CENTER FOR REPRODUCTIVE RIGHTS, *ABORTION WORLDWIDE: SEVENTEEN YEARS OF REFORM* (2011) [hereinafter *SEVENTEEN YEARS OF REFORM*]; *The World's Abortion Laws 2013*, CENTER FOR REPRODUCTIVE RIGHTS (2011), <http://worldabortionlaws.com/index.html> [hereinafter *World's Abortion Laws 2013*].

<sup>109</sup> *Developments in Laws on Induced Abortion*, *supra* note 99, at 117; *SEVENTEEN YEARS OF REFORM*, *supra* note 108; *World's Abortion Laws 2011*, *supra* note 108.

<sup>110</sup> *SEVENTEEN YEARS OF REFORM*, *supra* note 108.

<sup>111</sup> See *World's Abortion Laws 2013*, *supra* note 108.

<sup>112</sup> For more information see *World's Abortion Laws 2011*, *supra* note 108. Threats to the life or health of the woman may not arise until later in the pregnancy and many tests to detect fetal impairments are not available until beyond the gestational limit for which abortion is authorized without restriction as to reason. Reed Boland, *Second Trimester Abortion Laws Globally: Actuality, Trends and Recommendations*, 18 *REPRODUCTIVE HEALTH MATTERS*, 67, 68 (2010).

<sup>113</sup> For more information see *World's Abortion Laws 2011*, *supra* note 108.

<sup>114</sup> HUMAN RIGHTS WATCH, *ILLUSIONS OF CARE: LACK OF ACCOUNTABILITY FOR REPRODUCTIVE RIGHTS IN ARGENTINA* 35 (2010).

<sup>115</sup> Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover); CENTER FOR REPRODUCTIVE RIGHTS, *IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW* (2010); CENTER FOR REPRODUCTIVE RIGHTS, *FORSAKEN LIVES: THE HARMFUL IMPACT OF THE PHILIPPINE CRIMINAL ABORTION BAN* (2010).

<sup>116</sup> *PROMOTING SEXUAL AND REPRODUCTIVE HEALTH: WHO/UNFPA GUIDANCE*, *supra* note 49, at 6-7.

<sup>117</sup> SRVAW, *Rep. of the Special Rapporteur* (2012), *supra* note 53, para. 60; see also *FORGOTTEN SISTERS*, *supra* note 53.

<sup>118</sup> See, e.g., CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38/Rev. 1 (1999); *Colombia*, para. 393, U.N. Doc. A/54/38/Rev. 1; *Dominican Republic*, para. 337, U.N. Doc. A/53/38/Rev. 1, (1998); Human Rights Committee, *Concluding Observations: Mali*, para. 81(14), U.N. Doc. A/58/40 (Vol. I) (2003); *El Salvador*, para. 10, U.N. Doc. CCPR/C/SLV/CO/6 (2010) (“The Committee expresses its concern that the current Criminal Code criminalizes all forms of abortion, given that illegal abortions have serious detrimental consequences for women’s lives, health and well-being”); *Peru*, para. 20, U.N. Doc. CCPR/CO/70/PE (2000).

<sup>119</sup> See, e.g., CEDAW Committee, *Concluding Observations: Philippines*, para. 28, U.N. Doc. CEDAW/C/PHI/CO/6 (2006) (“The Committee recommends that the State party consider reviewing the laws relating to abortion with a view to removing punitive provisions imposed on women who have abortions and provide them with access to quality services for the management of complications arising from unsafe abortions and to reduce women’s maternal mortality rates in accordance with the Committee’s general recommendation 24 on women and health and the Beijing Declaration and Platform for Action.”); Human Rights Committee, *Concluding Observations: Morocco*, para. 29, U.N. Doc. CCPR/CO/82/MAR (2004) (“The State party should ensure that women are not forced to carry a pregnancy to full term where that would be incompatible with its obligations under the Covenant (arts. 6 and 7) and should relax the legislation relating to abortion.”); CEDAW Committee, *Concluding Observations: Nigeria*, para. 34, U.N. Doc. CEDAW/C/NGA/CO/6 (2008) (The Committee “also calls upon the State party to assess the impact of its abortion law on the maternal mortality rate and to give consideration to its reform or modification.”); CRC Committee, *Concluding Observations: Nicaragua*, para. 59(b), U.N. Doc. CRC/C/NIC/CO/4 (2010) (“Repeal the articles of the Penal Code that criminalize abortion and ensure that girls are not subject to criminal sanctions for seeking or obtaining an abortion under any circumstances”); Human Rights Committee, *Concluding Observations: Sri Lanka*, para. 12, CCPR/CO/79/LKA (2003) (“The State party should ensure that women are

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not compelled to continue with pregnancies, where this would be incompatible with obligations arising under the Covenant (art. 7 and General Comment 28), and repeal the provisions criminalizing abortion.”)

<sup>120</sup> Human Rights Committee, *Concluding Observations: Mongolia*, para. 8(b), U.N. Doc. CCPR/C/79/Add.120 (2000).

<sup>121</sup> Human Rights Committee, *Concluding Observations: Cameroon*, para. 13 U.N. Doc. CCPR/C/CMR/CO/4 (2010) (“The Committee remains concerned about high maternal mortality ... It is also concerned about the unavailability of abortion in practice even when the law permits it, for example in cases of pregnancy resulting from rape.”); *L.M.R. v. Argentina*, Human Rights Committee, Commc’n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).

<sup>122</sup> *L.C. v. Peru*, CEDAW Committee, Commc’n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

<sup>123</sup> CRPD Committee, *Concluding Observations: Spain*, paras. 17-18, U.N. Doc. CRPD/C/ESP/CO/1 (2011).

<sup>124</sup> CRPD Committee, *Concluding Observations: Hungary*, paras. 17-18, U.N. Doc. CRPD/C/HUN/Q/1 (2012); *Spain*, paras. 17-18, U.N. Doc. CRPD/C/ESP/CO/1 (2011).

<sup>125</sup> See COMITÉ ESPAÑOL DE REPRESENTANTES DE PERSONAS CON DISCAPACIDAD (CERMI), SUBMISSION TO THE CRPD COMMITTEE: HUMAN RIGHTS AND DISABILITY: ALTERNATIVE REPORT SPAIN 2010, Appendix 1 (2010); HUNGARIAN DISABILITY CAUCUS, DISABILITY RIGHTS OR DISABLING RIGHTS?: CRPD ALTERNATIVE REPORT, 73-76 (2010).

<sup>126</sup> For more information, see CENTER FOR REPRODUCTIVE RIGHTS, WHOSE RIGHT TO LIFE?: WOMEN’S RIGHTS AND PRENATAL PROTECTIONS UNDER HUMAN RIGHTS AND COMPARATIVE LAW (2012); CENTER FOR REPRODUCTIVE RIGHTS, RIGHTS AT RISK: THE TRUTH ABOUT PRENATAL PERSONHOOD (2012); Artavia Murillo y Otros (“Fecundación *In Vitro*”) vs. Costa Rica, Inter-Am. Ct. H.R., (Nov. 28, 2012).