**Submission to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health:**

**Questionnaire on Violence and the Right to Health**

***Violence and the Right to Health for Women, Girls, and Gender Minorities with Disabilities***

*January 18, 2022*

1. Introduction

Women Enabled International (WEI), Disabled Women in Africa (Malawi), Artykul 6 (Poland), Advocacy for Women with Disabilities Initiative (Nigeria), and Confederación Plena Inclusión España (Plena inclusion Confederation Spain) appreciate the opportunity to provide the Special Rapporteur with information for her forthcoming report on violence and the right to health.

Women and girls with disabilities are almost one-fifth of the world’s population of women.[[1]](#endnote-1) However, due to multiple and intersecting forms of sexism and ableism, women, girls, and gender minorities with disabilities face disproportionate rates of violence, including in healthcare settings, which impact on their right to the highest attainable standard of physical and mental health. These issues are compounded during times of crisis, such as the COVID-19 pandemic.

This submission provides a short summary of information gathered by our organizations in response to several of the questions posed by the Special Rapporteur in her questionnaire on violence and the right to health, including country examples where appropriate. The submission concludes with brief recommendations for the Special Rapporteur for consideration in drafting a report on this topic. Attached to this submission is also an Annex, which contains more detailed information from countries throughout the world on violence and its impact on the right to health.

Given the importance of this issue to women, girls, and gender non-conforming persons with disabilities worldwide and the rich body of information collected by our and other organizations on this topic, we encourage the Special Rapporteur to reach out to us any questions or requests for further information.

1. Responses to the Special Rapporteur’s Questionnaire

**Question #1: Data and statistics on violence against women and gender minorities with disabilities, including GBV**

Women and gender minorities with disabilities worldwide face disproportionate rates of gender-based violence, which takes on unique forms for this group that intersect with and impact their right to health. According to the former UN Special Rapporteur on Violence against Women (SRVAW), Rashida Manjoo, violence against women with disabilities can be of a “physical, psychological, sexual or financial nature and include neglect, social isolation, entrapment, degradation, detention, denial of health care, forced sterilization and psychiatric treatment.”[[2]](#endnote-2) Violence against women with disabilities also has unique causes, including violence that is perpetuated by stereotypes “that attempt to dehumanize or infantilize, exclude or isolate them, and target them for sexual and other forms of violence.”[[3]](#endnote-3)

Women, girls, and gender minorities with disabilities experience violence at the hands of partners, family members, support persons, staff of psychiatric hospitals or other institutions, police, and others.[[4]](#endnote-4) They are also more likely to experience certain forms of violence in medical settings, most notably forced reproductive health interventions—such as forced sterilization, forced abortion, and forced contraception—as a result of stereotypes about their ability to parent, invalid concerns about menstrual hygiene or for reasons of “protection” from sexual violence, and due to disability discrimination that can lead to formal or informal deprivations of their decision-making power in healthcare settings.[[5]](#endnote-5)

Many countries lack data on the topic of violence against women, girls, and gender minorities with disabilities, as such statistics are frequently not disaggregated and analyzed based on gender and disability. Where statistics on this topic do exist at the national level, however, they reinforce that women, girls, and gender minorities with disabilities experience violence at at least two to three times the rate of other women.[[6]](#endnote-6)

* In the **United Kingdom**, while approximately one in four women experiences domestic violence in their lifetime, nearly one in every two disabled women does,[[7]](#endnote-7) and persons with psychosocial disabilities experiencing violence at four times the rate of other persons.[[8]](#endnote-8) In a 2007 survey of 30 disabled women who were victims of domestic violence, all of them reported that being disabled worsened the abuse and created barriers to them leaving abusive homes.[[9]](#endnote-9)
* In **Poland**, data on violence against the wider population of people with disabilities and the wider population of women indicates that there are likely high rates of violence against women with disabilities in Poland. One 2009 survey conducted by the Institute of Psychology of the Polish Academy of Sciences found that over 30% of Poles knew of cases of violence, including sexual violence, against persons with disabilities.[[10]](#endnote-10) These abuses included hitting or beating, tugging or pushing, isolating or locking up individuals, and depriving them of material goods.[[11]](#endnote-11) Concerning the wider population of women, according to the European Union Agency for Fundamental Rights, one out of every five Polish women has experienced physical or sexual violence since the age of 15.[[12]](#endnote-12)
* In **Nigeria,** according to the 2015 survey of HIV prevalence among 624 persons with sensory or physical disabilities, over 10% of women with disabilities reported having experienced some form of sexual violence in their lifetimes[[13]](#endnote-13) as compared to 7% of women more broadly aged 15-49 in Nigeria,[[14]](#endnote-14) though both estimates are likely undercounts.

The COVID-19 pandemic has increased the risk of violence for women, girls, and gender minorities with disabilities worldwide, though comprehensive data on this phenomenon is not available. According to a 2021 study by Women Enabled International and the United Nations Population Fund (UNFPA), women, girls, and gender non-conforming persons with disabilities encountered significantly increased risk factors for emotional and physical violence. These included isolation with family members at home and rising tensions in households as family have had to take on new caregiving responsibilities towards persons with disabilities, as well as increased barriers to accessing overburdened police and justice systems and the unavailability and inaccessibility of support services during lockdowns or other restrictions on movement.[[15]](#endnote-15)

**Question #2: Legal frameworks and access to justice for victims/survivors of violence**

Legal frameworks surrounding gender-based violence frequently fail to consider the particular forms of violence experienced by women and gender non-conforming with disabilities, as those frameworks are developed without consultation with women, girls, and gender minorities with disabilities and their representative organizations.[[16]](#endnote-16)

One area where legal frameworks often fall short is regarding violence committed against women and gender minorities with disabilities in reproductive health settings. This includes forced reproductive health interventions such as forced sterilization, forced abortion, and forced contraception, as well as obstetric violence.[[17]](#endnote-17)

Furthermore, legal frameworks in countries throughout the world often specifically *permit* forms forced reproductive health interventions performed on women, girls, and gender minorities with disabilities. One way in which legal frameworks permit this kind of abuse is through systems of guardianship, which hand over decision-making power related to sexual and reproductive health from a woman (particularly one with a psychosocial or intellectual disability) and over to an appointed guardian.[[18]](#endnote-18) In 2011, FIGO adopted guidelines specifically regarding female contraceptive sterilization, stating that only women themselves can give ethically valid consent to their own sterilization.[[19]](#endnote-19) As such, a forced procedure occurs when a person is subjected without her knowledge or consent to the procedure, or is not given a chance to consent, including when the person is placed under guardianship.[[20]](#endnote-20)

Where legal frameworks prohibit forced sterilization, abortion, or contraception for women more broadly, laws and court decisions sometimes still specifically allow forced reproductive health interventions performed on women, girls, and gender minorities with disabilities.

* In **India**, under the Medical Termination of Pregnancy Act, 1971 (as amended in 2002), guardians can consent to abortions for women with psychosocial disabilities.[[21]](#endnote-21)
* In **South Africa**, as of 2019, the Sterilisation Act allowed for a substitute decision-maker to consent to the sterilization of a woman with a disability over the age of eighteen who had been deemed incapable of consenting.[[22]](#endnote-22) Furthermore. the Choice on Termination of Pregnancy Act allowed for substitute decision-makers to consent to the termination of a woman’s pregnancy if she had been classified as “severely mentally disabled,” without a requirement to even consult with or consider the views of the woman herself, let alone obtain her informed consent.[[23]](#endnote-23)
* In **Kenya**, the Reproductive Health Bill of 2014[[24]](#endnote-24) still allows guardians or parents to make the decision for a “mentally unstable person”—which includes women with intellectual or psychosocial disabilities—to undergo what amounts to a forced abortion.[[25]](#endnote-25)
* In **Indonesia**, a recent Bill on Sexual Violence Elimination being considered in Parliament criminalizes forced contraception broadly but contains an exception, stating: “With regard to implanting contraceptive devices to persons with mental disability performed upon the request of their family and is based on expert opinion to protect the well-being of the person in question should not be considered a crime.”[[26]](#endnote-26)
* As of 2015, eleven states in the **United States of America (U.S.)** retained statutory language authorizing a court to order the involuntary sterilization of or forced contraceptive use by persons with disabilities.[[27]](#endnote-27)

When women and gender minorities with disabilities experience violence, they encounter frequent barriers to seeking redress and support services. Women and gender minorities with disabilities may find that police stations and support services lack of physical and communications accessibility, that justice systems actors do not believe their accounts due to stereotypes based on their disability, and that information about the justice system or about support services is inaccessible to them, among other barriers.[[28]](#endnote-28) Frequently, this means impunity for perpetrators of violence against women and gender minorities with disabilities.

* In the **United Kingdom**, a 2014 Metropolitan Police Services report found that only 15% of rapes reported to the police in 2013 resulted in prosecutions, but those reported by disabled women—particularly those with learning or psychosocial disabilities—were significantly less likely to be prosecuted.[[29]](#endnote-29) The decision of a detective to refer a rape case for prosecution was rarely subjected to outside scrutiny.[[30]](#endnote-30) As the author of the 2014 Metropolitan Police Services report noted, “[v]ictim vulnerabilities effectively protect suspects from being perceived as credible rapists,” indicating that it is often the status of the victim herself as a disabled woman and the stereotypes associated with that disability that leads to these low rates of referral.[[31]](#endnote-31)
* In **Poland**, due to widespread ableism within the support sector, disabled parents are afraid to disclose violence against them or their children to any service providers, in healthcare or anywhere else, due to the fear of being deprived of custody of their children. This poses a threat to their health due to continuous exposure on violence.[[32]](#endnote-32)

**Question #3: Forms of structural and institutional violence, including in medical settings**

Women, girls, and gender minorities with disabilities are subjected to forced reproductive health procedures or medication, such as forced sterilization, forced abortion, and forced contraception, more often than men with disabilities or other women, frequently only with the consent of a parent, guardian, or doctor, but not with the individual’s consent.[[33]](#endnote-33) The Committee on the Rights of Persons with Disabilities (CRPD Committee) has further found that, when women with disabilities are deprived of legal capacity, this can “facilitate forced interventions, such as: sterilisation, abortion, [and] contraception…”[[34]](#endnote-34) Additionally, these practices are frequently based on false and discriminatory assumptions about the sexuality and ability of women with disabilities to parent or are based on the desire to control their menstrual cycles.[[35]](#endnote-35)

***Forced sterilization*** is a major interference with a woman’s reproductive health, bearing on many aspects of her personal integrity, including her physical and mental wellbeing and family life.[[36]](#endnote-36) Indeed, although in rare cases it may be reversible, female sterilization is considered a permanent form of contraception, meaning that women who undergo sterilization will not be able to become pregnant and give birth to children.[[37]](#endnote-37) As the former Special Rapporteur on the Rights of Persons with Disabilities noted in her 2017 report to the General Assembly, “the forced sterilization of girls and young women with disabilities represents a widespread human rights violation across the globe.”[[38]](#endnote-38)

* Recent unpublished research conducted specifically on women with disabilities in **Poland** suggests that women with intellectual disabilities living in institutions are sterilized against their will or without their informed consent,[[39]](#endnote-39) an all-too-common historical and ongoing practice in institutions throughout the world.
* In **India**, in recent years, sterilization methods using certain drugs have been tested on a large scale instead of teaching women with disabilities to manage menstrual hygiene and ensuring that they are protected from rape.[[40]](#endnote-40) Providers and communities also often classify sterilization of women with disabilities as a social good, because they perceive that women with disabilities cannot take care of themselves or others.[[41]](#endnote-41)

***Forced contraception*** of women, girls, and gender minorities with disabilities remains an under-documented phenomenon. Although forced contraception is usually reversible and only temporarily limits the ability of these individuals to become pregnant, it still has profound implications for their trust in the medical system, and if used for a long period of time, may also effectively take away their ability to have children.

* In **Nigeria**, the families of women with mental disabilities reported that they sometimes had contraceptive devices implanted in the women’s skin, without the women’s consent, so that these women would avoid getting pregnant if they were subjected to sexual abuse.[[42]](#endnote-42)
* Evidence received by organizations of persons with disabilities in **Kenya**[[43]](#endnote-43) points to women with intellectual disabilities and psychosocial disabilities having contraception administered to them against their will within the community,[[44]](#endnote-44) and a study by the Kenya National Commission on Human Rights on the rights of persons with disabilities found that “persons with disabilities were not being allowed to make choices on the mode of family planning with nurses dictating which methods to use.”[[45]](#endnote-45)
* In **Serbia**, Human Rights Watch and Mental Disability Rights International Serbia have documented the forced contraception of women with disabilities living in institutions. This has included the implantation of intrauterine devices (IUDs) without the consent of the women, including under general anesthesia, and the provision of contraceptive pills to the women without their consent. Though sometimes these institutions have the permission of guardians to provide contraception to these women, the consent of a guardian cannot substitute for the consent of the woman herself.[[46]](#endnote-46)

***Discrimination based on sexual orientation*** may also negatively impact the care that women and gender minorities with disabilities receive in healthcare settings. For instance, a 2021 study of disability, sexual orientation and care regimes in **Poland** documented several cases in which women with disabilities were denied needed healthcare—including pain medication and physical therapy—when they were identified as lesbian. As the study concluded:

The predicaments of having an inadequate care system for people with disabilities, dependence on support from the family of origin, and a lack of legal protection for the LGBT community all contribute to the research participants' perceptions of care regimes as hollow and porous. They do not receive adequate support, or have to hide their identity to receive support. The care systems remain unresponsive to the needs of this group.[[47]](#endnote-47)

*Please note that, beyond the examples provided above, structural and institutional violence against persons with disabilities, particularly women, girls, and gender minorities with disabilities, is commonplace and happens in a variety of settings, including in homes, in employment, in education, and in long-term residential care institutions. Due to the word limitations of this questionnaire, we have not outlined the full scope of structural and institutional violence against women, girls, and gender minorities with disabilities in this submission but would be happy to provide further information upon request.*

**Question #4: Impact of criminalization and harmful practices**

Due to provider biases and stereotypes, lack of provider training, and the inaccessibility of information and services, women, girls, and gender minorities with disabilities may also be subjected to specific mistreatment and violence in maternal health settings, including childbirth facilities. In some instances, this mistreatment is physical in nature, and even more frequently, it is verbal or psychological.

* In **Malawi**, women with disabilities experience discrimination in the context of pregnancy and childbirth and contraceptive access, among other areas. In particular, women with disabilities have reported mistreatment during antenatal clinics and delivery and postnatal services, stemming from negative stereotypes about women with disabilities' ability or entitlement to parent.[[48]](#endnote-48) In a 2014 baseline survey conducted by DIWA, 39% of girls and 24% of women with disabilities reported having experienced violence and abuse from health workers.[[49]](#endnote-49) In a follow-up study in 2021, 18% of women with disability respondents said that they had experienced negative attitudes from health personnel, including negative perceptions about their use of family planning methods or about childbearing, insinuating that women with disabilities are not supposed to be sexually active.
* In **Poland**,[[50]](#endnote-50) healthcare providers’ attitudes towards pregnant women with disabilities ranged from indifference, to patronizing treatment, to explicitly expressing negative opinions about their plans to have children or about their disabilities.[[51]](#endnote-51) Several women experienced degrading treatment in maternity wards, including aggressive observation, lack of communication, misunderstandings about their disabilities, and lack of respect for their decisions about how to give birth.[[52]](#endnote-52) This treatment increased their sense of isolation, vulnerability, and lack of self-determination.[[53]](#endnote-53)
* In **India**, women with physical disabilities are frequently criticized and taunted for getting pregnant. Providers and communities often highlight their supposed inability to look after themselves to perpetuate mistreatment.[[54]](#endnote-54)
* In **Nepal,** the Nepal Disabled Women Association documented a case in which a woman with a disability who underwent a C-section to deliver her baby was then put in an inaccessible room in the hospital for several days and was ignored by nursing staff when she asked for assistance for visiting the toilet. Her case is currently pending before the Supreme Court. In another case, when a woman with a physical disability went to the hospital for a delivery and was not able to push, an attending nurse started beating her abdomen and insulting her about her sexuality. The woman ultimately underwent a C-section to deliver the baby.
* In **Kenya**, pregnant women with disabilities cited that they were often insulted by female nurses when they visited hospitals and presented for treatment.[[55]](#endnote-55)

The removal of newborns from women and gender minorities with disabilities in healthcare settings is not yet comprehensively documented. However, recent studies and cases in North America highlight that this removal does occur, including while women with disabilities are in the hospital, and particularly impacts new parents with intellectual disabilities, with significant negative consequences for these individuals.[[56]](#endnote-56)

* A 2018 study in Ontario, **Canada**, found that women with intellectual disabilities were more than 25 times more likely than other women to have their newborns taken into protective custody shortly after birth.[[57]](#endnote-57) The study noted that these separations have negative consequences for both women and babies, because “they disrupt maternal-fetal bonding and breastfeeding” and may also lead to trauma and long-term mental health issues for these women.[[58]](#endnote-58)

**Question #5: Health response to forms of violence, including during the COVID-19 pandemic**

The COVID-19 pandemic has impacted the response to gender-based violence in all its forms against women, girls, and gender minorities with disabilities. In particular, healthcare personnel in many contexts have been allocated away from the provision and sexual and reproductive healthcare, including to survivors of violence, to instead provide treatment for COVID-19, while family planning clinics and other health centers in urban and rural communities have shutdown, limiting access to their services.[[59]](#endnote-59) Because accessible public transportation also became unavailable or unaffordable during the pandemic, women, girls, and gender minorities with disabilities—who disproportionately rely on those forms of transportation—could not access sexual and reproductive health services outside of their communities.[[60]](#endnote-60)

To the extent that sexual and reproductive health services were available, women, girls and gender minorities with disabilities faced other disability-specific barriers to accessing these services.

* For instance, deaf women in **Malawi** reported that they were no longer permitted to bring sign language interpreters with them to their sexual and reproductive health appointments, due to social distancing rules at those clinics that allowed only the patient to attend appointments.[[61]](#endnote-61)
* Advocates in **India** reported that women with disabilities were reluctant to go to hospitals to access sexual and reproductive health services, as many hospitals were also treating COVID-19, and women with disabilities felt particularly at risk from the virus due to various co-morbidities.[[62]](#endnote-62)
* **Globally**, as many services moved to telehealth or other virtual means, women with disabilities also faced accessibility barriers towards accessing those services.[[63]](#endnote-63)

**Question #8: Good practices in comprehensive health responses to violence**

There are some examples of respectful and quality sexual and reproductive health services to survivors of violence and to women, girls, and gender non-conforming persons with disabilities more broadly.

* In **Malawi**, a one-stop center for gender-based violence services located inside a hospital in Mzuzu takes proactive measures to include women and girls with disabilities and provide support they may need in the cases that the center handles. This has included ensuring access for them to accessible shelter and to psychosocial support services, among other services.
* Related to the COVID-19 response, in **Tajikistan**, the Ministry of Health worked with UNFPA and local organizations of persons with disabilities to establish accessible rooms, outside of hospital settings, for the delivery of sexual and reproductive healthcare and psychosocial support, including related to gender-based violence, to women with disabilities. These rooms were established in both urban and rural areas and were often located in places that persons with disabilities already accessed, such as local organizations of persons with disabilities or disability service providers, and were advertised through those disability support services. Between September and November 2020, these accessible rooms provided services to more than 450 women with disabilities throughout Tajikistan.[[64]](#endnote-64)

**Question #9: Good practices to prevent violence**

There are also some good practices towards the prevention of these forms of violence against women and gender minorities with disabilities, focusing on ensuring that these individuals know and can act on their rights and that advocacy organizations are taking on the priorities of women and gender minorities related to prevention of violence against them.

* For instance, in **Spain,** the paternalistic culture and the overprotection of families are obstacles to exercising sexual and reproductive rights on the basis of free and informed consent, particularly for women with intellectual and developmental disabilities. Women with intellectual and developmental disabilities are prevented from learning about their bodies and their sexuality and from receiving sexual education, which leads to greater vulnerability to gender-based violence. To respond to this reality, the organization Plena Inclusion in Spain implemented the project Promoters of Health. Through this project, Plena Inclusion gathered testimonies from women with intellectual and developmental disabilities in five autonomous regions in Spain and provided them with a forum to learn and talk about their right to health, including their sexual and reproductive health and rights. Two of the primary requests made by the women who participated in the project were (1) to be able to fully enjoy their sexuality and motherhood; and (2) not to be exposed to medical treatments without their consent, such as forced sterilizations or the administration of contraceptive methods. Plena Inclusion is now using this testimony to guide its work in this area and is working with these women to ensure they can advocate for their rights in this regard.
* In **Malawi**, the DIWA projects on Access to Justice and GBV raised awareness of rights to women with disabilities; documented positive stories of women with disabilities; engaged with local key authorities to develop community by-laws for protection of rights for persons with disabilities; established a collaboration with Malawi police in response to GBV cases and engaged with the judiciary to develop the police and judiciary disability management module; developed disability source book for schools; and held conferences on access to justice bringing together the police, the judiciary, civil society, women forums and private sectors working to prevent GBV and to promote justice for vulnerable groups. In addition, the initiatives during the 16 days of activism against GBV included a disability perspective.
1. Conclusions and Recommendations

The issue of violence and its impact on the right to health is one that is particularly salient for women, girls, and gender minorities with disabilities, because of both the high rates of gender-based violence and the long history of abuse in healthcare settings experienced by this group. As the examples above and in the resources cited in the attached Annex illustrate, though the legal frameworks and some particulars of the abuses may differ between countries, the global trend of gender-based violence and abuse in healthcare settings is consistent across the globe.

To fully ensure rights for women, girls, and gender minorities with disabilities, including the right to health, these abuses must be prevented and comprehensively addressed and redressed. Our organizations hope that the Special Rapporteur will include the following in her report:

* Women and girls with disabilities face gender-based violence at rates that are at least two to three times those experienced by other women, with impacts on their physical and mental health. Women, girls, and gender minorities with disabilities must be included to efforts to prevent and address this violence, to ensure a comprehensive and inclusive approach. Reproductive health interventions performed without the consent of the women or gender minority involved are forms of gender-based violence, with often severe physical, psychological, and emotional consequences for the individuals subjected to them. Women, girls, and gender minorities with disabilities are disproportionately impacted by forced reproductive health interventions, due to stereotypes about their ability to parent, for invalid reasons of menstrual hygiene or to “protect” them from gender-based violence, and because of formal or informal deprivations of their decision-making power in this context.
* There are no valid reasons for a forced reproductive health intervention, and the consent of a guardian, doctor, parent, or other third party does not constitute valid consent for such an intervention. States must amend their legal frameworks to eliminate systems that allow for third party consent in this context and to prohibit all forced reproductive health interventions, including those performed on women, girls, and gender minorities with disabilities.
* States must also ensure that health services, including sexual and reproductive health, are accessible, affordable, and inclusive of persons with disabilities, including services that survivors of gender-based violence need. are affordable and accessible to persons with disabilities; that they are available in their communities or by accessible and affordable public transportation; and that staff are trained to work with and provide respectful care to persons with disabilities. During times of crisis, States must ensure that these services continue to be provided and continue to provide accessible, affordable, and quality services to persons with disabilities.
* States must ensure that women and gender minorities with disabilities, including survivors of GBV, receive social and financial support to mitigate the risk of GBV and ensure their livelihood after experiencing GBV.
* States must ensure that referral systems are in place and are accessible and inclusive of women and gender minorities with disabilities, to prevent and respond to GBV in a timely and safe manner. States must support women initiatives on GBV prevention and SRH services, with enough funding and resources.

Thank you again for attention to this submission. Should you have questions about the submission, or would like further information, please do not hesitate to contact the compiler of this submission, Women Enabled International, at a.mcrae@womenenabled.org.

**Annex – Additional Information on Violence and the Right to Health for Women, Girls, and Gender Minorities with Disabilities**

Further information on violence and the right to health for women, girls, and gender minorities with disabilities can be found in the following resources:

UNFPA & WEI, *Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights* (2018), <https://womenenabled.org/reports/wei-and-unfpa-guidelines-disability-gbv/>

Disabled Women in Africa, Study on Women with disabilities’ experiences of GBV in Malawi (June 2021) (attached to this submission)

* Agnieszka Wołowicz, Agnieszka Król & Justyna Struzik. *Disabled Women, Care Regimes, and Institutionalised Homophobia: A Case Study From Poland* 8 (2021), [https://link.springer.com/article/10.1007%2Fs13178-021-00586-7](https://link.springer.com/article/10.1007/s13178-021-00586-7)
* UNFPA, WEI & Pacific Disability Forum, *Needs Assessments on Sexual and Reproductive Health and Rights and Gender-based Violence for Women and Youth with Disabilities: Fiji, Samoa, Vanuatu* (forthcoming 2022).
1. World Health Organization (WHO) & World Bank, World Report on DISABILITY at 28 (2011), https://www.who.int/disabilities/world\_report/2011/report/en/. [↑](#endnote-ref-1)
2. UN Special Rapporteur on Violence against Women, *Report of the Special Rapporteur on violence against women, its causes and consequences*,**¶** 31, U.N. Doc. A/67/227 (2012). [↑](#endnote-ref-2)
3. *Id.*,**¶** 32. [↑](#endnote-ref-3)
4. CRPD Committee, *General Comment No. 3: Article 6: Women and girls with disabilities*, U.N. Doc. CRPD/C/GC/3 (2016). [↑](#endnote-ref-4)
5. *See, e.g.*, *id.* [↑](#endnote-ref-5)
6. United States Agency for International Development (USAID), United States Strategy to Prevent and Respond to Gender-based Violence Globally 7 (2012).

 It is worth noting that no global data exists on the incidence of such violence, and studies draw on different sources of data. [↑](#endnote-ref-6)
7. Women’s Aid, *What is Domestic Violence/Forms of Domestic Violence* (2007), <http://www.domesticviolencelondon.nhs.uk/1-what-is-domestic-violence-/21-domestic-abuse-perpetrated-against-people-with-disabilities.html> [↑](#endnote-ref-7)
8. *Id.* at 10. [↑](#endnote-ref-8)
9. Gill Hague, Ravi Thiara, Pauline Magowa & Audrey Mullender, *Making the Links: Disabled Women and Domestic Violence* 33, 42 (2007), https://www.researchgate.net/publication/251496743\_Disabled\_Women\_and\_Domestic\_Violence\_Making\_the\_Links (joint project conducted by Women’s Aid, the Gender and Violence Research Group at the University of Bristol, and the Centre for the Study of Safety and Well-being at the University of Warwick). [↑](#endnote-ref-9)
10. Institute of Psychology of the Polish Academy of Sciences, *Study on violence against persons with disabilities inside the family* (2009). [↑](#endnote-ref-10)
11. *Id.* [↑](#endnote-ref-11)
12. European Union Agency for Fundamental Rights, *Violence against women survey: Poland* (2017), <http://fra.europa.eu/en/publications-and-resources/data-and-maps/survey-data-explorer-violence-against-women-survey> [↑](#endnote-ref-12)
13. ENR, *HIV prevalence and sexual behaviours of persons with disabilities in Nigeria* 25 (2015), <https://www.popcouncil.org/uploads/pdfs/2015HIV_ENR-PersonsWithDisabilities.pdf>. [↑](#endnote-ref-13)
14. National Population Commission, Federal Republic of Nigeria & ICF International, Nigeria Demographic and Health Survey 307 (2013), <https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf>. [↑](#endnote-ref-14)
15. United Nations Population Fund (UNFPA) & Women Enabled International (WEI), *The Impact of COVID-19 on Women and Girls with Disabilities: A Global Assessment and Case Studies on Sexual and Reproductive Health and Rights, Gender-Based Violence, and Related Rights* 17 (2021), <https://womenenabled.org/wei-unfpa/UNPRPD%2C%20UNFPA%2C%20WEI%20-%20The%20Impact%20of%20COVID-19%20on%20Women%20and%20Girls%20with%20Disabilities.pdf> [hereinafter UNFPA & WEI, *COVID-19 Impact Assessment*]. [↑](#endnote-ref-15)
16. *See, e.g.*, Women Enabled International, AWWDI, LEDAP & Inclusive Friends Association, *NGO Submission to the CEDAW Committee Pre-Sessional Working Group for Nigeria* (Oct. 2016), <https://womenenabled.org/reports/wei-and-nigeria-partners-cedaw-review-submission/>. [↑](#endnote-ref-16)
17. For instance, in India, the Criminal Law (Amendment) Act 2013 fails to criminalize forced or coerced sterilization or abortion for women with disabilities, meaning that it is unclear whether there are any sanctions or punishments for those who participate in these human rights violations. [↑](#endnote-ref-17)
18. For instance, in India, although the Ministry of Health issued guidelines in 2006 to prevent sterilization without informed consent in the country, these guidelines do not address the situation of when a guardian or parent gives consent for a woman or girl with disabilities to undergo sterilization. Furthermore, these guidelines do not provide guidance on how to ensure reasonable accommodation and support to ensure that women with disabilities give their informed consent to sterilization. *See* *Women with Disabilities Submission to the Special Rapporteur on the Rights of Persons with Disabilities on the Right to Health: Annex D (India)* (Mar. 30, 2018), <https://womenenabled.org/pdfs/Annex%20D%20-%20India.docx> [↑](#endnote-ref-18)
19. Committee for the Ethical Aspects of Human Reproduction and Women's Health (FIGO), *Female Contraceptive Sterilization*, 115 Int'l J. of Gynecology And Obstetrics 88 at 88-89, ¶ 8 (2011), http://www.cehat.org/uploads/files/Female%20Contraceptive%20Sterilization%20Statement%281%29.pdf [↑](#endnote-ref-19)
20. *Id.* [↑](#endnote-ref-20)
21. Medical Termination of Pregnancy Act, § 3(4)(a) (1971) (India), <http://tcw.nic.in/Acts/MTP-Act-1971.pdf>. [↑](#endnote-ref-21)
22. Sterilisation Act, 44 of 1998, **§** 2(2) (South Africa), <https://www.gov.za/documents/sterilisation-act#:~:text=to%20provide%20for%20the%20right,due%20to%20mental%20disability%3B%20and>. [↑](#endnote-ref-22)
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56. Recently in the U.S. state of New York**,** a young woman with an intellectual disability had her newborn child removed from her custody by the Administration for Children’s Services (ACS) before she was discharged from the hospital. The child was removed on the basis that the woman had neglected the newborn by failing to attend parenting and treatment programs she had previously been assigned. However, ACS had failed to provide the woman with the reasonable accommodations she needed to attend these classes and further failed to accommodate her during the conference to determine the removal of her newborn, despite knowing the mother had an intellectual disability and required documented reasonable accommodations. This case was recently decided by the New York Court of Appeals, which noted that ACS has an obligation to ensure reasonable accommodations under U.S. law in cases like these. *Lacee L*., 2018 N.Y. 06966 (slip op.) [↑](#endnote-ref-56)
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