

**NGO information to the United Nations**

**Committee on the Elimination of Discrimination against Women**

**For consideration when compiling the addendum to**

**General Recommendation No. 19:**

**accelerating the elimination of gender-based violence against women**

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Submitted by the

Mental Disability Advocacy Centre (MDAC)

30 September 2016

1. **OVERVIEW**
2. This written submission provides an outline of the basic principles that can be considered when updating the United Nations Committee on the Elimination of Discrimination Against Women’s General Recommendation No. 19 (1992): Accelerating efforts on gender based violence against women. Our suggestions will have a focus on the enjoyment of rights by women with disabilities, particularly women with intellectual disabilities and women with psychosocial disabilities.
3. The submission has been written by the Mental Disability Advocacy Centre (MDAC), an international human rights organisation that uses the law to secure equality, inclusion and justice for people with mental disabilities worldwide. MDAC’s vision is a world of equality where emotional, mental and learning differences are valued equally; where the inherent autonomy and dignity of each person is fully respected; and where human rights are realised for all persons without discrimination of any form. MDAC has participatory status at the Council of Europe, and observer status at ECOSOC. For more information, please visit [www.mdac.org](http://www.mdac.org).
4. Women with disabilities are affected by multiple forms of discrimination and violence which result from the intersection between gender and disability, often in conjunction with other factors such as ethnicity, age and social and/or economic status. We use the term “women with disabilities” throughout this submission to refer to women, girls, intersex, trans\* and self-identified women with actual or perceived disabilities. These terms are imperfect, but reflect the need for an inclusive and intersectional approach.
5. The forms of violence perpetrated against women with disabilities result from and are frequently enabled by discriminatory law, policy and practices. Our submission is that the General Comment should target specific forms of violence which affect large numbers of women with disabilities globally, including deprivation of legal capacity (both *de jure* and *de facto*); forced or non-consensual interference with the integrity of the person (including forced health, medical and related interventions); deprivation of liberty and institutionalisation; and obstacles in accessing justice.

**II. DEPRIVATION OF LEGAL CAPACITY**

1. Equality before the law is a central principle of international human rights law (ICCPR Article 14, CEDAW Article 15) and legal capacity is an inherent human attribute to be enjoyed by all persons regardless of their gender, disability or other status (Article 12 CRPD, among others).
2. Deprivation of legal capacity is a legal measure which was traditionally meant as a protective measure for people adjudged as unable or incapable of managing their affairs, due to their actual or perceived impairment, or because of their gender. Women with disabilities are acutely affected by paternalistic measures which subject them to the authority of *inter alia* husbands, male relatives, guardians, representatives of health and social care systems and religious or other cultural institutions.[[1]](#footnote-1) These legal measures are reinforced by social norms and informal practices which deny, restrict and curtail the exercise of the autonomy of women with disability.[[2]](#footnote-2)
3. Restriction or denial of legal capacity has far-reaching consequences for women with disabilities. This was recognised in the adoption of the Convention on the Rights of Persons with Disabilities (Perambulatory paragraph q, Articles 6 and 12), CRPD General Comment 3 (“Women and girls with disabilities), CEDAW Article 15 and CEDAW General Recommendations including GR29 (“Article 16: Economic consequences of marriage, family relations and their dissolution”) and GR33 (“Women’s access to justice”).
4. Deprivation of legal capacity has, in practice, a wide variety of implications which can constitute gender and disability based violence. For example, it restricts women’s access to financial means; reinforce cycles of poverty; render them vulnerable to sexual and reproductive violence; enables deprivation of liberty through institutionalisation; facilitates forced medical/health interventions; and denies effective access to justice.

1. MDAC submits that the restriction of legal capacity as a protective measure in fact facilitates abuse and violence against women with disabilities. Instead, both the CRPD and CEDAW require that States take appropriate measures to provide access by women with disabilities to the support they may require in exercising their legal capacity and ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent exploitation, violence and abuse.

**MDAC submits that the following should be included in the General Recommendation:**

* States must abolish all legal systems which restrict or deny the legal capacity of women with disabilities on the basis of gender, disability, or other status.
* States must also take measures to modify and eliminate social and cultural practices which have the purpose or effect of restricting or denying the legal capacity of women with disabilities.
* Systems of substitute decision-making must be replaced by providing women with disabilities access to the support they may require in exercising their legal capacity.
* States shall ensure that all measures of support provided to women with disabilities ensure appropriate and effective safeguards with the purpose of identifying and preventing exploitation, violence and abuse.

**III. FORCED AND NON-CONSENSUAL MEDICAL/HEALTH INTERVENTIONS**

1. Women with disabilities are often subjected to forced and non-consensual health/medical interventions on the basis of their disability and gender which fundamentally violate their right to integrity of the person.
2. Examples of such interventions against women with disabilities include forced and non-consensual psychiatric treatment, hospitalisation, sterilisation,[[3]](#footnote-3) abortion and contraception. These forms of violence particularly affect women with disabilities in psychiatric hospitals, social care institutions, residential centres (public/private) or who are subject to other forms of institutional care.[[4]](#footnote-4) In some circumstances these interventions can amount to torture, cruel, inhuman or degrading treatment or punishment, some of which disproportionately affect women with intellectual or psychosocial disabilities.[[5]](#footnote-5)
3. Women with disabilities are frequently subjected to medical/health treatment for which they do not provide full and informed consent. In some cases this is facilitated by national legal systems which permit legal guardians to make substitute decisions which do not respect the will and preferences of the woman concerned. Some of these are based upon wrongful theories of incapacity, therapeutic necessity and laws based on paternalistic “best interests” principles.[[6]](#footnote-6)

**MDAC submits that the following should be included in the General Recommendation:**

* States must ensure that medical and health interventions must be provided on the basis of free and full informed consent in all situations, including for women with intellectual disabilities and women with psychosocial disabilities, in private and public health, social care and related fields. Practices such as advanced directives and powers of attorney should be encouraged and provided with legal recognition.
* Forced or non-consensual treatment of women with disabilities constitutes a form of violence on the basis of gender and disability, and can amount to torture or ill-treatment. Such interventions must be strictly prohibited in all cases, including in those which are based on notions such as medical necessity, incapacity and best interests.
* States must ensure that women with disabilities who are victims of forced or non-consensual medical/health treatment or interventions have an effective right to redress, including reparations, recognition, restitution, guarantees of non-repetition and rehabilitation.

**IV. INSTITUTIONALISATION**

1. MDAC has conducted extensive research in central and eastern Europe which continues to highlight the problem of mass institutionalisation of people with disabilities on the basis of a perceived or actual impairment. This frequently means involuntary detention in psychiatric facilities, placement in medium or long-term residential social care or ‘rehabilitation’ centres’, and other residential institutional settings. Article 19 of the CRPD clearly sets out the right of all women with disabilities to live independently and be included in the community on an equal basis with others.
2. Institutionalisation renders women with disabilities additionally vulnerable to exploitation, violence and abuse including gender based violence such as rape, sexual violence and physical abuse. Institutionalisation itself may amount to violence on the basis of gender and disability.
3. Institutionalisation implies social isolation, reduced environmental stimulation and loss of control over almost all aspects of daily life, which can have extremely detrimental effects on the health and well-being of individuals, and damages their independence and autonomy.[[7]](#footnote-7) Institutions are often situated in remote locations or, even when situated within communities, residents have little chance of interacting with people outside of the institution. Even when such interactions do take place, they do not happen on a regular basis, which makes establishing social contact extremely difficult.
4. Reduced activity and stimulation strongly impacts on physical and psychological development, especially when imposed from a young age or/and for extended periods of time. Studies indicate that reduced sensory input can also lead to reduced brain activity.[[8]](#footnote-8) Institutionalisation comes with a label of incompetence which “play[s] out as a self-fulfilling prophecy. Once a finding is reached that a person is incompetent to perform certain tasks, such person shall not be given any opportunity to engage in or learn those tasks, […] [which] forces people to **learn helplessness**.”[[9]](#footnote-9) (emphasis added)

“Institutionalised living often means that residents are forced to sleep as a group, eat as a group, wash as a group, spend their day as a group and – to the extent that employment is possible in an institution – work as a group. There is no room for individual autonomy […] and behavior diverging from the norm is punished.”[[10]](#footnote-10)

“[T]he ‘totality of control’ means that […] [people] become so reliant on [somebody else] […] to organize their lives and daily routines that they lose the capacity to exercise personal autonomy. This may render them dysfunctional in society upon their release.”[[11]](#footnote-11)

**MDAC submits that the following should be included in the General Recommendation:**

* States must enshrine in law and policy the right of women with disabilities to live independently and be included in the community, with access to individual and general services which can achieve this goal and prevent against isolation and segregation. To this end, states must ensure persons with disabilities have the opportunity to choose their place of residence and where and with whom they live and ensure they are not obliged to live in a particular living arrangement;
* Women with disabilities must have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
* States must ensure that community services and facilities for the general population are available on an equal basis to women with disabilities and are responsive to their needs.
* States must ensure independent human rights monitoring of institutions in the interim, with the final goal to enable women with disabilities to live independently and be included in the community.

**V. COMMENTS ON SPECIFIC PARAGRAPHS OF THE DRAFT UPDATE TO GENERAL RECOMMENDATION NO. 19**

1. Paragraph 12: MDAC suggests adding that gender-based violence is also perpetuated in institutional settings where women with disabilities live and/or are treated (such as psychiatric hospitals, social care homes, rehabilitation centres, living centres, orphanages, etc.);

1. Paragraph 15: As to subparagraph (d), MDAC suggests to add that States Parties must ensure effective access to justice for women with disabilities on an equal basis with others, including through ensuring accessible justice systems, provision of procedural and age-appropriate accommodations and reasonable accommodations to facilitate their effective role as direct and indirect participants, including as witnesses, in all stages of legal proceedings, including at investigative and other preliminary stages.
2. Paragraph 15: As to subparagraph (a)(iv) on protection and redress, MDAC recommends redrafting this paragraph to call on States to recognise that non-penal institutionalisation is a form of violence against women with disabilities and take comprehensive legislative, policy and other measures to combat the causes and consequences of institutionalisation, with the goal of achieving full inclusion for women with disabilities in their communities with necessary supports. **MDAC strongly recommends that the Committee avoids implying that any form of institutionalisation of women with disabilities can be justified in light of the obligations under Article 19 CRPD.**

For further information, please contact:

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1. See, for example, Committee on the Elimination of All Forms of Discrimination Against Women, *Concluding observations on the Republic of Moldova, Combined Fourth and Fifth Periodic Reports*, 29 October 2013, CEDAW/C/MDA/CO/4-5, at paras. 35-38. [↑](#footnote-ref-1)
2. See, for example: MDAC, USPK and KAIH, *The right to legal capacity in Kenya* (Budapest: MDAC, 2014), available online at <http://mdac.info/sites/mdac.info/files/mdac_kenya_legal_capacity_2apr2014.pdf> (accessed 30 September 2016). [↑](#footnote-ref-2)
3. See, for example, CRPD/C/MUS/CO/1, para. 29; CRPD/C/NZL/1, para. 37. [↑](#footnote-ref-3)
4. Oana Girlescu, ‘Sexuality and disability: an assessment of practices under the Convention on the Rights of People with Disabilities (Thesis) (Central European University, 2012), p. 28, available online at <http://www.etd.ceu.hu/2013/girlescu_oana.pdf> (accessed 30 September 2016). [↑](#footnote-ref-4)
5. Committee on the Rights of Persons with Disabilities, *General Comment No. 3: Article 6 – Women and girls with disabilities*, 2 September 2016, CRPD/C/GC/3, para. 53-4. [↑](#footnote-ref-5)
6. Ibid., para. 54. [↑](#footnote-ref-6)
7. Commissioner for Human Rights of the Council of Europe, *Issue Paper: Right of people with disabilities to live independently and be included in the community* (Strabourg: Council of Europe, 2012), p. 37. [↑](#footnote-ref-7)
8. Shalev Sharon, *A sourcebook on solitary confinement*. (London: London School of Economics and Mannheim Centre for Criminology, 2008), p. 19. [↑](#footnote-ref-8)
9. Amita Dhanda, *Legal capacity in the Disability Rights Convention: stranglehold of the past or lodestar for the future?* [2007] Syracuse Journal of International Law and Commerce 436. [↑](#footnote-ref-9)
10. Association for Social Affirmation of People with Mental Disabilities (SHINE), *Out of Sight.Human Rights in Psychiatric Hospitals and Social Care Institutions in Croatia (Zagreb:* Mental Disability Advocacy Center and SHINE, 2011), p. 58. [↑](#footnote-ref-10)
11. Supra note 8, p. 20. [↑](#footnote-ref-11)