Response to call for submissions from the Special Rapporteur on the rights with persons with disabilities, Ms. Catalina Devandas Aguilar, on the Study on the sexual and reproductive health and rights of girls with disabilities

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Ipas is grateful for this opportunity to provide a submission to The UN Special Rapporteur on the rights of persons with disabilities for her consideration of her forthcoming report on the right to sexual and reproductive health of girls with disabilities. Ipas, as a global non-governmental organization, has been engaging with UN human rights bodies, including Special Procedures, for many years.

Founded in 1973, Ipas is dedicated to ending preventable deaths and disabilities from unsafe abortion. Through local, national and global partnerships, Ipas works to ensure that women and girls can obtain safe, respectful and comprehensive abortion care, including counseling and contraception to prevent future unintended pregnancies. Ipas works towards ensuring every woman and girl has a right to safe reproductive health choices, including safe abortion care; that no woman or girl should have to risk her life, her health, her fertility, her well-being or the well-being of her family because she lacks reproductive health care, and that women and girls everywhere must have the opportunity to determine their futures, care for their families and manage their fertility.

Along with caring, committed health professionals and other colleagues worldwide, Ipas tackles this neglected public health problem head on in some of the world’s poorest countries. While many international donors and governments have focused attention and resources elsewhere, we struggle against the fundamental social injustice that results in the deaths of so many women in the prime of their lives.

The exercise of reproductive rights is based on many rights including the right to decide freely on the number and spacing of one’s children, the right to the highest attainable standard of health, the right to be free from torture and other ill-treatment, and the right to non-discrimination. Central to the exercise of reproductive rights is ensuring

that women and girls, including those with disabilities, can achieve equality and overcome discrimination by exercising their autonomy and self-determination, a core legal obligation outlined in in many human rights treaties, including the Convention on the Rights of Persons with Disabilities (CRPD).[[1]](#footnote-1) Reproductive rights are explicitly enumerated in CRPD and 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,”[[2]](#footnote-2) to retain fertility on an equal basis with others, including for children with disabilities,[[3]](#footnote-3) and to health on an equal basis with others, “including in the area of sexual and reproductive health and population-based public health programs.”[[4]](#footnote-4)

However, women and girls across the globe face barriers, in law and/or in practice, on the exercise of their reproductive rights.[[5]](#footnote-5) And although all women and girls face such hurdles, women and girls with disabilities face particular barriers and difficulty in exercising their reproductive rights which undermine their autonomy and right to be free from discrimination.[[6]](#footnote-6) Women and girls with disabilities face 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. State failure to take positive measures to ensure access to reproductive health services for women and girls with disabilities, to eliminate wrongful stereotypes and to prevent and punish violations, contribute to the barriers faced in exercising their reproductive rights, and promote stigma and discrimination.[[7]](#footnote-7)

As the CRPD and many other treaties recognize, women and girls with disabilities are subject to multiple discrimination because of both their gender and disability statuses, and because of their age (when it comes to girls).[[8]](#footnote-8) The CRPD, The Convention on the Rights of the Child, the Convention on Economic, Social and Cultural Rights and the Convention on Elimination of Discrimination against Women require states to take measures to address this multiple discrimination, which also manifests itself in the exercise of reproductive rights.[[9]](#footnote-9)

This submission focuses on issues concerning access to abortion, including in the context of the Zika virus. It also presents an innovative initiative taken at the local level by Ipas Nigeria to promote and ensure access to sexual and reproductive health services of deaf women and girls in Abuja, the capitol of Nigeria.

**Access to Abortion**

Although the overwhelming majority of maternal deaths are preventable, 800 women and adolescents continue to die each day from pregnancy-related causes.[[10]](#footnote-10) Laws and policies that restrict reproductive health care, including abortion, deny women and adolescents the right to determine if and when to bear children and are a key driver of these preventable maternal deaths. Approximately 120 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.[[11]](#footnote-11) These abortion laws not only deprive women and girls of their autonomy concerning decisions about their reproductive lives; they also pose significant risks to women’s health and lives.[[12]](#footnote-12) The legal status of abortion will largely determine whether they can access abortion services in safe or unsafe conditions.[[13]](#footnote-13) In circumstances in which abortion is restricted by law, women and girls are more likely to undergo clandestine, unsafe abortions, which increase their risk of maternal mortality and morbidity.[[14]](#footnote-14) Barriers to lawful abortion services also undermine their access to abortion.[[15]](#footnote-15)

Women and girls living in countries with restrictive laws are often unable to access abortion services in the limited circumstances for which they are permitted due to a variety of factors. These factors include lack of clarity about the legal grounds for abortion, lack of training for health care workers on the law; restrictions on types of providers lawfully allowed to perform abortions; lack of information about legal abortion services to women; stigma around performing and obtaining abortions; criminal penalties attached to undergoing and performing illegal abortion and the chilling effect it has on health care workers performing even legal abortions.[[16]](#footnote-16) Combined with the barriers already experienced by women and girls with disabilities in accessing reproductive health services, including physical access barriers; information barriers, such as the absence of alternative formats of information and communication; lack of disability-related support services, and stigma,[[17]](#footnote-17) abortion services become virtually inaccessible for women and girls with disabilities.

In addition, 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 an unsafe abortion. Since women with disabilities experience sexual violence at higher rates than other women, they are least two to three times more likely than women without disabilities to experience violence and abuse, which includes sexual violence, and they are likely to experience abuse over a longer period of time, resulting in more severe injuries.[[18]](#footnote-18) As such, they may more often be subjected to carrying a pregnancy resulting from rape.

Lack of access to safe and legal abortion services has a devastating impact on women’s and girls health and lives. Approximately 22 million women undergo unsafe abortions each year and 47,000 women die from unsafe abortions annually,[[19]](#footnote-19) accounting for up to 13 percent of maternal deaths worldwide.[[20]](#footnote-20) No data is available on the percentage of women with disabilities undergoing abortion because of lack of disaggregated data. Under international human rights law, states have an obligation to gather disaggregated data on numerous characteristics, including relating to the health of women and girls with disabilities.[[21]](#footnote-21)

Adolescent girls, especially those with disabilities, are particularly at risk because of their age and they often face obstacles to accessing contraceptives and health services, increasing the risk of unintended pregnancy and unsafely performed abortions.[[22]](#footnote-22) Confidential and child-sensitive counseling services are a human rights obligation[[23]](#footnote-23) and should thus, also be implemented. Adolescent pregnancies and childbirth pose serious health risks. For example, every year, adolescents account for 16 percent of all births in sub-Saharan Africa. Globally, adolescents between the ages of 15 and 19 have twice the risk of dying due to pregnancy-related complications compared to women in their twenties, while girls under the age of 15 have times the risk of pregnancy-related deaths worldwide. Pregnancy also compels girls to drop out of school or result in expulsion by school authorities.[[24]](#footnote-24)

Both the Committee on the Rights of the Child and the UN Special Rapporteur on Health have noted these additional risks of associated morbidity and mortality faced by adolescent girls when they do not have access to safe abortion services, requiring states to ensure access to safe abortion services and to ensure that girls can make autonomous and informed decisions on their reproductive health.[[25]](#footnote-25) The UN Committee on the Rights of the Child has urged states to consider allowing children to consent to certain medical treatment without the consent of a parent or guardian, including sexual and reproductive health services such as contraception and safe abortion.[[26]](#footnote-26) In addition, the Special Rapporteur on the Right to Health’s most recent report on adolescents, recognizes that mandatory consent laws fail to acknowledge adolescents’ capacity to seek out necessary reproductive health needs and prevent the full realization of adolescents’ sexual and reproductive health and rights. He has recommended that states ensure of a legal presumption of capacity for adolescents seeking preventive and time-sensitive sexual and reproductive services. [[27]](#footnote-27) Because of the marginalization of women and girls with disabilities, their access is even further limited.[[28]](#footnote-28)

Wrongful stereotypes around sexuality of women and girls with disabilities are particular barriers to sexual and reproductive health services, including abortion services. Persons with disabilities are very often perceived as asexual or sexually inactive. However, they are sexual beings in the same way as other people, and should not be deprived of their sexual and reproductive rights. [[29]](#footnote-29) CRPD also recognizes that harmful stereotypes perpetuate violence against women with disabilities, because these stereotypes “infantilize women with disabilities, call into question their ability to make judgments, and [reinforce] perceptions of women with disabilities as being asexual, or hypersexual....”[[30]](#footnote-30)

CRPD affirms the legal capacity of persons with disabilities and their right to equality and non- discrimination in all aspects of life. The CRPD recognizes that persons with disabilities should have access to sexual and reproductive health services, including abortion, on an equal basis with others and that these services must be based on full, free and informed consent, free of discrimination coercion and violence.[[31]](#footnote-31) This includes ensuring access to abortion and importantly to be free from forced abortion. [[32]](#footnote-32) Forced abortion is of particular concern to women and girls with disabilities, given the long history across the globe of controlling the fertility of women with disabilities. Any medical procedure or intervention performed without free and informed consent, including procedures and interventions related to contraception and abortion is a violation of the human rights, including the dignity, of women and girls with disabilities.[[33]](#footnote-33)

CRPD has noted in its General Comment 3 on women with disabilities:

In practice, the choices of women with disabilities, especially women with psychosocial or intellectual disabilities are often ignored, their decisions are often substituted by third parties, including legal representatives, service providers, guardians and family members, thus violating their rights under article 12. All women with disabilities must be able to exercise their legal capacity by taking their own decisions, with support when desired with regard to medical and/or therapeutic treatment, including decisions on: retaining their fertility, reproductive autonomy, their right to choose the number and spacing of children, to consent and accept a statement of fatherhood, and the right to establish relationships.[[34]](#footnote-34)

UN Human rights bodies recognize women’s and girls’ access to safe and legal abortion as a human rights issue calling on states to remove legal restrictions, including criminal provisions, on abortion and ensure women’s and girls’ access to safe abortion services. UN treaty monitoring bodies and special procedures have framed maternal deaths due to unsafe abortion as a violation of women’s right to life and other human rights and has recognized the detrimental consequences of criminalizing abortion on women’s health, and well-being. They have called on states to review and repeal laws that criminalize abortion. [[35]](#footnote-35)

They have also addressed this issue as a violation of the right to non-discrimination, recognizing that the problem of maternal mortality due to unsafe abortion is evidence of discrimination against women and girls.[[36]](#footnote-36) Moreover, they have called on states to ensure women’s and girls access to safe abortion services where legal.[[37]](#footnote-37) Notably, the CEDAW Committee has also indicated that, forcing a girl to continue a pregnancy constitutes discrimination.[[38]](#footnote-38) 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.[[39]](#footnote-39)

**Zika and access to abortion[[40]](#footnote-40)**

Government responses to the Zika virus have been weak, disregarding the best interests of pregnant women and those who may become pregnant. Brazil, Colombia, El Salvador and Ecuador have all called for women to delay pregnancy until the Zika virus is no longer a threat, while ignoring the existing challenges Latin American women face in regulating their fertility. High rates of sexual violence and limited access to contraceptives and abortion mean that many women cannot control when they get pregnant. These government recommendations place the greatest burden on women and girls, and do not provide the support needed to prevent pregnancy.

Latin American countries’ substandard responses to the Zika epidemic highlight the region’s problem of gender inequity and neglect of women’s reproductive rights. Many of the women most at risk of Zika live in poverty. They face significant barriers to accessing reproductive health services and information on the potential consequences of contracting Zika during pregnancy. These are the women who most need accurate, comprehensive information about their health-care choices and counseling on health risks in order to make informed decisions about whether to continue a pregnancy. Women and girls also need basic health services and access to rapid diagnosis of the Zika virus. Lastly, they need access to comprehensive sexual and reproductive health care, including information, services and support to women infected with Zika who choose to continue their pregnancies and give birth to children with microcephaly or other impairments.

**Ipas increases access to sexual and reproductive health services for deaf women in Nigeria**

Ipas Nigeria in partnership with Australian AID, initiated a pilot project aimed at facilitating the availability of sign language interpretation within the health facilities in Abuja, Nigeria and to advocate and promote the health rights, including their right to sexual and reproductive health information for hearing impaired women.[[41]](#footnote-41) The initiative was designed to alleviate the difficulties experienced by deaf women in accessing reproductive and other healthcare facilities, by ensuring that they are provided with accurate and right-based information through the service of sign language interpreters. Deaf Women Association of Nigeria worked with Ipas to help them understand the barriers deaf women face. Ipas has since recruited sign language interpreters and posted them to select hospitals in Abuja Nigeria.

Ipas Nigeria, together with its partners, recognize that many women living with this disability have resolved not to seek health care due to the barriers they face in accessing service. Noting, for example, that some deaf women have died or have lost their babies trying to give birth at home. In addition, most deaf women and girls have never learned about the laws that protect them and because of the communication barriers that exists because of their disability, it is difficult not only to access such information but also to make a case for prevention and ensure effective responses against any forms of abuses or discrimination.

Ipas Nigeria is providing training for health providers to give the deaf women the best sexual and reproductive health services possible. The pilot project is also aimed at sensitizing stakeholders and members of the public on the need for deaf women to have increased access to health information. It is hoped that the government will collaborate with and other NGOs to replicate the project across the country.

1. See for example, CRPD Committee, General Comment No. 3 on women and girls with disabilities, U.N. Doc. CRPD/C/GC/3 (2016), General Comment 1 on equal recognition before the law (11th Sess.), U.N. Doc CRPD/C/GC/1 (2014). [↑](#footnote-ref-1)
2. Convention on the Rights of Persons with Disabilities, art. 23 (b), adopted Dec. 13, 2006, art. 6, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611, (entered into force May, 3 2008) [hereinafter CRPD]. [↑](#footnote-ref-2)
3. *Id.* art. 23 (c). [↑](#footnote-ref-3)
4. *Id.* art. 25 (a). [↑](#footnote-ref-4)
5. See, for example, CESCR Committee General Comment No. 22 on the Right to sexual and reproductive health, para. 10, U.N. Doc. E/C.12/GC/22 (2016). [↑](#footnote-ref-5)
6. See, for example, CRPD Committee, General Comment No. 3 on women and girls with disabilities, U.N. Doc. CRPD/C/GC/3 (2016). [↑](#footnote-ref-6)
7. *Id.* [↑](#footnote-ref-7)
8. CRPD; CESCR General Comment 22 on the right to sexual and reproductive health, U.N. Doc. E/C12/CG/22 (2016). [↑](#footnote-ref-8)
9. CRPD Committee, General Comment No. 3 on women and girls with disabilities, U.N. Doc. CRPD/C/GC/3 (2016); CRC Committee, General Comment 15 on the right of the child to the highest attainable standard of health, U.N. Doc. CRC/C/GC/15 (2013); CESCR General Comment 22 on the right to sexual and reproductive health (2016); CEDAW General Recommendation 24 on women and health (1999). [↑](#footnote-ref-9)
10. World Health Organization,Maternal Mortality Factsheet No. 348 (2016), http://www.who.int/mediacentre/factsheets/fs348/en/. [↑](#footnote-ref-10)
11. Center for Reproductive Rights, World’s Abortion Laws (2017), http://worldabortionlaws.com/map/. [↑](#footnote-ref-11)
12. Center for Reproductive Rights, World’s Abortion Laws (2017), http://worldabortionlaws.com/map/. [↑](#footnote-ref-12)
13. Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008,* 379 The Lancet 625 (2012). [↑](#footnote-ref-13)
14. World Health Organization, Safe abortion: technical and policy guidance for health systems 96-97 (2nd ed., 2012) *p. 23.*  [↑](#footnote-ref-14)
15. 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); World Health Organization, Safe abortion: Technical and Policy Guidance for Health Systems 96-97 (2nd ed., 2012). [↑](#footnote-ref-15)
16. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Interim report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, para. 24, U.N. Doc. A/66/254 (2011). [↑](#footnote-ref-16)
17. CRPD Committee, General Comment No. 3 on women and girls with disabilities, U.N. Doc. CRPD/C/GC/3 (2016). [↑](#footnote-ref-17)
18. Special Rapporteur on Violence against Women, Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo, para. 31, U.N. Doc. A/67/227 (2012). [↑](#footnote-ref-18)
19. Guttmacher Institute, Facts on Induced abortion Worldwide (2012), https://www.guttmacher.org/sites/default/files/pdfs/pubs/fb\_IAW.pdf. [↑](#footnote-ref-19)
20. *Id.* [↑](#footnote-ref-20)
21. See, for example, CRPD, General Comment 3 on women with disabilities. [↑](#footnote-ref-21)
22. UNFPA, Status Report Adolescents and Young People in Sub-Saharan Africa Opportunities and Challenges (2012), http://www.prb.org/pdf12/status-report-youth-subsaharan-Africa.pdf. [↑](#footnote-ref-22)
23. See for example, CRC Committee, General Comment 15 on the right of the child to the enjoyment of the highest attainable standard of health (2013) and CRC Committee, General Comment 20 on the implementation of the rights of the child during adolescence (2016). [↑](#footnote-ref-23)
24. UNFPA, Motherhood in Childhood (2013), https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013.pdf [↑](#footnote-ref-24)
25. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, para. 60, U.N. Doc. A/HRC/32/32 (2016). [↑](#footnote-ref-25)
26. CRC Committee, General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health, paras. 21 & 31, U.N. Doc. CRC/C/GC/15 (2013); See CRC Committee, Gen. Comment No. 3 on HIV/AIDS and the Rights of the Child, para. 20, U.N. Doc. CRC/GC/2003/3 (2003); See CRC Committee, General Comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child, para. 36, U.N. Doc. CRC/GC/2003/4 (2003). [↑](#footnote-ref-26)
27. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, para. 60, U.N. Doc. A/HRC/32/32 (2016). [↑](#footnote-ref-27)
28. CESCR Committee General Comment No. 22 on the Right to Sexual and Reproductive Health, para. 10 U.N. Doc. E/C.12/GC/22 (2016). [↑](#footnote-ref-28)
29. World Health Organization, Interagency statement on Eliminating Forced, Coercive, and otherwise Involuntary Sterilization (2014), <http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325_eng.pdf?ua=1>; CRPD Committee, General Comment No. 3 on Women and Girls with Disabilities, U.N. Doc. CRPD/C/GC/3 (2016). [↑](#footnote-ref-29)
30. *Id. para. 32.* [↑](#footnote-ref-30)
31. *Id.* [↑](#footnote-ref-31)
32. *Id.* [↑](#footnote-ref-32)
33. *See, for example, id.* [↑](#footnote-ref-33)
34. *Id.* para 44. [↑](#footnote-ref-34)
35. CESCR Committee General Comment No. 22 on the right to sexual and reproductive health, para. 10, U.N. Doc. E/C.12/GC/22 (2016); Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, para. 24, U.N. Doc. A/66/254 (2011); Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/HRC/31/57 (2016); Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/HRC/22/53 (2013). [↑](#footnote-ref-35)
36. *See for example*, Working Group on discrimination against women in law and practice, Report of the Working Group on the issue of Discrimination Against Women in Law and in Practice, U.N. Doc. A/HRC/32/44 (2016); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, para. 60, U.N. Doc. A/HRC/32/32 (2016); Human Rights Committee, Concluding Observations: Mongolia, para. 8(b), U.N. Doc. CCPR/C/79/Add.120 (2000). [↑](#footnote-ref-36)
37. L*.M.R. v. Argentina*, Human Rights Committee, Commc’n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011). [↑](#footnote-ref-37)
38. L.C. v. Peru, CEDAW Committee, Commc’n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); See also *Mellet v Ireland* Human Rights Committee (2016). [↑](#footnote-ref-38)
39. World Health Organization, Safe abortion: technical and policy guidance for health systems 96-97 (2nd ed., 2012). [↑](#footnote-ref-39)
40. Ipas, Zika Underscores Need for Reproductive Justice for all Women (2016) http://www.ipas.org/en/Resources/Ipas%20Publications/Zika-underscores-need-for-reproductive-justice-for-all-women.aspx. [↑](#footnote-ref-40)
41. The Authority, How Ipas Nigeria Supports the Deaf through Healthcare Interpreters (2016) http://authorityngr.com/2016/09/How-IPAS-Nigeria-supports-the-deaf-through-healthcare-interpreters/ [↑](#footnote-ref-41)