GENDER, DISABILITY & HEALTH:
THE SEXUAL & REPRODUCTIVE HEALTH & RIGHTS
OF
WOMEN & GIRLS WITH DISABILITIES

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Resources on the Right to Health, Including Sexual and Reproductive Health, for Women & Girls with Disabilities¹

Sexual and reproductive rights are fundamental human rights. They embrace human rights that are already recognized in international, regional, and national legal frameworks, standards, and agreements. These rights include the fundamental right to autonomy and self-determination—the right of everyone to make free and informed decisions and have full control over their body, sexuality, health, and relationships, and if, when and with whom to partner, marry, and have children—without any form of discrimination, stigma, coercion, or violence. This includes the right of everyone to enjoy and express their sexuality, be free from interference in making personal decisions about sexuality and reproductive matters, and to access sexual and reproductive health information, education, services, and support. It also includes the right to be free from torture and from cruel, inhumane, or degrading treatment or punishment; and to be free from violence, abuse, exploitation, and neglect.

However, women and girls with disabilities throughout the world have failed to be afforded, or benefit from, these provisions in international, regional and national legal frameworks, standards, and agreements. Instead, systemic prejudice and discrimination against them continues to result in multiple and extreme violations of their sexual and reproductive rights, through practices such as forced and/or coerced sterilization, forced contraception and/or limited or no contraceptive choices, a focus on menstrual and sexual suppression, lack of access to appropriate and accessible sexual and reproductive health care, poorly managed pregnancy and birth, forced or coerced abortion, termination of parental rights, denial of or forced marriage, lack of sexual and reproductive health information and education in school and in the community, and other forms

¹ Note: This resource list is a “work in progress” and will continue to be edited, updated, and posted on the Women Enabled International website at www.WomenEnabled.org. Please share additional resources and comments with us at WomenEnabled@gmail.com.
of torture and violence, including gender-based violence. Women and girls with disabilities also experience systemic exclusion from sexual and reproductive health care services. These practices and violations are framed within traditional social attitudes, patriarchy, and entrenched disability-based and gender-based stereotypes that continue to characterize disability as a personal tragedy, a burden, and/or a matter for medical management and rehabilitation, flowing from a medical, rather than a social, model of disability.

This resource list highlights relevant documents from United Nations Conventions and the findings of its treaty bodies, reports of Special Rapporteurs and other resources.

Would an index (w/page numbers) be helpful? Also, I bolded the names of the governing bodies and/or authors to make it a little easier to read. -Natalie

**International Human Rights Law**


Article 5: States Parties shall take all appropriate measures:
(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;
(b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases. *Convention on the Elimination of All Forms of Discrimination against Women*, art. 5, Dec. 18, 1979, 1249 U.N.T.S. 13.

Article 10
States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: . . .

Article 11
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:
   (e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;
   (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

2. In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:
(a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;
(b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;
(c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;
(d) To provide special protection to women during pregnancy in types of work proved to be harmful to them. **Convention on the Elimination of All Forms of Discrimination against Women**, art. 11, Dec. 18, 1979, 1249 U.N.T.S. 13.

Article 12
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. **Convention on the Elimination of All Forms of Discrimination against Women**, art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13.

Article 14
States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right . . . To have access to adequate health care facilities, including information, counselling and services in family planning. **Convention on the Elimination of All Forms of Discrimination against Women**, art. 14, Dec. 18, 1979, 1249 U.N.T.S. 13.

Article 15
1. States Parties shall accord to women equality with men before the law.
2. States Parties shall accord to women, in civil matters, a legal capacity identical to that of men and the same opportunities to exercise that capacity. In particular, they shall give women equal rights to conclude contracts and to administer property and shall treat them equally in all stages of procedure in courts and tribunals.
3. States Parties agree that all contracts and all other private instruments of any kind with a legal effect which is directed at restricting the legal capacity of women shall be deemed null and void.

Article 16
1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:
   (a) The same right to enter into marriage;
   (b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;
   (c) The same rights and responsibilities during marriage and at its dissolution;
   (d) The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;
(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

(f) The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;

(g) The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation;

(h) The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration. Convention on the Elimination of All Forms of Discrimination against Women, art. 16, Dec. 18, 1979, 1249 U.N.T.S. 13.


Note: Interactive map of state parties and signatories to various international human rights treaties, including the Convention on the Elimination of All Forms of Discrimination against Women, is available at: http://indicators.ohchr.org/.


The Committee on the Elimination of Discrimination against Women . . . recommends that States parties provide information on disabled women in their periodic reports, and on measures taken to deal with their particular situation, including special measures to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life.


Background

1. Gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men. . .

4. The Committee concluded that not all the reports of States parties adequately reflected the close connection between discrimination against women, gender-based violence, and violations of human rights and fundamental freedoms. The full implementation of the Convention required States to take positive measures to eliminate all forms of violence against women.
5. The Committee suggested to States parties that in reviewing their laws and policies, and in reporting under the Convention, they should have regard to the following comments of the Committee concerning gender-based violence.

General comments
6. . . . The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.
7. Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of article 1 of the Convention. These rights and freedoms include:
   (a) The right to life;
   (b) The right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment;
   (c) The right to equal protection according to humanitarian norms in time of international or internal armed conflict;
   (d) The right to liberty and security of person;
   (e) The right to equal protection under the law;
   (f) The right to equality in the family;
   (g) The right to the highest standard attainable of physical and mental health;
   (h) The right to just and favourable conditions of work.
8. The Convention applies to violence perpetrated by public authorities. . . .
9. It is emphasized, however, that discrimination under the Convention is not restricted to action by or on behalf of Governments (see articles 2(e), 2(f) and 5). For example, under article 2(e) the Convention calls on States parties to take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise. Under general international law and specific human rights covenants, States may also be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation.

Comments on specific articles of the Convention

Articles 2 and 3
10. Articles 2 and 3 establish a comprehensive obligation to eliminate discrimination in all its forms in addition to the specific obligations under articles 5-16.

Articles 2(f), 5 and 10(c)
11. Traditional attitudes by which women are regarded as subordinate to men or as having stereotyped roles perpetuate widespread practices involving violence or coercion, such as family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision. Such prejudices and practices may justify gender-based violence as a form of protection or control of women. The effect of such violence on the physical and mental integrity of women is to deprive them the equal enjoyment, exercise and knowledge of human rights and fundamental freedoms. . . . [T]he underlying consequences of these forms of gender-based violence help to maintain women in subordinate roles and contribute to the low level of political participation and to their lower level of education, skills and work opportunities.
12. These attitudes also contribute to the propagation of pornography and the depiction and other commercial exploitation of women as sexual objects, rather than as individuals. This in turn contributes to gender-based violence.

Article 6
13. States parties are required by article 6 to take measures to suppress all forms of traffic in women and exploitation of the prostitution of women.
14. Poverty and unemployment increase opportunities for trafficking in women. In addition to established forms... there are new forms of sexual exploitation, such as sex tourism, the recruitment of domestic labour from developing countries to work in developed countries and organized marriages between women from developing countries and foreign nationals. These practices are incompatible with the equal enjoyment of rights by women and with respect for their rights and dignity. They put women at special risk of violence and abuse.
15. Poverty and unemployment force many women, including young girls, into prostitution. Prostitutes are especially vulnerable to violence because their status, which may be unlawful, tends to marginalize them. They need the equal protection of laws against rape and other forms of violence.
16. Wars, armed conflicts and the occupation of territories often lead to increased prostitution, trafficking in women and sexual assault of women, which require specific protective and punitive measures.

Article 11
17. Equality in employment can be seriously impaired when women are subjected to gender-specific violence, such as sexual harassment in the workplace.
18. Sexual harassment includes such unwelcome sexually determined behaviour as physical contact and advances, sexually coloured remarks, showing pornography and sexual demand, whether by words or actions. Such conduct can be humiliating and may constitute a health and safety problem; it is discriminatory when the woman has reasonable grounds to believe that her objection would disadvantage her in connection with her employment, including recruitment or promotion, or when it creates a hostile working environment.

Article 12
19. States parties are required by article 12 to take measures to ensure equal access to health care.
20. In some States there are traditional practices perpetuated by culture and tradition that are harmful to the health of women and children. These practices include dietary restrictions for pregnant women, preference for male children and female circumcision or genital mutilation.

Article 14
21. Rural women are at risk of gender-based violence because traditional attitudes regarding the subordinate role of women that persist in many rural communities. Girls from rural communities are at special risk of violence and sexual exploitation when they leave the rural community to seek employment in towns.

Article 16 (and article 5)
22. Compulsory sterilization or abortion adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children.
23. Family violence is one of the most insidious forms of violence against women. It is prevalent in all societies. Within family relationships women of all ages are subjected to violence of all kinds, including battering, rape, other forms of sexual assault, mental and other forms of violence, which are perpetuated by traditional attitudes. Lack of economic independence forces many
women to stay in violent relationships. The abrogation of their family responsibilities by men can be a form of violence, and coercion. These forms of violence put women's health at risk and impair their ability to participate in family life and public life on a basis of equality.

Specific recommendation
24. In light of these comments, the Committee on the Elimination of Discrimination against Women recommends that:
(a) States parties should take appropriate and effective measures to overcome all forms of gender-based violence, whether by public or private act;
(b) States parties should ensure that laws against family violence and abuse, rape, sexual assault and other gender-based violence give adequate protection to all women, and respect their integrity and dignity. Appropriate protective and support services should be provided for victims. Gender-sensitive training of judicial and law enforcement officers and other public officials is essential for the effective implementation of the Convention;
(c) States parties should encourage the compilation of statistics and research on the extent, causes and effects of violence, and on the effectiveness of measures to prevent and deal with violence;
(d) Effective measures should be taken to ensure that the media respect and promote respect for women;
(e) States parties in their reports should identify the nature and extent of attitudes, customs and practices that perpetuate violence against women and the kinds of violence that result. They should report on the measures that they have undertaken to overcome violence and the effect of those measures;
(f) Effective measures should be taken to overcome these attitudes and practices. States should introduce education and public information programmes to help eliminate prejudices that hinder women's equality (recommendation No. 3, 1987);
(g) Specific preventive and punitive measures are necessary to overcome trafficking and sexual exploitation;
(h) States parties in their reports should describe the extent of all these problems and the measures, including penal provisions, preventive and rehabilitation measures that have been taken to protect women engaged in prostitution or subject to trafficking and other forms of sexual exploitation. The effectiveness of these measures should also be described;
(i) Effective complaints procedures and remedies, including compensation, should be provided;
(j) States parties should include in their reports information on sexual harassment, and on measures to protect women from sexual harassment and other forms of violence of coercion in the workplace;
(k) States parties should establish or support services for victims of family violence, rape, sexual assault and other forms of gender-based violence, including refuges, specially trained health workers, rehabilitation and counselling;
(l) States parties should take measures to overcome such practices and should take account of the Committee's recommendation on female circumcision (recommendation No. 14) in reporting on health issues;
(m) States parties should ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control;
(n) States parties in their reports should state the extent of these problems and should indicate the measures that have been taken and their effect;
(o) States parties should ensure that services for victims of violence are accessible to rural women and that where necessary special services are provided to isolated communities;
(p) Measures to protect them from violence should include training and employment opportunities and the monitoring of the employment conditions of domestic workers;
(q) States parties should report on the risks to rural women, the extent and nature of violence and abuse to which they are subject, their need for and access to support and other services and the effectiveness of measures to overcome violence;
(r) Measures that are necessary to overcome family violence should include:
(i) Criminal penalties where necessary and civil remedies in cases of domestic violence;
(ii) Legislation to remove the defence of honour in regard to the assault or murder of a female family member;
(iii) Services to ensure the safety and security of victims of family violence, including refuges, counselling and rehabilitation programmes;
(iv) Rehabilitation programmes for perpetrators of domestic violence;
(v) Support services for families where incest or sexual abuse has occurred;
(s) States parties should report on the extent of domestic violence and sexual abuse, and on the preventive, punitive and remedial measures that have been taken;
(t) States parties should take all legal and other measures that are necessary to provide effective protection of women against gender-based violence, including, inter alia:
(i) Effective legal measures, including penal sanctions, civil remedies and compensatory provisions to protect women against all kinds of violence, including inter alia violence and abuse in the family, sexual assault and sexual harassment in the workplace;
(ii) Preventive measures, including public information and education programmes to change attitudes concerning the roles and status of men and women;
(iii) Protective measures, including refuges, counselling, rehabilitation and support services for women who are the victims of violence or who are at risk of violence;
(u) States parties should report on all forms of gender-based violence, and such reports should include all available data on the incidence of each form of violence and on the effects of such violence on the women who are victims;
(v) The reports of States parties should include information on the legal, preventive and protective measures that have been taken to overcome violence against women, and on the effectiveness of such measures.


21. The responsibilities that women have to bear and raise children affect their right of access to education, employment and other activities related to their personal development. They also impose inequitable burdens of work on women. The number and spacing of their children have a similar impact on women's lives and also affect their physical and mental health, as well as that of their children. For these reasons, women are entitled to decide on the number and spacing of their children.
22. Some reports disclose coercive practices which have serious consequences for women, such as forced pregnancies, abortions or sterilization. Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government. In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10 (h) of the Convention.

“The Committee on the Elimination of Discrimination against Women, affirming that access to health care, including reproductive health is a basic right under the Convention on the Elimination of Discrimination against Women, determined at its 20th session, pursuant to article 21, to elaborate a general recommendation on article 12 of the Convention.”

In Article 24, the Committee on the Elimination of Discrimination against Women recommends that states take measures to address and prevent all forms of gender violence. Such measures include, but are not limited to, providing support services for victims, compiling statistics about the prevalence of gender violence, training for media representatives to ensure positive media representation of women, penal sanctions for human trafficking, and preventive measures tackling domestic violence.


[Note from Stephanie to Maggie: is there more in the above general recommendation 24 on health that we should be quoting here? Thanks. My trouble with quoting from this recommendation is that it is extremely lengthy and is all relevant to our topic – it seems too long to quote. That said, let me know if that’s what you’d like me to do, and I'll be happy to. – Maggie]

Maggie, perhaps you can summarize and then state “See the complete text of the General Recommendation available at: http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm
(Did so, see above- Natalie)


The concrete forms of discrimination against older women may differ considerably in various socioeconomic circumstances and socio-cultural environments, in which equality of opportunities and choices regarding education, work, health, family and private life have been enhanced or limited. In many countries the lack of telecommunication skills, access to internet or adequate housing and social services, loneliness and isolation pose problems for older women while older women living in rural areas or urban slums often suffer a severe lack of basic resources for subsistence, income security, access to healthcare and information on and enjoyment of their entitlements and rights. Paragraph 11.

[L]ack of or limited access to health care services for diseases and geriatric conditions such as diabetes, cancer, in particular the most prevalent forms of cancer among older women, hypertension, heart disease, cataract, osteoporosis and Alzheimer prevent older women from enjoying their full human rights. Paragraph 14.

Gender stereotyping and traditional and customary practices can have harmful impacts on all areas of the lives of older women, in particular older women with disabilities,
including on family relationships, community roles, their portrayal in the media, attitudes of employers, health workers and other service providers and can result in violence and psychological, verbal and financial abuse. Paragraph 16.

Older refugee and internally displaced women are sometimes denied access to health care because they lack legal status in the country of asylum, lack legal documentation, and are resettled far from health-care facilities, or experience cultural and language barriers in accessing services. Paragraph 18.

The right to self-determination and consent regarding health care of older women are not always respected. Social services, including provisions for long term care, for older women might be disproportionately reduced when public expenditure is cut. Postmenopausal, post-reproductive and age-related physical and mental health conditions and diseases tend to be neglected in research, academic studies, public policy and service provision. Information on sexual health, HIV and AIDS is rarely provided in a form that is acceptable, accessible and appropriate for older women. Many older women have no private health insurance or are excluded from State-provided schemes because they have not contributed to schemes during a lifetime of work in the informal sector or in unpaid care. Paragraph 21.

States parties, in order to support legal reform and policy formulation, should collect, analyse and disseminate data disaggregated by age and sex and so provide information on the situation of older women, including those living in rural areas, in areas of conflict, older women belonging to minority groups, and older women with disabilities. Such data should especially focus on, amongst other issues: poverty, illiteracy, violence, unpaid work, including care-giving to those living with or affected by HIV/AIDS, and migration, as well as access to health care, housing, social and economic benefits and employment. Paragraph 32.

States parties should adopt a comprehensive health care policy for the protection of the health needs of older women in keeping with General Recommendation 24 on women and health. This should ensure affordable and accessible health care to all older women through, where appropriate, the elimination of user fees for them, the training of health workers in geriatric illnesses, the provision of medicine to treat age-related chronic and non-communicable diseases, long term health and social care, including care that allows for independent living, and palliative care. This should also include interventions promoting behavioural and lifestyle changes to delay onset of health problems, such as healthy nutritional practices and active living, and affordable access to healthcare services, including screening and treatment for diseases, in particular those most prevalent among older women. Health policies must also ensure that health care provided to older women, including those with disabilities, is based on the free and informed consent of the person concerned. Paragraph 45.

States parties should adopt special programmes tailored to address the physical, mental, emotional, and health needs of older women with special focus on women belonging to minorities and women with disabilities and those tasked with caring for grandchildren and other young family dependents due to the migration of young adults or caring for family members living with or affected by HIV/AIDS. Paragraph 46.

Committee on the Elimination of Discrimination against Women, Concluding observations on the fourth periodic reports of Kyrgyzstan, CEDAW/C/KGZ/CO/4, March 6, 2015, available at:
B. Principle Areas of Concern and Recommendations:

10. The Committee urges the State party to:

(a) Ensure that the discriminatory draft law No. 6-11804/14 is not adopted; and

(b) Adopt comprehensive anti-discrimination legislation which prohibits discrimination against women on all grounds. . .

Ratification of other treaties

43. The Committee notes that the adherence of the State party to the nine major international human rights instruments would enhance the enjoyment by women of their human rights and fundamental freedoms in all aspects of life. The Committee therefore encourages the State party to consider ratifying the International Convention for the Protection of All Persons from Enforced Disappearance and the Convention on the Rights of Persons with Disabilities, to which it is not yet a party.

Committee on the Elimination of Discrimination against Women ,
Concluding observations on the eighth and ninth periodic reports of Ecuador, CEDAW/C/ECU/CO/8-9, March 6, 2015, available at:

B. Positive Aspects

6. The Committee welcomes the State party’s ratification, since the consideration of its previous periodic report in 2008, of the following international instruments. . .


C. Principle Areas of Concern and Recommendations:

Legislation on discrimination against women

10. The Committee acknowledges the adoption of the Comprehensive Organic Criminal Code (COIP), stating that the following conducts constitute criminal conducts “femicide” (art. 146), and “discrimination” on the basis of “sex”, “gender identity”, “sexual orientation” and other grounds (art. 176). It also welcomes the State party comprehensive legislative and policy framework for the elimination of discrimination against women. However, the Committee is concerned about:

(a) The challenges for the effective implementation of such a framework, in particular at the local level and in remote areas, and the slow progress in bringing about the necessary changes in institutions to enforce legislation and public policies; and

(b) De facto and intersectional discrimination faced by indigenous, Afro-Ecuadorian and Montubio women, women with disabilities, migrant women, women asylum seekers, and refugee women, and the limited information disaggregated by sex, ethnicity and social condition on the impact of legislation and policies on the situation of women.
Temporary Special measures

16. The Committee welcomes the constitutional and legislative provisions adopted by the State party to accelerate equality between women and men in the areas of political and economic participation. The Committee, however, is concerned at the limited implementation of these provisions at the local level. It notes with concern the absence of information on the adoption of temporary special measures aimed at reducing discrimination against indigenous, Afro-Ecuadorian and Montubio women, migrant women, and women with disabilities.

17. The Committee recommends that the State party:

(a) Ensure that public authorities effectively apply temporary special measures at the local level, and monitor and evaluate the impact and results of temporary special measures in areas where women are still underrepresented; and

(b) Distinguish in its policies and programmes between general social and economic policies that benefit women and temporary special measures under article 4 (1) of the Convention that are necessary to accelerate the achievement of substantive equality of women and men, as clarified by the Committee in its general recommendation 25 on temporary special measures, and use temporary special measures with specific targets and timeframes, to accelerate the achievement of substantive gender equality for disadvantaged groups of women such as indigenous, Afro-Ecuadorian and Montubio women, migrant women, and women with disabilities in fields such as political participation, education, employment and health.

21. The Committee, recalling its General Recommendation No. 19 on violence against women (1992), urges the State party to:

(c) Enact legislation providing for immediate protection of women victims of violence upon the first report of violence, including through restraint orders against alleged perpetrators;

(d) Ensure that a sufficient number of State-funded shelters are available to women victims of domestic violence and their children, and that support services such as counselling and rehabilitation are fully accessible to women living in rural and remote areas and women with disabilities.

Committee on the Elimination of Discrimination against Women,

B. Positive Aspects
5. The Committee also welcomes the fact that, in the period since the consideration of the previous report, the State party has ratified or acceded to the following international instruments:

   (a) The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, in 2014.

C. Principal Areas of Concern and Recommendations:

17. The Committee calls upon the State party to increase the use of temporary special measures, in accordance with article 4 (1) of the Convention and the Committee’s General Recommendation No. 25 (2004) on temporary special measures, as a necessary strategy to accelerate the achievement of substantive equality of women and men; in particular to enhance the rights of rural women, older women and women with disabilities, and in all areas covered by the Convention where women are underrepresented or disadvantaged. The temporary special measures used, in particular quotas, should be available to all women, irrespective of their political affiliation.

Ratification of other treaties

49. The Committee notes that the adherence of the State party to the nine major international human rights instruments would enhance the enjoyment by women of their human rights and fundamental freedoms in all aspects of life. The Committee therefore encourages the State party to consider ratifying the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, the Convention on the Rights of Persons with Disabilities and the International Convention for the Protection of All Persons from Enforced Disappearance, to which it is not yet a party.

Committee on the Elimination of Discrimination against Women,
Concluding observations on the Sixth periodic report of Gabon,
CEDAW/C/GAB/CO/6, March 6, 2015, available at:

B. Positive Aspects:

6. The Committee welcomes the ratification by the State party of the following international treaties since the consideration of its previous report:

   (a) Convention for the Protection of All Persons from Enforced Disappearance, in 2011; and

C. Principal Areas of Concern and Recommendations

Disadvantaged groups of women

40. The Committee is concerned at the lack of disaggregated data on the challenges that disadvantaged groups of women face in the enjoyment of their rights under the Convention, including internally displaced women, refugee women, girls living in the street, older women, women with disabilities, widows, women migrant workers, women prisoners, and women living in poverty.
41. The Committee calls upon the State party to collect disaggregated data on the status of disadvantaged groups of women, including refugee women, girls living in the street, older women, women with disabilities, widows, women migrant workers, women prisoners and women living in poverty, focusing on intersecting forms of discrimination which they encounter; and pay special attention to their needs to ensure that they enjoy equal access to basic services.

Ratification of other treaties

51. The Committee notes that the adherence of the State party to the nine major international human rights instruments [including the Convention on the Rights of Persons with Disabilities] would enhance the enjoyment by women of their human rights and fundamental freedoms in all aspects of life.

Committee on the Elimination of Discrimination against Women,

B. Positive Aspects

5. The Committee welcomes the progress achieved since the consideration in 2009 of the State party's combined initial and second periodic reports (CEDAW/C/TUV/2) in undertaking legislative reforms, in particular the adoption of:

(a) The Family Protection and Domestic Violence Act (2014), which prohibits domestic violence offences and provides enhanced protection of women and girls from domestic violence;

7. The Committee welcomes the fact that, in the period since the consideration of the previous report, the State party has acceded to the Convention on the Rights of Persons with Disabilities, in 2013.

Data collection and analysis

35. The Committee is concerned at the general lack of data disaggregated by sex, age, race, ethnicity, geographical location and socioeconomic background in the areas covered by the Convention, which are necessary for an assessment of the situation of women, informed and targeted policymaking and for the systematic monitoring and evaluation of progress achieved in the realization of women’s substantive equality in all areas covered by the Convention.

36. The Committee calls on the State party to implement systems of collection, analysis and dissemination of comprehensive data disaggregated by sex, age, disability, race, ethnicity, geographic location and socioeconomic background and to use measurable indicators to assess trends in the situation of women and the progress achieved in the realization of women’s substantive equality in all areas covered by the Convention. In this regard, it draws the State party’s attention to the Committee’s general recommendation No. 9 (1989) on statistical data
concerning the situation of women, and encourages it to develop gender-sensitive indicators that could be used in the formulation, implementation, monitoring, evaluation and, when necessary, review of gender equality policies. . .

Ratification of other treaties

42. The Committee notes that the adherence of the State party to the nine major international human rights instruments would enhance the enjoyment by women of their human rights and fundamental freedoms in all aspects of life. The Committee therefore encourages the State party to consider ratifying the treaties to which it is not yet a party, namely, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, the International Convention for the Protection of All Persons from Enforced Disappearance and the Convention on the Rights of Persons with Disabilities.

Committee on the Elimination of Discrimination against Women,


A. Introduction

2. The Committee appreciates that the State party submitted its fifth periodic report. It also appreciates the State party's written replies to the list of issues and questions raised by its pre-session working group. It welcomes the constructive dialogue with the delegation, the oral presentation of the delegation and the further clarifications provided in response to the questions posed orally by the Committee during the dialogue. . .

C. Principle Areas of Concern and Recommendations

Temporary special measures

18. The Committee is concerned that despite the provision in Article 3.2.6 of the Law on Guarantees of Gender Equality, temporary special measures have been underutilized by the State Party to accelerate de facto equality and to address the under representation of women in public and political life as well as the situation of disadvantaged and marginalized women who are subjected to intersecting forms of discrimination, such as rural women, women with disabilities, internally displaced women, refugees and older women.

19. The Committee recommends that the State party adopt temporary special measures, including quotas, in accordance with article 4 (1) of the Convention and in line with the Committee’s General Recommendation No. 25, 2004 on the subject, as part of a necessary strategy to accelerate the achievement of substantive equality of women and men. It also recommends that the State party adopt temporary special measures targeting disadvantaged and marginalized groups of women, including rural women, women with disabilities, internally displaced women, refugees and older women, evaluate the impact of such measures and make its findings, including gender-relevant statistics, available to the public.
Committee on the Elimination of Discrimination against Women,
Concluding observations on the combined third and fourth periodic reports of the Maldives, CEDAW/C/TUV/CO/4-5, March 6, 2015, available at:

A. Introduction

2. The Committee appreciates that the State party submitted its combined fourth and fifth combined periodic reports. It also appreciates the State party's written replies to the list of issues and questions. It welcomes the constructive dialogue that took place between the delegation and the Committee, and the further clarifications provided in response to the questions posed orally by the Committee during the dialogue...

B. Positive Aspects

5. The Committee welcomes the State party’s efforts to improve its institutional and policy framework aimed at accelerating the elimination of discrimination against women and promoting equality of women and men, in particular the establishment of the Family Protection Authority, in 2012, and the adoption of the Domestic Violence Prevention National Strategy (2014-2016).

6. The Committee welcomes the fact that, in the period since the consideration of the previous report, the State party has ratified the Convention on the Rights of Persons with Disabilities.

C. Principal areas of concern and recommendations . . .

19. The Committee recommends that the State party:

(a) Intensify its efforts to sensitize political parties on the nature and scope of temporary special measures with a view to familiarizing them with the concept of temporary special measures; and

(b) Include a legislative basis for the adoption of temporary special measures in the Gender Equality Bill and implement temporary special measures in various forms, such as outreach and support programmes, quotas and other proactive and results-oriented measures aimed at achieving substantive equality of women with men in all areas, especially in economic, political and public life, where women are underrepresented; and to use these measures to address the disadvantages and inequalities faced by women outside of Male and in remote islands, by migrant women, women with disabilities and women heads of household.


Consideration of the merits
11.1 The Committee has considered the present communication in light of all the information made available to it by the author and by the State party, as provided in article 7, paragraph 1, of the Optional Protocol.
11.2 According to Article 10 (h) of the Convention:

With respect to the claim that the State party [Hungary] violated article 10 (h) of the Convention by failing to provide information and advice on family planning, the Committee recalls its general recommendation No. 21 on equality in marriage and family relations, which recognizes in the context of “coercive practices which have serious consequences for women, such as forced … sterilization” that informed decision-making about safe and reliable contraceptive measures depends upon a woman having “information about contraceptive measures and their use, and guaranteed access to sex education and family planning services”. The Committee notes the State party’s arguments that the author was given correct and appropriate information . . . as well as its argument that, according to the decision of the lower court, the author had been in a condition in which she was able to understand the information provided. On the other hand, the Committee notes the author’s reference to the judgement of the appellate court, which found that the author had not been provided with detailed information about the sterilization, including the risks involved and the consequences of the surgery, alternative procedures or contraceptive methods. The Committee considers that the author has a right protected by article 10 (h) of the Convention to specific information on sterilization and alternative procedures for family planning in order to guard against such an intervention being carried out without her having made a fully informed choice. Furthermore, the Committee notes the description given of the author’s state of health on arrival at the hospital and observes that any counselling that she received must have been given under stressful and most inappropriate conditions. . . . [T]he Committee finds a failure of the State party . . . to provide appropriate information and advice on family planning, which constitutes a violation of the author’s right under article 10 (h) of the Convention.

11.3 With regard to the question of whether the State party violated the author’s rights under article 12 of the Convention by performing the sterilization surgery without obtaining her informed consent, the Committee takes note of the author’s description of the 17 minute timespan from her admission to the hospital up to the completion of two medical procedures. Medical records revealed that the author was in a very poor state of health upon arrival at the hospital; she was feeling dizzy, was bleeding more heavily than average and was in a state of shock. During those 17 minutes, she was prepared for surgery, signed the statements of consent for the caesarean section, the sterilization, a blood transfusion and anaesthesia and underwent two medical procedures, namely, the caesarean section to remove the remains of the dead foetus and the sterilization. The Committee further takes note of the author’s claim that she did not understand the Latin term for sterilization that was used on the barely legible consent note that had been handwritten by the doctor attending to her, which she signed. The Committee also takes note of the averment of the State party to the effect that, during those 17 minutes, the author was given all appropriate information in a way in which she was able to understand it. The Committee finds that it is not plausible that . . . hospital personnel provided the author with thorough enough counselling and information about sterilization, as well as alternatives, risks and benefits, to ensure that the author could make a well-considered and voluntary decision to be sterilized. The Committee also takes note of the unchallenged fact that the author enquired of the doctor when it would be safe to conceive again, clearly indicating that she was unaware of the consequences of sterilization. According to article 12 of the Convention, States parties shall “ensure to women appropriate services in connexion with pregnancy, confinement, and the post-natal period”. The Committee explained in its general recommendation No. 24 on women and health that “[A]cceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity…” The Committee further stated that “States parties should not permit forms of coercion, such as non-consensual sterilization … that violate women’s rights to informed consent and dignity”. The Committee considers in the present case that the
State party has not ensured that the author gave her fully informed consent to be sterilized and that consequently the rights of the author under article 12 were violated.

11.4. As to whether the State party violated the rights of the author under article 16, paragraph 1 (e) of the Convention, the Committee recalls its general recommendation No. 19 on violence against women in which it states that “[C]ompulsory sterilization ... adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children”. The sterilization surgery was performed on the author without her full and informed consent and must be considered to have permanently deprived her of her natural reproductive capacity. Accordingly . . . the author’s rights under article 16, paragraph 1 (e) . . . have been violated.

11.5 Acting under article 7, paragraph 3 of the Optional Protocol to the [CEDAW], the Committee on the Elimination of Discrimination against Women is of the view that the facts before it reveal a violation of articles 10 (h), 12 and 16, paragraph 1 (e) of the Convention and makes the following recommendations to the State party:

I. Concerning the author of the communication: provide appropriate compensation to Ms. A. S. commensurate with the gravity of the violations of her rights.

II. General:

• Take further measures to ensure that the relevant provisions of the Convention and the pertinent paragraphs of the Committee’s general recommendations Nos. 19, 21 and 24 in relation to women’s reproductive health and rights are known and adhered to by all relevant personnel in public and private health centres, including hospitals and clinics.

• Review domestic legislation on the principle of informed consent in cases of sterilization and ensure its conformity with international human rights and medical standards, including the Convention of the Council of Europe on Human Rights and Biomedicine (“the Oviedo Convention”) and World Health Organization guidelines. In that connection, consider amending the provision in the Public Health Act whereby a physician is allowed “to deliver the sterilization without the information procedure generally specified when it seems to be appropriate in given circumstances”.

• Monitor public and private health centres, including hospitals and clinics, which perform sterilization procedures so as to ensure that fully informed consent is being given by the patient before any sterilization procedure is carried out, with appropriate sanctions in place in the event of a breach.

11.6 In accordance with article 7, paragraph 4, the State party shall give due consideration to the views of the Committee, together with its recommendations, and shall submit to the Committee, within six months, a written response, including any information on any action taken in the light of the views and recommendations of the Committee. The State party is also requested to publish the Committee’s views and recommendations and to have them translated into the Hungarian language and widely distributed in order to reach all relevant sectors of society.


26. The Committee notes with concern that, despite a large number of policies and programmes adopted by the State party to address underrepresentation of certain vulnerable groups of women, including indigenous women, women with disabilities, migrant women, women from culturally and linguistically diverse backgrounds and women from remote or rural communities, there has been slow progress in ensuring . . . their equal access to education, employment and health. The Committee continues to be concerned that the State party does not favour adoption of temporary
special measures in the form of compulsory targets and quotas to address . . . the persistent inequality of their access to education, employment opportunities and health-care services.

40. . . . The Committee . . . continues to be concerned that indigenous women have fewer opportunities and more restricted access to quality education, health care and legal aid services.

41. The Committee . . . urges the State party to implement specific strategies within the national plan to address violence against Aboriginal and Torres Straits Islander women, including funding culturally appropriate indigenous women’s legal services in urban, rural and remote areas of Australia. It recommends that the State party pay particular attention to ensuring access to quality education, including post-graduate education, vocational training, adequate health and social services, legal literacy and access to justice.

42. . . . The Committee . . . notes with concern that non-therapeutic sterilizations of women and girls with disabilities continue to be practiced in some states in Australia and notes that the Commonwealth Government considers this to be a matter for state governments to regulate.

43. The Committee urges the State party, in the light of its recent ratification of the Convention on the Rights of Persons with Disabilities, to undertake a comprehensive assessment of the situation of women with disabilities in Australia. . . . The Committee recommends that the State party enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilization of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.

45. The Committee urges the State party to ensure the full and effective enforcement of the measures taken to protect migrant women. . . . The Committee urges the State party to develop a broad framework for health services for migrant women that will take into account their specific health profiles.


17. The Committee notes the efforts of the State party to address conflict-related gender-based violence, including sexual violence, such as Law No. 1448 (2011). . . . In this context, it is particularly concerned at:

(b) The obstacles faced by women seeking access to justice, such as sex and gender discrimination against them by police officers and prosecutors, the lack of adequate training and sensitization for justice officials, the lack of legal aid and the limited health-care and psychosocial services for victims of sexual violence, including immediate access to forensic testing.

18. The Committee recommends that the State party . . . [e]nsure the access of victims to comprehensive medical treatment, mental health care and psychosocial support provided by health professionals who are appropriately trained to detect sexual violence and to treat its consequences; and ensure that women victims of sexual violence are promptly provided access to forensic testing.

Health
29. The Committee expresses its concern at:
(a) The very limited implementation of Constitutional Court ruling C-355 (2006), which guarantees access to legal abortion under the grounds of life or health risks for the mother, rape and serious malformations of the foetus; the public campaigning against its implementation by high authorities of the State party; and the prevalence of invasive and expensive abortion procedures;
(b) The high number of unsafe abortions and the refusal by health professionals to provide post-abortion services to women;
(c) The high prevalence of teenage pregnancy;
(d) The high rate of childbearing women who use sterilization as a family planning method;
(e) Cases of forced sterilization of women with disabilities and those living with HIV/AIDS.

30. The Committee recommends that the State party:
(a) Guarantee women’s access to legal abortion by ensuring compliance with Constitutional Court ruling C-355 (2006), developing monitoring and accountability mechanisms, including sanctions, sensitizing the relevant authorities and professionals on health and sexual and reproductive rights; and expanding the availability of medically safe modern abortion methods;
(b) Ensure the provision of post-abortion health-care services for women who have undergone an unsafe abortion;
(c) Effectively implement the Policy on the Prevention of Teenage Pregnancies (2012) and ensure universal access to health services and information on sexual and reproductive health and rights and education, particularly of adolescent girls and boys;
(d) Take measures to decrease the use of sterilization as a family planning method by conducting awareness-raising campaigns on the use of modern reversible contraceptive methods and ensuring their availability for girls and women of childbearing age;
(e) Amend and develop the regulatory framework, as well as guidance provided to medical practitioners, to ensure that sterilization is carried out with the free and informed consent of women, including women with disabilities and those living with HIV/AIDS.

34. The Committee recommends that the State party:
(c) [E]nsure that indigenous and Afro-Colombian women have adequate access to health-care services . . . .


21. In accordance with its general recommendation No. 19 (1992) on violence against women and the recommendations contained in its previous concluding observations, the Committee urges the State party to . . . ensure appropriate and easily accessible health-care services for women victims of rape combined with immediate medical and forensic examination to collect the evidence needed for prosecution of the perpetrators.

Health

30. The Committee notes the State party’s statement that the new article in the Fundamental Law protecting life from the moment of conception will not be used to restrict the present legislation and the access of women to abortion. The Committee is concerned about campaigns, including a recent poster campaign, supported by the State party that stigmatize abortion and seek to negatively influence the public view on abortion and contraception; the limited access to
emergency contraceptives; the subjection of women who want surgical abortion to biased mandatory counselling and a three-day medically unnecessary waiting period; and at the increasing resort to conscientious objection by health professionals in the absence of an adequate regulatory framework. The Committee is also concerned at the limited access to modern, efficient methods of contraception, and the lack of choice for women on whether to give birth at home or in the hospital, due to various obstacles, including the non-recognition of midwives as independent professionals.

31. The Committee urges the State party to:
   (a) Cease all negative interference with women’s sexual and reproductive rights, including by ending campaigns that stigmatize abortion and seek to negatively influence the public view on abortion and contraception;
   (b) Provide adequate access to family planning services and affordable contraceptives, including emergency contraception, to all women including women with disabilities, Roma women, women living with HIV/AIDS and migrant and refugee women, i.e., by covering the costs of range of modern contraceptives under the public health insurance and eliminating the prescription requirement for emergency contraception;
   (c) Ensure access to safe abortion without subjecting women to mandatory counselling and a medically unnecessary waiting period as recommended by the World Health Organization;
   (d) Establish an adequate regulatory framework and a mechanism for monitoring of the practice of conscientious objection by health professionals and ensure that conscientious objection is accompanied by information to women about existing alternatives and that it remains a personal decision rather than an institutionalized practice; and
   (e) Ensure women’s choice to give birth at home or in the hospital by recognizing trained midwives as independent professionals and by elaborating a legal framework and guidelines on security of home deliveries, and providing training of obstetricians.

32. The Committee also notes with concern the limited access to and inadequate quality of sexual and reproductive health services for women with disabilities, women with low income, Roma women, women living in rural areas and women living with HIV/AIDS, including in view of their privatization. The Committee remains concerned that women with disabilities face sterilization without their free and informed consent, and are excluded from gynaecological and breast-screening tests. The Committee is further concerned at the absence or insufficient quality of education on sexual and reproductive health and rights in regular school curricula.

33. The Committee urges the State party to:
   (a) Improve the quality of and increase women’s access to sexual and reproductive health services, in particular for women with disabilities, women with low income, Roma women and women living in rural areas, and ensure that women living with HIV/AIDS or suffering from sexually transmitted diseases have access to health services;
   (b) Eliminate forced sterilization of women with disabilities by training health professionals, raising their awareness toward their own prejudices, and repeal or amend Act CLIV of 1997 which enables doctors to perform forced sterilizations on very wide grounds, contrary to international health standards on free and informed consent of persons with disabilities; and
   (c) Ensure adequate and continuous age and gender-sensitive education on sexual and reproductive health and rights in primary and secondary schools by properly trained teachers.

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,” to retain fertility on an equal basis with others, including for children with disabilities, and to health on an equal basis with others, “including in the area of sexual and reproductive health and population-based public health programs.”

Art. 3: The principles of the present Convention shall be . . . [e]quality between men and women.

Art. 6: Women with disabilities

1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.

2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

Art. 7: Children with disabilities

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.

2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.

3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

Art. 8: Awareness-raising

1. States Parties undertake to adopt immediate, effective and appropriate measures . . . [t]o combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life.

Article 12:

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time
possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests. . .

Article 13: Access To Justice
1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.
2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff. . .

Article 16
Freedom from exploitation, violence and abuse
1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.

2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Article 23
Respect for home and the family
1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

(a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;
(b) The rights of persons with disabilities 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 are recognized, and the means necessary to enable them to exercise these rights are provided;

(c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

Article 25
Health

1. States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people’s own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent . . . ;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Art. 28: Adequate standard of living and social protection

2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures . . . [t]o ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes.

Women with disabilities (Art. 6)

13. The Committee takes note with concern of the unconvincing measures taken by the State party to address the specific needs of women and girls with disabilities, and it regrets the lack of proper protection for their rights (see CEDAW/C/ARG/CO/6, paras. 43 and 44). It is particularly concerned that there is no strategy for mainstreaming gender and disability issues into legislation and programmes focusing on women, including those that deal with violence, access to justice, sexual and reproductive rights, and access to the labour market.

14. The Committee urges the State party to adopt a strategy for guaranteeing full protection and enjoyment of the rights of women and girls with disabilities, while also ensuring their effective participation in decision-making processes. In addition, the Committee recommends that the State party incorporate a disability perspective into all gender-equality policies and programmes, thereby guaranteeing the full and effective participation of women with disabilities on the same footing as other women.

Freedom from exploitation, violence and abuse (art. 16)

29. The Committee notes with concern that neither Act No. 26.485 on comprehensive protection and the prevention, punishment and elimination of violence against women nor Act No. 26.061 on the comprehensive protection of the rights of children and adolescents takes account of the specific situation of women with disabilities and children with disabilities, respectively. The Committee is also concerned about the lack of protection against violence and abuse for institutionalized persons with disabilities.

30. The Committee urges the State party to guarantee protection for women with disabilities and children with disabilities in, respectively, the revised versions of Act No. 26.485 and Act. No. 26.061 and their implementing regulations. It also urges the State party to incorporate a disability perspective into policies and programmes developed on the basis of these acts. In addition, it recommends that the State party draw up appropriate guidelines for the prevention of violence against persons with disabilities who are institutionalized. The Committee also recommends that the State party collect data and information on violence and abuse against persons with disabilities, paying particular attention to women, children and persons who are institutionalized. To that end, the State party should, inter alia, establish institutional mechanisms for the early detection of situations in which violence may occur, diligently investigate allegations of violent acts and make any adjustments in procedures that may be needed so that victims can testify and those responsible can be prosecuted.

Protecting the integrity of the person (art. 17)

31. The Committee regrets that, in cases where a woman with disabilities is under guardianship, her legal representative may give consent for a legal abortion on her behalf. It is likewise concerned that persons with disabilities are being sterilized without their free and informed consent.

32. The Committee recommends that the State party amend article 86 of its Criminal Code and article 3 of Contraceptive Surgery Act No. 26.130 so that they will be in accordance with the
Convention and take steps to provide the necessary support to women under guardianship or trusteeship to ensure that the women themselves are the ones who give their informed consent for a legal abortion or for sterilization.

Respect for home and the family (art. 23)

35. The Committee notes with concern that the right to form a family is denied to some persons with disabilities, especially those declared “insane” or “lacking legal capacity”, in accordance with article 309 of the State party’s Civil Code.

36. The Committee urges the State party to amend the Civil Code to bring it into line with article 12 and article 23, paragraph 1 (b), of the Convention and to make support services to assist with the demands of parenthood available to persons with disabilities who require them.


Equality and non-discrimination (art. 5)

14. The Committee is concerned that the scope of the protected rights and grounds of discrimination in the Disability Discrimination Act of 1992 is narrower than that provided for under the Convention and does not provide the same level of legal protection to all persons with disabilities.

15. The Committee recommends that the State party strengthen anti-discrimination laws to address intersectional discrimination and to guarantee protection from discrimination on the grounds of disability so as to explicitly cover all persons with disabilities, including children, indigenous people, women and girls, the hearing impaired, the deaf and persons with psychosocial disabilities.

Women with disabilities (art. 6)

16. The Committee is concerned at reports of the high incidence of violence against, and sexual abuse of, women with disabilities.

17. The Committee recommends that the State party include a more comprehensive consideration of women with disabilities in public programmes and policies on the prevention of gender-based violence, particularly so as to ensure access for women with disabilities to an effective, integrated response system.

Liberty and security of the person (art. 14)

31. The Committee is concerned that persons with disabilities who are deemed unfit to stand trial due to an intellectual or psychosocial disability can be detained indefinitely in prisons or psychiatric facilities without being convicted of a crime and for periods that can significantly exceed the maximum period of custodial sentence for the offence. The Committee is equally concerned that persons with disabilities are overrepresented in both the prison and juvenile justice systems, in particular women, children, Aboriginal and Torres Strait Islander persons with disability.
32. The Committee recommends that the State party, as a matter of urgency:

(a) End the unwarranted use of prisons for the management of unconvicted persons with disabilities, focusing on Aboriginal and Torres Strait Islander persons with disabilities, by establishing legislative, administrative and support frameworks that comply with the Convention;

(b) Establish mandatory guidelines and practice to ensure that persons with disabilities in the criminal justice system are provided with appropriate support and accommodation;

(c) Review its laws that allow for the deprivation of liberty on the basis of disability, including psychosocial or intellectual disabilities, and repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability.

33. The Committee is further concerned that under Australian law a person can be subjected to medical intervention against his or her will, if the person is deemed to be incapable of making or communicating a decision about treatment.

34. The Committee recommends that the State party repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.

Freedom from exploitation, violence and abuse (art. 16)

37. The Committee is concerned at reports of high rates of violence perpetrated against women and girls living in institutions and other segregated settings.

38. The Committee recommends that the State party investigate without delay the situations of violence, exploitation and abuse experienced by women and girls with disabilities in institutional settings, and that it take appropriate measures on the findings.

Integrity of the person (art. 17)

39. The Committee is deeply concerned that the Senate inquiry report into the involuntary or coerced sterilization of persons with disabilities, released in July 2013, puts forward recommendations that would allow this practice to continue. The Committee further regrets the State party’s failure to implement the recommendations made by the Committee on the Rights of the Child (CRC/C/15/Add.268; CRC/C/AUS/CO/4), the Working Group on the Universal Periodic Review (A/HRC/17/10) and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53), which address concerns regarding sterilization of children and adults with disabilities.

40. The Committee urges the State party to adopt uniform national legislation prohibiting the sterilization of boys and girls with disabilities, and adults with disabilities, in the absence of their prior, fully informed and free consent.

Right to work (art. 27)

49. The Committee is concerned that employees with disabilities in Australian Disability Enterprises are still being paid wages based on the Business Services Wage Assessment Tool.
50. The Committee recommends that the State party adopt initiatives to increase employment participation by women with disabilities by addressing the specific underlying structural barriers to their workforce participation.

Statistics and data collection (art. 31)

53. The Committee regrets the low level of disaggregated data collected on persons with disabilities and reported publicly. It further regrets that there is little data on the specific situation of women and girls with disability, in particular indigenous women and girls with disabilities.

54. The Committee recommends that the State party develop nationally consistent measures for data collection and public reporting of disaggregated data across the full range of obligations provided for in the Convention, and that all data be disaggregated by age, gender, type of disability, place of residence and cultural background. The Committee further recommends that the State party commission and fund a comprehensive assessment of the situation of girls and women with disabilities, in order to establish a baseline of disaggregated data against which future progress towards the implementation of the Convention can be measured.

56. The Committee recommends that the State party systematically collect, analyse and disseminate data, disaggregated by gender, age and disability, on the status of children, including any form of abuse and violence against children. It further recommends that the State party commission and fund a comprehensive assessment of the situation of children with disabilities in order to establish a baseline of disaggregated data against which future progress towards the implementation of the Convention can be measured.


Equality and non-discrimination (art. 5)

15. The Committee recommends that the State party abolish any distinction, allowed by law, in the period within which a pregnancy can be terminated based solely on disability.

Women with disabilities (art. 6)

18. The Committee recommends that the State party adopt effective and specific measures to ensure equality and to prevent multiple forms of discrimination against women and girls with disabilities. The Committee encourages the State party to mainstream a gender perspective in its disability legislation and policy, and to facilitate advocacy by and on behalf of women and girls with disabilities. The Committee also encourages the State party, including the Länder, to offer services which are targeted and accessible to women with disabilities.

Work and employment (art. 27)

47. The Committee recommends that the State party enhance programmes to employ persons with disabilities in the open labour market. The Committee further recommends that measures be put in place to narrow the employment and pay gender gap.

Statistics and data collection (art. 31)
51. The Committee recommends that the State party systematize the collection, analysis and dissemination of data on women and girls with disabilities, and enhance capacity-building in this regard. It should develop gender-sensitive indicators to support legislative developments, policymaking and institutional strengthening for monitoring, and report on progress made with regard to the implementation of the various provisions of the Convention.

CRPD Committee, Concluding Observations, China, U.N. Doc. CRPD/C/CHN/CO/1 (2012); China. UN Doc. No: CRPD/C/CHN/CO/1; 27 September 2012

Respect for home and the family (art. 23)

34. The Committee calls upon the State party to revise its laws and policies in order to prohibit compulsory sterilization and forced abortion on women with disabilities.

Women with disabilities (art. 6)

58. The Committee recommends that the Women’s Commission of Hong Kong, China, should integrate the amelioration of the living situation of women and girls with disabilities into their mandate and include a representative of women with disabilities in its Commission. It also asks Hong Kong, China, to raise awareness on article 6 of the Convention, so as to ensure that women with disabilities enjoy their rights on an equal basis with men. In addition, the Committee calls upon Hong Kong, China, to prevent domestic violence against women with disabilities and to prosecute and punish the perpetrators and all those responsible.

Freedom from exploitation, violence, and abuse (art. 16)

66. The Committee suggests that Hong Kong, China, continue investigating these incidents and prosecute the perpetrators and all those responsible. It also recommends that sex education be taught to children and adolescents with intellectual disabilities and that the law enforcement personnel be trained on handling violence against women and girls with disabilities.

CRPD Committee, Concluding Observations, El Salvador.

Women with disabilities (art. 6)

18. The Committee recommends that the State party recognize in the law the multiple forms of discrimination against women and girls with disabilities and that it adopt specific legislation and strategies to fight them. The Committee recommends setting up a mechanism for the collection of disaggregated data on the situation of women and girls with disabilities, in consultation with organizations of women with disabilities.

Access to justice (art. 13)

30. The Committee calls on the State party to:

(a) Put in place reasonable procedural accommodation with a gender and age focus to ensure access to justice for persons with disabilities and to provide free legal assistance, information on each case — as early as the police investigation — in accessible formats, access to judicial buildings and the services of trained Salvadoran sign-language interpreters; . . .
(d) Adopt measures to secure access to justice for women and girls with disabilities, with due consideration paid to their role as witnesses and victims during the trial phase.

Freedom from exploitation, violence, and abuse (art. 16)

36. The Committee urges the State party:

(a) To adopt legislation to prevent, investigate and punish exploitation, violence and abuse involving persons with disabilities, with a particular focus on women and children; . . .

(d) To follow up on the recommendations made by the Committee on the Elimination of Discrimination against Women to El Salvador following the consideration of its report regarding the need to take a comprehensive approach to violence against women and girls. . . .

Protecting the integrity of the person (art. 17)

38. The Committee recommends that the State party repeal provisions permitting the forced sterilization of women with disabilities and that it prevent and investigate the practice of aborting pregnancies resulting from sexual abuse.

Health (art. 25)

52. The Committee recommends that the State party:

(a) Adopt the requisite legislative measures to protect persons with disabilities against discrimination in health matters; ensure their access to health insurance schemes; carry out public health campaigns directed at persons with disabilities, including components on gender and age, sexual and reproductive rights and HIV/AIDS prevention and care; and involve women with disabilities in campaigns to prevent breast and cervical cancer. . . .


14. The Committee recommends that the State party take effective measures to consult with and actively involve persons with disabilities, including children and women with disabilities, through their representative organizations, in the planning, execution and monitoring of public decision-making processes at all levels and in particular in the matters affecting them, giving them reasonable and realistic timelines for providing their views, and providing them with adequate funding in order to enable them to fulfil their role under article 4, paragraph 3, of the Convention.

Women with disabilities (art. 6)

20. The Committee calls upon the State party to adopt effective and specific measures to ensure equality and prevent multiple forms of discrimination of women and girls with disabilities in its policies, and to mainstream a gender perspective in its disability-related legislation and policies.

Freedom from exploitation, violence, and abuse (art. 16)

The Committee recommends that the State party take effective measures to ensure protection of women, men, girls and boys with disabilities from exploitation, violence and abuse, in accordance
with the Convention, inter alia, the establishment of protocols for the early detection of violence, above all in institutional settings, procedural accommodation to gather testimonies of victims, and prosecution of those persons responsible, as well as redress for victims. It also recommends that the State party ensure that protection services are age-, gender- and disability-sensitive and accessible.

Respect for home and the family (art. 23)

38. The Committee calls upon the State party to take appropriate and urgent measures to protect persons with disabilities from forced sterilization.


Women with disabilities (art. 6)

18. The Committee recommends that the State party institute as a matter of urgency effective measures to identify, prevent and provide protection from the multiple discrimination suffered by women and girls with disabilities, in particular women and girls with intellectual and psychosocial disabilities and hearing impairments. The Committee also recommends the establishment of accessible care centres for women and girls who are victims of these forms of violence in urban and rural areas, in consultation with organizations representing women with disabilities.


Women with disabilities (art. 6)

15. The Committee urges the State party to accelerate its efforts to eradicate and prevent discrimination against women and girls with disabilities, by incorporating gender and disability perspectives in all programmes, as well as by ensuring their full and equal participation in decision-making. The Committee urges the State party to amend its legislative framework to provide special protection to women and girls with disabilities, as well as to adopt effective measures to prevent and redress violence against women and girls with disabilities.


Women with disabilities (art. 6)

21. The Committee is concerned that public programmes and policies on the prevention of gender-based violence do not sufficiently take into consideration the particular situation of women with disabilities. The Committee is also concerned that employment policies do not include a comprehensive gender perspective and that unemployment, inactivity and training rates are significantly worse for women than for men with disabilities.
22. The Committee recommends that the State party:
(a) Include a more comprehensive consideration of women with disabilities in public programmes and policies on the prevention of gender-based violence, particularly so as to ensure access for women with disability to an effective, integrated response system;
(b) Include a gender perspective in employment policies, and particularly specific measures for women with disabilities;
(c) Elaborate and develop strategies, policies and programmes, especially in the fields of education, employment, health and social protection, to promote the autonomy and full participation of women and girls with disability in society, and to combat violence against them.

Integrity of the person (art. 17)

37. The Committee is concerned that persons with disabilities whose legal capacity is not recognized may be subjected to sterilization without their free and informed consent.
38. The Committee urges the State party to abolish the administration of medical treatment, in particular sterilization, without the full and informed consent of the patient; and ensure that national law especially respects women’s rights under articles 23 and 25 of the Convention.


Women with disabilities (art. 6)
14. While noting the improvements in the condition of women in general, the Committee is concerned by the negative perception of women with disabilities within the family and society, and the reported cultural, traditional and family pressures that favour the concealment of women with disabilities, and prevents them from obtaining a disability card, thereby limiting their opportunities to participate in society, and develop to their full potential.

15. The Committee recommends that the State party:
(a) Design and implement awareness-raising campaigns and education programmes throughout society, including at the family level, on women with disabilities in order to foster respect for their rights and dignity; combat stereotypes, prejudices and harmful practices; and promote awareness of their capabilities and contributions;
(b) Ensure the visibility of women with disabilities in the collection of data and statistics (see paragraph 37 below);
(c) Undertake studies and research in order to identify the situation and specific requirements of women with disabilities, with a view to elaborating and adopting strategies, policies and programmes, especially in the fields of education, employment, health and social protection, to promote their autonomy and full participation in society, and to combat violence against women.

Freedom from exploitation, violence and abuse (art. 16)

26. The Committee expresses concern at the situation of violence that women and children with disabilities might face.

27. The Committee encourages the State party to include women and girls with disabilities in the National Strategy for the prevention of violence in the family and society, and to adopt comprehensive measures for them to have access to immediate protection, shelter and legal aid. It requests the State party to conduct awareness campaigns and develop educational programmes on
the greater vulnerability of women and girls with disabilities with respect to violence and abuse.

Freedom from exploitation, violence and abuse (art. 16)
26. The Committee expresses concern at the situation of violence that women and children with disabilities might face.
27. The Committee encourages the State party to include women and girls with disabilities in the National Strategy for the prevention of violence in the family and society, and to adopt comprehensive measures for them to have access to immediate protection, shelter and legal aid. It requests the State party to conduct awareness campaigns and develop educational programmes on the greater vulnerability of women and girls with disabilities with respect to violence and abuse.

Integrity of the person (art. 17)
28. The Committee is concerned about the lack of clarity concerning the scope of legislation to protect persons with disabilities from being subjected to treatment without their free and informed consent, including forced treatment in mental health services.
29. The Committee recommends that the State party incorporate into the law the abolition of surgery and treatment without the full and informed consent of the patient, and ensure that national law especially respects women’s rights under article 23 and 25 of the Convention.

The CRPD Committee’s commitment to increasing the focus on women and girls with disabilities, is reflected in its 9th session Half Day of General Discussion on Women and Girls with Disabilities, available at: http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGD17April2013.aspx

At this session, sexual and reproductive rights, violence against women and girls with disabilities, and the intersectionality of gender and discrimination, were prioritized as key themes for action. The CRPD Committee plans to develop a General Comment on women with Disabilities in 2016.

Maggie, perhaps you could look to see if any of the submissions to the CRPD Committee specifically reference sexual and reproductive rights, e.g., the Center for Reproductive rights if they did such comments?


Article 3
The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

ESCR Committee, General Comment No. 14, The right to the highest attainable standard of health, E/C.12/2000/4 Available at: http://www.escr-net.org/docs/i/425238

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party: . . .

(b) Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions: . . .

(ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities. . .

(c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

Article 12.2 (a). The right to maternal, child and reproductive health

14. “The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child” (art. 12.2 (a))10 may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care,11 emergency obstetric services and access to information, as well as to resources necessary to act on that information.

Women and the right to health

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women’s right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women’s health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Specific legal obligations

34. In particular, States are under the obligation to respect the right to health by, inter alia . . . abstaining from imposing discriminatory practices relating to women’s health status and needs. . . In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people’s participation in health-related matters. . .
35. . . . States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people’s access to health-related information and services.

36. . . . Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. . . .

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as . . . the failure to protect women against violence or to prosecute perpetrators.

Convention on the Rights of the Child, G.A. Res. 44/25, Nov. 20, 1989, available at http://www.unhcr.org/refworld/docid/3ae6b38f0.html. Stephanie, I didn’t see any references that are specific to women or girls, so I haven’t quoted any sections here. – Maggie

I have included excerpts-Natalie

Preamble

The States Parties to the present Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,
Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity . . .

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth" . . .

Have agreed as follows:

Article 1

PART I

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members . . .

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health
care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for
the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Note: CRC Committee General Comments and Recommendations. Concluding Observations and Decisions on Complaints are available at: http://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx


The human, social and economic costs of denying children’s rights to protection are enormous and unacceptable. Direct costs may include medical care, legal and social welfare services and alternative care. Indirect costs may include possible lasting injury or disability, psychological costs or other impacts on a victim’s quality of life, disruption or discontinuation of education, and productivity losses in the future life of the child.

They also include costs associated with the criminal justice system as a result of crimes committed by children who have experienced violence. The social costs arising from a demographic imbalance due to the discriminatory elimination of girls before birth are high and have potential implications for increased violence against girls including abduction, early and forced marriage, trafficking for sexual purposes and sexual violence.

19. Forms of violence – overview. The following non-exhaustive lists outlining forms of violence apply to all children in all settings and in transit between settings. Children can experience violence at the hands of adults, and violence may also occur among children. Furthermore, some children harm themselves. The Committee recognizes that forms of violence often co-occur and that they can span the categories used here for convenience. Both girls and boys are at risk of all forms of violence, but violence often has a gender component. For example, girls may experience more sexual violence at home than boys whereas boys may be more likely to encounter – and experience violence within – the criminal justice system.

23. Children with disabilities may be subject to particular forms of physical violence such as:
(a) Forced sterilization, particularly girls . . . .

29. Harmful practices. These include, but are not limited to:
(a) Corporal punishment and other cruel or degrading forms of punishment;
(b) Female genital mutilation;
(c) Amputations, binding, scarring, burning and branding;
(d) Violent and degrading initiation rites; force-feeding of girls; fattening; virginity testing (inspecting girls’ genitalia);
(e) Forced marriage and early marriage;
(f) “Honour” crimes; “retribution” acts of violence (where disputes between different groups are taken out on children of the parties involved); dowry-related death and violence;
(g) Accusations of “witchcraft” and related harmful practices such as “exorcism”;
(h) Uvulectomy and teeth extraction.

72. Elements to be mainstreamed into national coordinating frameworks. The following elements need to be mainstreamed across the measures (legislative, administrative, social and educational) and stages of intervention (from prevention through to recovery and reintegration):

(a) Child rights approach.

(b) The gender dimensions of violence against children. States parties should ensure that policies and measures take into account the different risks facing girls and boys in respect of various forms of violence in various settings. States should address all forms of gender discrimination as part of a comprehensive violence-prevention strategy. This includes addressing gender-based stereotypes, power imbalances, inequalities and discrimination which support and perpetuate the use of violence and coercion in the home, in school and educational settings, in communities, in the workplace, in institutions and in society more broadly. Men and boys must be actively encouraged as strategic partners and allies, and along with women and girls, must be provided with opportunities to increase their respect for one another and their understanding of how to stop gender discrimination and its violent manifestations.

(f) Risk factors. Proactive, tailored measures need to be taken to reduce the risk factors to which individual children or groups of children may be exposed in general or in particular contexts. This includes parental risk factors such as substance abuse, mental health problems and social isolation as well as family risk factors such as poverty, unemployment, discrimination and marginalization. At a universal level all children aged 0-18 years are considered vulnerable until the completion of their neural, psychological, social and physical growth and development. Babies and young children are at higher risk due to the immaturity of their developing brain and their complete dependency on adults. Both girls and boys are at risk, but violence often has a gender component;

(g) Children in potentially vulnerable situations. Groups of children which are likely to be exposed to violence include, but are not limited to, children . . . in early marriage (especially girls, and especially but not exclusively forced marriage).

**Convention Against Torture** and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res 39/46, 10 December 1984, available at: [http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx](http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx)

**Article 1**

1. For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

**Stephanie, any guidance on what to quote from the CAT would be appreciated, since they don’t have any provisions specific to women or girls, and that makes it harder to distinguish sections that might be especially worthy of quotation. Would a general reference be most appropriate here? Thanks! - Maggie**

Maggie, look for the sections which are referenced in the comments and such below for the provisions to quote here.

I quoted from Article 1 (definition of torture)- Natalie
The UN Special Rapporteur on Torture [and other cruel, inhuman or degrading treatment or punishment], in addressing reproductive rights violations under the torture framework, clarified that forced sterilization of people with disabilities, regardless of whether the practice is permitted under national laws or justified by theories of asserted incapacity and therapeutic necessity, violates the absolute prohibition of torture and cruel, inhuman and degrading treatment.


Violence against women
14. The Committee is concerned at reports on widespread violence against women and girls, including domestic and sexual violence and femicide, and at the low numbers of investigations and prosecutions in such cases, as well as the lack of statistics on sexual violence. . . [T]he Committee is concerned that domestic violence and forms of sexual violence and harassment, other than the crime of rape, are not defined as offences in the Criminal Code and at the obstacles victims of violence face when accessing justice, combined with the insufficient number of shelters available to them (arts. 2, 12, 13 and 16). The State party should intensify its efforts and urgently ensure the implementation of effective protective measures to prevent and combat all forms of violence against women and girls and amend its legislation to include domestic violence and forms of sexual violence as offences under the Criminal Code, as is the case with rape, and develop a better overview on the prevalence of the offence. The State should further strengthen all efforts to prevent violence against women, enhance the access of victims to justice, ensure that all acts of violence are promptly, effectively and impartially investigated and prosecuted, perpetrators brought to justice and victims provided with redress. The State party should set up not only an effective complaints mechanism for women and girls but also a monitoring mechanism to prevent all forms of violence against them. The Ministry of Health should provide specialized training to health personnel dealing with victims of violence and a single, consolidated system for keeping records on cases of violence against women should be established. Broad awareness-raising campaigns should be initiated and training on combating and preventing violence against women and girls for law enforcement officers, judges, lawyers, and social workers should be provided.

Reproductive rights and health
15. The Committee is seriously concerned that illegal abortions are one of the main causes of high maternal mortality in the State party and that the interpretation of therapeutic and legal abortion in cases of medical necessity is too restrictive and lacks clarity, leading women to seek unsafe illegal abortions. The Committee is particularly concerned at the criminalization of abortions in cases of rape and incest as well as the prohibition by the Constitutional Court of the distribution of oral emergency contraception to victims of rape. It is further concerned at the fact that the existing law obliges physicians to bring information on women resorting to post-abortion health services to the attention of the authorities and which may lead to investigation and criminal
prosecution, which creates such fear of punishment that, in practice, this constitutes a denial of legal abortion services. The Committee is also concerned at the forced sterilization of women, namely the 2,000 women who were subjected to forced sterilizations under the National Reproductive Health and Family Planning Program between 1996 and 2000, and who have not yet received redress (arts. 2, 10, 12, 13, 14, 15 and 16).

The State party should review its legislation with a view to:
(a) Amending the general prohibition for cases of therapeutic abortion and pregnancy resulting from rape and incest and provide free health coverage in cases of rape;
(b) Legalizing the distribution of oral emergency contraception to victims of rape;
(c) Ensuring that health professionals are aware of and informed about the protocols regarding legal abortions by the Ministry of Health and guarantee immediate and unconditional treatment for persons seeking emergency medical care;
(d) Eliminating the practice of extracting confessions for prosecution purposes from women seeking emergency medical care as a result of illegal abortion and penalizing medical personnel for the exercise of their professional responsibilities;
(e) Enhancing its provision of family planning information and services and conducting a broad public campaign to raise awareness about cases when therapeutic abortions are legal and the administrative framework to access them. The State party should accelerate all current investigations related to forced sterilization, initiate prompt, impartial and effective investigations of all similar cases and provide adequate redress to all victims of forced sterilization.

Impunity for acts of torture and ill-treatment during the internal armed conflict
16. The Committee is gravely concerned at the slow progress of establishing accountability for the estimated 70,000 deaths or enforced disappearances during the internal armed conflict from 1980 to 2000, and at the very small number of convictions and high rate of acquittals in cases prosecuted. It is further concerned at the slow pace of exhumations, identification of and return of bodies to their relatives and the scarcity of qualified personnel. It is also concerned at the requirement by the National Criminal Court that evidence be direct and documentary, and its unwillingness to credit the testimony of victims or their relatives. The Committee is seriously concerned at the absence of full cooperation of the Ministry of Defence to furnish information relevant for the investigations, including lists of army officers present in patrols and army bases in different regions affected by the conflict, and to inform on the aliases and code names frequently used by military officials. While taking note of the introduction of the Victim and Witness Assistance Programme and acknowledging the challenges and difficulties, the Committee is concerned that lack of effective implementation prevents courts from obtaining testimonies and that there are no special measures to protect victims of torture. It is concerned further at the underreporting of cases of sexual violence against women and girls during the armed conflict, the limited number of investigations, the absence of sentences and the lack of effective redress to victims of sexual violence during the conflict. It is also concerned that rape is the only form of sexual violence that may give rise to individual economic compensation under Law No. 28592 and that all forms of sexual violence are not covered by the law on reparation.

The Committee takes note that the State party ratified the Rome Statute in 2001, but is concerned that Bill No. 1707/2007/CR on rape as a crime against humanity, was submitted to Congress in 2007, but has not been passed to date (arts. 2, 12, 13, 14 and 16). The State party should enhance its efforts to investigate, prosecute and bring to justice the perpetrators of human rights violations, including torture, during the internal armed conflict and ensure the access to truth, justice and compensation for victims. It should strengthen the capacity of the specialized judicial subsystem established for this purpose to conduct trials in an impartial, public and transparent manner, in accordance with international law. It also recommends that the Institute for Legal Medicine enhance its specialized forensic teams to accelerate the exhumations and analysis of human
remains, their identification and handing over to relatives. The Committee urges the Ministry of Defence to cooperate with the prosecutors and judges and invites the National Criminal Court to reconsider its criteria for obtaining evidence in cases of human rights violations. Witnesses and victims should be protected and provided with sufficient financial resources under the witness protection programme. The State party should enhance the investigation and prosecution of all cases of human rights violations committed during the armed conflict, including sexual violence, and provide redress to victims. All forms of sexual violence should be included in national legislation prohibiting torture and Law No. 28592 should be enacted in order to allow for individual economic compensation for such crimes. The Committee recommends that the State party expedite the implementation of the Rome Statute in national legislation.

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:


Cruel, inhuman or degrading treatment

23. The Committee is concerned at reports of women undergoing involuntary sterilization. It has also been informed that medical personnel employed by the State denies the medical treatment required to ensure that pregnant women do not resort to illegal abortions that put their lives at risk. Current legislation severely restricts access to voluntary abortion, even in cases of rape, leading to grave consequences, including the unnecessary deaths of women. According to reports received, the State party has failed to take steps to prevent acts that put women’s physical and mental health at grave risk and that constitute cruel and inhuman treatment.

The State party should take whatever legal and other measures are necessary to effectively prevent acts that put women’s health at grave risk, by providing the required medical treatment, by strengthening family planning programmes and by offering better access to information and reproductive health services, including for adolescents.

CAT Committee 2012 (see relevant excerpts quoted above). Maggie, I don’t know what this line means???
I'm also not sure what this means? - Natalie


Treatment of the Roma minority

12. The Committee is concerned about reports of sterilization of Roma women without free and informed consent, the destruction of medical records on involuntary sterilizations and the difficulties of victims to obtain redress. (arts. 2, 14 and 16) The Committee recommends that the State party investigate promptly, impartially and effectively all allegations of involuntary sterilization of Roma women, extend the time limit for filing complaints, prosecute and punish the perpetrators and provide victims with fair and adequate redress. Medical personnel
conducting sterilizations without free, full and informed consent could be held criminally liable and medical records concerning possible involuntary sterilization should not be destroyed within the time frame prescribed by law. Medical personnel should be trained on appropriate means of how to obtain free and informed consent from women undergoing sterilization and all written materials relating to sterilization should be translated into the Roma language.

Redress and compensation, including rehabilitation

13. The Committee is concerned about the absence of statistical data concerning compensation to victims of torture and ill-treatment, including victims of involuntary sterilization and surgical castration as well as ill-treatment in medical and psychiatric settings, violent attacks against ethnic minorities, trafficking and domestic and sexual violence. It is also concerned about the time limits set for filing complaints (arts. 14 and 16).

The Committee recommends that the State party ensure that victims of torture and ill-treatment are entitled to and provided with redress and adequate compensation, including rehabilitation, in conformity with article 14 of the Convention. It recommends that the State party provide it with statistical data on the number of victims, including victims of involuntary sterilization and surgical castration as well as ill-treatment in medical and psychiatric settings, violent attacks against ethnic minorities, trafficking and domestic and sexual violence, who have received compensation and other forms of assistance. It also recommends the extension of the time limit for filing claims.


Medical research . . .

38. Vulnerable individuals, such as persons with severe disabilities, pregnant and breastfeeding women, children, persons in life-threatening emergencies, and elderly persons, require special protections. Consent for medical research participation must only be sought from such individuals in the absence of any comparably effective alternative research population, and only if participation risks are minimized and benefits are conferred on group members.45 Authorized proxies providing consent for individuals unable to exercise legal capacity must not be offered incentives beyond appropriate compensation for time and effort. Research on persons lacking the ability to exercise legal capacity or otherwise unable to consent is permissible “only if the physical or mental condition that prevents giving informed consent is a necessary characteristic of the research population”. If medical experimentation is required for life-saving treatment of an individual deemed unable to provide consent, the consent of a legally authorized representative must be sought, and any assent or dissent communicated by the patient respected.

C. Women

54. Gender inequalities reinforced by political, economic and social structures result in women being routinely coerced and denied information and autonomy in the health-care setting. Women’s sexual and reproductive health rights demand special considerations; pregnant women are at times denied consent along an appropriate health-care continuum justified by the best interests of the unborn child.
55. Social and legal norms limit women’s independent access to sexual and reproductive health services. Evidence reveals that women are often entirely excluded from decision-making in health care. Women are often coerced into “routine” HIV/AIDS testing in ante-natal care settings without links to counselling and treatment. Forced sterilization or contraception continues to affect women, injuring their physical and mental health and violating their right to reproductive self-determination, physical integrity and security. Women are often provided inadequate time and information to consent to sterilization procedures, or are never told or discover later that they have been sterilized. Numerous countries have taken inadequate action against individuals who perform non-consensual sterilizations, and some have even sanctioned such procedures in national “family planning” initiatives with anti-natalist undertones based on racial or ethnic discrimination. Stigma and discrimination against women from marginalized communities, including indigenous women, women with disabilities and women living with HIV/AIDS, have made women from these communities particularly vulnerable to such abuses.

56. Regrettably, female genital mutilation continues to be performed throughout the world, even on two-year-old girls. It is physically and mentally injurious, has no health benefits, and is a violation of bodily integrity and personal autonomy of the girl/woman. Female genital mutilation is virtually never a woman’s independent decision, owing to its strong cultural significance concerning virginity, marriage eligibility and social status.

57. The need for special protections guaranteeing a woman’s right to informed consent is reinforced by the Beijing Declaration. Women have the right to freely consent to or refuse services (including sterilization services) that are non-coercive and respectful of autonomy, privacy and confidentiality; and information provided by properly trained personnel. Any requirement for preliminary authorization by a third party is a violation of a woman’s autonomy. Sexual and reproductive health services must be free from coercion, discrimination or lack of information. States must ensure absence of any form of coercion in reproductive health services, including testing procedures for sexually transmitted infections or pregnancy as a pre-condition of employment. The Beijing Platform highlights the right of a woman to make reproductive decisions free of discrimination, coercion and violence; and the International Conference on Population and Development (ICPD) Programme of Action protects the right to decide freely and responsibly the number and spacing of one’s children. Forced sterilization, when committed as part of a widespread or systematic attack, is a crime against humanity.

58. Reproductive freedom should never be limited by individuals or States as a family planning method, HIV/AIDS prevention, or any other public health agenda. States should ensure that laws respect the woman’s right to autonomy and decision-making and do not support substituted consent by spouses and that harmful traditional practices like female genital mutilation are eliminated as a matter of urgency.

59. Health-care providers are critical actors in ensuring that women are provided adequate information, especially information regarding reversible family planning.

59. Health-care providers are critical actors in ensuring that women are provided adequate information, especially information regarding reversible family planning options, and personnel must be adequately trained and sensitized in this respect. Health-care providers should strive to collaborate with women’s groups that provide support at the community level in the provision of information, counselling, empowerment and social sensitization to gender equality.

60. Guidance concerning situations of maternal-foetal conflict should capitalize on the potential of proper counselling and comprehensive support services through women’s networks to mitigate
restrictions of autonomous decision-making of the woman and any potentially harmful effects to the child.

F. Persons with disabilities . . .

71. Forced sterilization of girls and women with disabilities has been documented internationally and is even being currently proposed in Rwanda. Persons with disabilities, including children, continue to be exposed to non-consensual medical experimentation.

G. Persons living with HIV/AIDS

75. As discussed in section III, people living with HIV/AIDS often discover their status as the result of involuntary testing procedures. They subsequently face stigma and can be deterred from accessing appropriate services, undermining long-term prevention and treatment efforts. Lack of information and the relative powerlessness of communities involved in HIV/AIDS clinical trials (especially when vulnerable groups are targeted) further compromise informed consent.

76. Examples of violations include non-consensual testing, sterilizations and abortions, and compromised confidentiality of women living with HIV/AIDS, HIV/AIDS-related clinical trials conducted among pregnant women, sex workers and people who use drugs have raised a number of ethical concerns relating to, among other things, the inadequate provision of information.


II. STRENGTHENING THE PROTECTION OF WOMEN FROM TORTURE

A. Introduction: towards a gender-sensitive interpretation of torture

25. The present chapter seeks to respond to and complement initiatives in the area of gender mainstreaming and combating violence against women, such as Human Rights Council resolution 6/30, the Secretary-General’s in-depth study on all forms of violence against women, together with the United Nations follow-up campaign on violence against women to be launched in 2008, the focus of the High Commissioner for Human Rights on ending impunity, especially for sexual violence, and the call by the Special Rapporteur on violence against women to fully apply the human rights framework to the concerns of women.

26. The aim is to ensure that the torture protection framework is applied in a gender-inclusive manner with a view to strengthening the protection of women from torture. While a variety of international instruments explicitly or implicitly provide for an extensive set of obligations with respect to violence against women or rape, classifying an act as “torture” carries a considerable additional stigma for the State and reinforces legal implications, which include the strong obligation to criminalize acts of torture, to bring perpetrators to justice and to provide reparation to victims.

27. Torture is prohibited under a wide range of international instruments, such as article 7 of the International Covenant on Civil and Political Rights (ICCPR) and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). Torture is also prohibited by many regional instruments as well as under international criminal law and
international humanitarian law. CAT is the only legally binding instrument at the universal level concerned exclusively with the eradication of torture. Its article 1 lays down a definition, which sets out four elements required to meet the threshold of torture:

31. Severe pain and suffering, physical or mental;

32. Intent;

33. Purpose;

34. State involvement.

28. The Special Rapporteur has suggested adding to these elements the criterion of powerlessness. A situation of powerlessness arises when one person exercises total power over another, classically in detention situations, where the detainee cannot escape or defend him/herself. Rape is an extreme expression of this power relation, of one person treating another person as merely an object. Applied to situations of “private violence”, this means that the degree of powerlessness of the victim in a given situation must be tested. If it is found that a victim is unable to flee or otherwise coerced into staying by certain circumstances, the powerlessness criterion can be considered fulfilled.

29. The element of powerlessness also allows the specific status of the victim to be taken into consideration, such as sex, age and physical and mental health, in some cases also religion, which might render a specific person powerless in a given context. A society’s indifference to or even support for the subordinate status of women, together with the existence of discriminatory laws and a pattern of State failure to punish perpetrators and protect victims, create the conditions under which women may be subjected to systematic physical and mental suffering, despite their apparent freedom to resist.

30. In regard to violence against women, the purpose element is always fulfilled, if the acts can be shown to be gender-specific, since discrimination is one of the elements mentioned in the CAT definition. Moreover, if it can be shown that an act had a specific purpose, the intent can be implied.

31. The central role of the State in article 1 of the Convention, which restricts the definition of torture to acts “when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity”, has frequently been used to exclude violence against women outside direct State control from the scope of protection of CAT. However, the Special Rapporteur wishes to recall that the language used in article 1 of the Convention concerning consent and acquiescence by a public official clearly extends State obligations into the private sphere and should be interpreted to include State failure to protect persons within its jurisdiction from torture and ill-treatment committed by private individuals. Also, article 1 of CAT should be seen as reinforcing - and reinforced by - the Declaration on the Elimination of Violence against Women adopted by the General Assembly in resolution 48/104.

32. Article 4 (c) of this Declaration proclaims that States should “exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons”. Recently, the behaviour perceived as non-consonant with gender roles and stereotypes or at asserting or
perpetuating male domination over women. Committee against Torture indicated that “Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State’s indifference or inaction provides a form of encouragement and/or de facto permission”. Similarly, other universal and regional bodies have been applying the due diligence test.

33. Whereas the Committee against Torture often does not specify whether a violation amounts to torture or to other forms of ill-treatment, it has stressed that ill-treatment is often conducive to torture, and therefore torture and cruel, inhuman and degrading treatment are closely intertwined. In the view of the Special Rapporteur, the main elements distinguishing cruel, inhuman and degrading treatment are the powerlessness of the victim and the purpose of the act.

B. What constitutes torture?

1. Torture and ill-treatment of women in the public sphere

(a) Rape and sexual violence

34. Custodial violence against women very often includes rape and other forms of sexual violence such as threats of rape, touching, “virginity testing”, being stripped naked, invasive body searches, insults and humiliations of a sexual nature, etc. It is widely recognized, including by former Special Rapporteurs on torture and by regional jurisprudence, that rape constitutes torture when it is carried out by or at the instigation of or with the consent or acquiescence of public officials. In a 1997 decision on a case of custodial rape the European Court of Human Rights acknowledged that “rape of a detainee by an official of the State must be considered to be an especially grave and abhorrent form of ill-treatment given the ease with which the offender can exploit the vulnerability and weakened resistance of the victim” and “rape leaves deep psychological scars on the victims which do not respond to the passage of time as quickly as other forms of physical and mental violence”.

35. In the area of international criminal law, the International Criminal Tribunal for the former Yugoslavia decisions in the Celebici and Furundzija cases have contributed to the international recognition of rape as a form of torture. Also, international criminal tribunals, in their jurisprudence, have broadened the scope of crimes of sexual violence that can be prosecuted as rape to include oral sex and vaginal or anal penetration through the use of objects or any part of the aggressor’s body. This is crucial because in many countries rape is still defined as “carnal access”, reducing it to penetration with the male sexual organ. It is noteworthy that other forms of sexual violence, whether defined as rape or not, may constitute torture or ill-treatment and must not be dealt with as minor offences.

36. The case law presented here has, without exception, emphasized the severe pain and suffering endured by victims of rape. However, the Special Rapporteur wishes to highlight some of the unique dimensions of this form of torture. When Government officials use rape, the suffering inflicted might go beyond the suffering caused by classic torture, partly because of the intended and often resulting isolation of the survivor. In some cultures a rape victim may be rejected or formally banished from her community or family. This rejection greatly hinders the psychological recovery of the victim and often condemns her to destitution and extreme poverty. Even when rape survivors are not rejected they still face important difficulties in establishing intimate relationships. Furthermore, raped women are often infected with sexually transmitted diseases or may experience unwanted pregnancies, miscarriages, forced abortions or denial of abortion.
Because of the stigma attached to sexual violence, official torturers deliberately use rape to humiliate and punish victims but also to destroy entire families and communities. This is particularly clear when State officials force family members to rape their female relatives or to witness their rape. The Akayesu decision, in which the International Criminal Tribunal for Rwanda (ICTR) recognized rape as a form of genocide in the same way as any other act committed with specific intent to destroy a particular group, is a striking acknowledgment of the destructive potential of rape. The ICTR made it explicit that these rapes resulted in the physical and psychological destruction of Tutsi women, their families and their communities.

(b) Violence against pregnant women and denial of reproductive rights

37. In its general comment No. 28 (2000) on article 3 (The equality of rights between men and women), the Human Rights Committee explicitly indicated that breaches of article 7 include forced abortion as well as denial of access to safe abortion to women who have become pregnant as a result of rape. The Committee against Torture has also identified reproductive decisions as a context in which women are particularly vulnerable and expressed concern regarding domestic legislation that severely restricts access to voluntary abortion in cases of rape. They have also condemned the practice of attempting to obtain confessions as a condition of potentially life-saving medical treatment after abortion. Whereas, in a case where a woman’s health was threatened if she gave birth, the European Court of Human Rights recently found a violation of the applicant’s right to her private life, it regrettably did not establish that this amounted to inhuman treatment.

38. The Human Rights Committee has referred to the sterilization of women without their consent as a breach of ICCPR article 7. The Special Rapporteur also stresses that, given the particular vulnerability of women with disabilities, forced abortions and sterilizations of these women if they are the result of a lawful process by which decisions are made by their “legal guardians” against their will, may constitute torture or ill-treatment.

39. According to the Office of the United Nations High Commissioner for Refugees (UNHCR), laws or policies prescribing the use of forced abortion or forced sterilization as methods of enforcement, or as punishment for non-compliance, would be considered inherently persecutory and will therefore give rise to justified claims for refugee status in view of the serious human rights violations each individual subject to these measures would suffer. It is also worth noting that, in the asylum context, forced sterilization has been found to constitute


The present report aims to deepen the findings of the OHCHR study and further examine the manifestations, causes and consequences of violence against women with disabilities. In addition, the report briefly examines relevant international and regional legal frameworks and provides recommendations.

Grover, Anand, Report of the **Special Rapporteur** on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN General Assembly, UN Doc. A/69/299. (2014)
The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, has clarified that States that use the law as a tool to regulate the conduct and decision-making of individuals in the context of their sexual and reproductive rights represent serious violations of the right to health of affected persons and are ineffective as public health interventions.

**Grover, Anand,** Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/66/254 3 August 2011


Maggie, have all documents of SRs on health together please.

"In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health considers the interaction between criminal laws and other legal restrictions relating to sexual and reproductive health and the right to health. The right to sexual and reproductive health is a fundamental part of the right to health. States must therefore ensure that this aspect of the right to health is fully realized. The Special Rapporteur considers the impact of criminal and other legal restrictions on abortion; conduct during pregnancy; contraception and family planning; and the provision of sexual and reproductive education and information. Some criminal and other legal restrictions in each of those areas, which are often discriminatory in nature, violate the right to health by restricting access to quality goods, services and information. They infringe human dignity by restricting the freedoms to which individuals are entitled under the right to health, particularly in respect of decision-making and bodily integrity. Moreover, the application of such laws as a means to achieving certain public health outcomes is often ineffective and disproportionate.

Realization of the right to health requires the removal of barriers that interfere with individual decision-making on health-related issues and with access to health services, education and information, in particular on health conditions that only affect women and girls. In cases where a barrier is created by a criminal law or other legal restriction, it is the obligation of the State to remove it. The removal of such laws and legal restrictions is not subject to resource constraints and can thus not be seen as requiring only progressive realization. Barriers arising from criminal laws and other laws and policies affecting sexual and reproductive health must therefore be immediately removed in order to ensure full enjoyment of the right to health."

**Maggie, I assume you have not yet gotten to the below documents, right?**


35. Promote and protect all human rights of women and girls;

36. Intensify efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of such factors as their race, age, language, ethnicity, culture, religion, or disability, or because they are indigenous people. . .
Chapter 3: Critical Areas of Concern

41. The advancement of women and the achievement of equality between women and men are a matter of human rights and a condition for social justice and should not be seen in isolation as a women's issue. They are the only way to build a sustainable, just and developed society. Empowerment of women and equality between women and men are prerequisites for achieving political, social, economic, cultural and environmental security among all peoples.

42. Most of the goals set out in the Nairobi Forward-looking Strategies for the Advancement of Women have not been achieved. Barriers to women's empowerment remain, despite the efforts of Governments, as well as non-governmental organizations and women and men everywhere. Vast political, economic and ecological crises persist in many parts of the world. Among them are wars of aggression, armed conflicts, colonial or other forms of alien domination or foreign occupation, civil wars and terrorism. These situations, combined with systematic or de facto discrimination, violations of and failure to protect all human rights and fundamental freedoms of all women, and their civil, cultural, economic, political and social rights, including the right to development and ingrained prejudicial attitudes towards women and girls are but a few of the impediments encountered since the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, in 1985.

43. A review of progress since the Nairobi Conference highlights special concerns - areas of particular urgency that stand out as priorities for action. All actors should focus action and resources on the strategic objectives relating to the critical areas of concern which are, necessarily, interrelated, interdependent and of high priority. There is a need for these actors to develop and implement mechanisms of accountability for all the areas of concern.

44. To this end, Governments, the international community and civil society, including non-governmental organizations and the private sector, are called upon to take strategic action in the following critical areas of concern:

37. The persistent and increasing burden of poverty on women
38. Inequalities and inadequacies in and unequal access to education and training
39. Inequalities and inadequacies in and unequal access to health care and related services
40. Violence against women
41. The effects of armed or other kinds of conflict on women, including those living under foreign occupation
42. Inequality in economic structures and policies, in all forms of productive activities and in access to resources
43. Inequality between men and women in the sharing of power and decision-making at all levels
44. Insufficient mechanisms at all levels to promote the advancement of women
45. Lack of respect for and inadequate promotion and protection of the human rights of women
46. Stereotyping of women and inequality in women’s access to and participation in all communication systems, especially in the media

47. Gender inequalities in the management of natural resources and in the safeguarding of the environment

48. Persistent discrimination against and violation of the rights of the girl child.

CHAPTER IV - STRATEGIC OBJECTIVES AND ACTIONS

45. In each critical area of concern, the problem is diagnosed and strategic objectives are proposed with concrete Actions to be taken by various actors in order to achieve those objectives. The strategic objectives are derived from the critical areas of concern and specific Actions to be taken to achieve them cut across boundaries of equality, development and peace - the goals of the Nairobi Forward-looking Strategies for the Advancement of Women - and reflect their interdependence. The objectives and actions are interlinked, of high priority and mutually reinforcing. The Platform for Action is intended to improve the situation of all women, without exception, who often face similar barriers while special attention should be given to groups that are the most disadvantaged.

46. The Platform for Action recognizes that women face barriers to full equality and advancement because of such factors as their race, age, language, ethnicity, culture, religion or disability, because they are indigenous women or because of other status. Many women encounter specific obstacles related to their family status, particularly as single parents; and to their socio-economic status, including their living conditions in rural, isolated or impoverished areas. Additional barriers also exist for refugee women, other displaced women, including internally displaced women as well as for immigrant women and migrant women, including women migrant workers. Many women are also particularly affected by environmental disasters, serious and infectious diseases and various forms of violence against women.

ACTIONS TO BE TAKEN

80. By Governments:

49. (a) Advance the goal of equal access to education by taking measures to eliminate discrimination in education at all levels on the basis of gender, race, language, religion, national origin, age or disability, or any other form of discrimination and, as appropriate, consider establishing procedures to address grievances;

Section C. WOMEN AND HEALTH

89. Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. However, health and well-being elude the majority of women. A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups. In national and international forums, women have emphasized that to attain optimal health throughout the life
cycle, equality, including the sharing of family responsibilities, development and peace are necessary conditions.

90. Women have different and unequal access to and use of basic health resources, including primary health services for the prevention and treatment of childhood diseases, malnutrition, anaemia, diarrhoeal diseases, communicable diseases, malaria and other tropical diseases and tuberculosis, among others. Women also have different and unequal opportunities for the protection, promotion and maintenance of their health. In many developing countries, the lack of emergency obstetric services is also of particular concern. Health policies and programmes often perpetuate gender stereotypes and fail to consider socio-economic disparities and other differences among women and may not fully take account of the lack of autonomy of women regarding their health. Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women.

92. Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, discrimination due to race and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health. Lack of food and inequitable distribution of food for girls and women in the household, inadequate access to safe water, sanitation facilities and fuel supplies, particularly in rural and poor urban areas, and deficient housing conditions, all overburden women and their families and have a negative effect on their health. Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.

93. Discrimination against girls, often resulting from son preference, in access to nutrition and health-care services endangers their current and future health and well-being. Conditions that force girls into early marriage, pregnancy and child-bearing and subject them to harmful practices, such as female genital mutilation, pose grave health risks. Adolescent girls need, but too often do not have, access to necessary health and nutrition services as they mature. Counselling and access to sexual and reproductive health information and services for adolescents are still inadequate or lacking completely, and a young woman's right to privacy, confidentiality, respect and informed consent is often not considered. Adolescent girls are both biologically and psychosocially more vulnerable than boys to sexual abuse, violence and prostitution, and to the consequences of unprotected and premature sexual relations. The trend towards early sexual experience, combined with a lack of information and services, increases the risk of unwanted and too early pregnancy, HIV infection and other sexually transmitted diseases, as well as unsafe abortions. Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall, for young women early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on the quality of their lives and the lives of their children. Young men are often not educated to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.

94. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to
decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

95. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

96. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

97. Further, women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction. Complications related to pregnancy and childbirth are among the leading causes of mortality and morbidity of women of reproductive age in many parts of the developing world. Similar problems exist to a certain degree in some countries with economies in transition. Unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk. Most of these deaths, health problems and injuries are preventable through improved access to adequate health-care services, including safe and effective family planning methods and emergency obstetric care, recognizing the right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods
of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. These problems and means should be addressed on the basis of the report of the International Conference on Population and Development, with particular reference to relevant paragraphs of the Programme of Action of the Conference. In most countries, the neglect of women's reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of women to control their own fertility forms an important basis for the enjoyment of other rights. Shared responsibility between women and men in matters related to sexual and reproductive behaviour is also essential to improving women's health.

98. HIV/AIDS and other sexually transmitted diseases, the transmission of which is sometimes a consequence of sexual violence, are having a devastating effect on women's health, particularly the health of adolescent girls and young women. They often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment. Women, who represent half of all adults newly infected with HIV/AIDS and other sexually transmitted diseases, have emphasized that social vulnerability and the unequal power relationships between women and men are obstacles to safe sex, in their efforts to control the spread of sexually transmitted diseases. The consequences of HIV/AIDS reach beyond women's health to their role as mothers and caregivers and their contribution to the economic support of their families. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective.

99. Sexual and gender-based violence, including physical and psychological abuse, trafficking in women and girls, and other forms of abuse and sexual exploitation place girls and women at high risk of physical and mental trauma, disease and unwanted pregnancy. Such situations often deter women from using health and other services.

100. Mental disorders related to marginalization, powerlessness and poverty, along with overwork and stress and the growing incidence of domestic violence as well as substance abuse, are among other health issues of growing concern to women. Women throughout the world, especially young women, are increasing their use of tobacco with serious effects on their health and that of their children. Occupational health issues are also growing in importance, as a large number of women work in low-paid jobs in either the formal or the informal labour market under tedious and unhealthy conditions, and the number is rising. Cancers of the breast and cervix and other cancers of the reproductive system, as well as infertility affect growing numbers of women and may be preventable, or curable, if detected early.

101. With the increase in life expectancy and the growing number of older women, their health concerns require particular attention. The long-term health prospects of women are influenced by changes at menopause, which, in combination with life-long conditions and other factors, such as poor nutrition and lack of physical activity, may increase the risk of cardiovascular disease and osteoporosis. Other diseases of ageing and the interrelationships of ageing and disability among women also need particular attention. . .

Section (L) The Girl Child

259. The Convention on the Rights of the Child recognizes that "States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's
race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or status” (article 2, par. 1). However, in many countries available indicators show that the girl child is discriminated against from the earliest stages of life, through her childhood and into adulthood. In some areas of the world, men outnumber women by 5 in every 100. The reasons for the discrepancy include, among other things, harmful attitudes and practices, such as female genital mutilation, son preference - which results in female infanticide and prenatal sex selection - early marriage, including child marriage, violence against women, sexual exploitation, sexual abuse, discrimination against girls in food allocation and other practices related to health and well-being. As a result, fewer girls than boys survive into adulthood.

Section (I). Human Rights of Women

225. Many women face additional barriers to the enjoyment of their human rights because of such factors as their race, language, ethnicity, culture, religion, disability or socio-economic class or because they are indigenous people, migrants, including women migrant workers, displaced women or refugees. They may also be disadvantaged and marginalized by a general lack of knowledge and recognition of their human rights as well as by the obstacles they meet in gaining access to information and recourse mechanisms in cases of violation of their rights.

227. While women are increasingly using the legal system to exercise their rights, in many countries lack of awareness of the existence of these rights is an obstacle that prevents women from fully enjoying their human rights and attaining equality. Experience in many countries has shown that women can be empowered and motivated to assert their rights, regardless of their level of education or socio-economic status. Provision of human rights education is essential for promoting an understanding of the human rights of women, including knowledge of recourse mechanisms to redress violations of their rights. It is necessary for all individuals, especially women in vulnerable circumstances, to have full knowledge of their rights and access to legal recourse against violations of their rights.

228. Women engaged in the defence of human rights must be protected. Governments have a duty to guarantee the full enjoyment of all rights set out in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights by women working peacefully in a personal or organizational capacity for the promotion and protection of human rights. Non-governmental organizations, women's organizations and feminist groups have played a catalytic role in the promotion of the human rights of women through grass-roots activities, networking and advocacy and need encouragement, support and access to information from Governments in order to carry out these activities.

229. In addressing the enjoyment of human rights, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that, before decisions are taken, an analysis is made of the effects on women and men, respectively.


Further actions and initiatives to implement the Beijing Declaration and Platform for Action
I. Introduction

1. The Governments which came together at the special session of the General Assembly have reaffirmed their commitment to the goals and objectives contained in the Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women in 1995 as contained in the report of the Conference. The Beijing Declaration and Platform for Action set as goals gender equality, development and peace and constituted an agenda for the empowerment of women. The Governments reviewed and appraised progress and identified obstacles and current challenges in the implementation of the Platform for Action. They recognized that the goals set and commitments made in the Platform for Action have not been fully achieved and implemented, and have agreed upon further actions and initiatives at the local, national, regional and international levels to accelerate the implementation of the Platform for Action and to ensure that commitments for gender equality, development and peace are fully realized.

3. The objective of the Platform for Action, which is in full conformity with the purposes and principles of the Charter of the United Nations and international law, is the empowerment of all women. The full realization of all human rights and fundamental freedoms of all women is essential for the empowerment of women. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms. The implementation of the Platform for Action, including through national laws and the formulation of strategies, policies, programmes and development priorities, is the sovereign responsibility of each State, in conformity with all human rights and fundamental freedoms, and the significance of and full respect for various religious and ethical values, cultural backgrounds and philosophical convictions of individuals and their communities should contribute to the full enjoyment by women of their human rights and the achievement of equality, development and peace.

5. The Platform for Action recognizes that women face barriers to full equality and advancement because of such factors as their race, age, language, ethnicity, culture, religion or disability, because they are indigenous women or of other status. Many women encounter specific obstacles related to their family status, particularly as single parents, and to their socio-economic status, including their living conditions in rural, isolated or impoverished areas. Additional barriers also exist for refugee women, other displaced women, including internally displaced women, as well as for immigrant women and migrant women, including women migrant workers. Many women are also particularly affected by environmental disasters, serious and infectious diseases and various forms of violence against women.


1.1. The 1994 International Conference on Population and Development occurs at a defining moment in the history of international cooperation. With the growing recognition of global population, development and environmental interdependence, the opportunity to adopt suitable macro- and socio-economic policies to promote sustained economic growth in the context of sustainable development in all countries and to mobilize human and financial resources for global problem-solving has never been greater. Never before has the world community had so many resources, so much knowledge and such powerful technologies at its disposal which, if suitably redirected, could foster sustained economic growth and sustainable development. None
the less, the effective use of resources, knowledge and technologies is conditioned by political and economic obstacles at the national and international levels. Therefore, although ample resources have been available for some time, their use for socially equitable and environmentally sound development has been seriously limited.

1.8. Over the past 20 years, many parts of the world have undergone remarkable demographic, social, economic, environmental and political change. Many countries have made substantial progress in expanding access to reproductive health care and lowering birth rates, as well as in lowering death rates and raising education and income levels, including the educational and economic status of women. While the advances of the past two decades in areas such as increased use of contraception, decreased maternal mortality, implemented sustainable development plans and projects and enhanced educational programmes provide a basis for optimism about successful implementation of the present Programme of Action, much remains to be accomplished. The world as a whole has changed in ways that create important new opportunities for addressing population and development issues. Among the most significant are the major shifts in attitude among the world's people and their leaders in regard to reproductive health, family planning and population growth, resulting, inter alia, in the new comprehensive concept of reproductive health, including family planning and sexual health, as defined in the present Programme of Action. A particularly encouraging trend has been the strengthening of political commitment to population-related policies and family-planning programmes by many Governments.

1.12. The present Programme of Action recommends to the international community a set of important population and development objectives, as well as qualitative and quantitative goals that are mutually supportive and of critical importance to these objectives. Among these objectives and goals are: sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health.

Chapter II: Principles

Principle 1  All human beings are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Everyone has the right to life, liberty and security of person.

Principle 4  Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community.

Principle 10  Everyone has the right to education, which shall be directed to the full development of human resources, and human dignity and potential, with particular attention to women and the girl child. Education should be designed to strengthen respect for human rights and fundamental freedoms, including those relating to population and development. The best
interests of the child shall be the guiding principle of those responsible for his or her education and guidance; that responsibility lies in the first place with the parents….

Section B: Population, sustained economic growth and poverty

3.16. The objective is to raise the quality of life for all people through appropriate population and development policies and programmes aimed at achieving poverty eradication, sustained economic growth in the context of sustainable development and sustainable patterns of consumption and production, human resource development and the guarantee of all human rights, including the right to development as a universal and inalienable right and an integral part of fundamental human rights. Particular attention is to be given to the socio-economic improvement of poor women in developed and developing countries. As women are generally the poorest of the poor and at the same time key actors in the development process, eliminating social, cultural, political and economic discrimination against women is a prerequisite of eradicating poverty, promoting sustained economic growth in the context of sustainable development, ensuring quality family planning and reproductive health services, and achieving balance between population and available resources and sustainable patterns of consumption and production. . .

3.17. Investment in human resource development, in accordance with national policy, must be given priority in population and development strategies and budgets, at all levels, with programmes specifically directed at increased access to information, education, skill development, employment opportunities, both formal and informal, and high-quality general and reproductive health services, including family planning and sexual health care, through the promotion of sustained economic growth within the context of sustainable development in developing countries and countries with economies in transition.

3.18. Existing inequities and barriers to women in the workforce should be eliminated and women’s participation in all policy-making and implementation, as well as their access to productive resources, and ownership of land, and their right to inherit property should be promoted and strengthened. Governments, non-governmental organizations and the private sector should invest in, promote, monitor and evaluate the education and skill development of women and girls and the legal and economic rights of women, and in all aspects of reproductive health, including family planning and sexual health, in order to enable them to effectively contribute to and benefit from economic growth and sustainable development...

Section E: Persons with disabilities

6.28. Persons with disabilities constitute a significant proportion of the population. The implementation of the World Programme of Action concerning Disabled Persons (1983-1992) contributed towards increased awareness and expanded knowledge of disability issues, increased the role played by persons with disabilities and by concerned organizations, and contributed towards the improvement and expansion of disability legislation. However, there remains a pressing need for continued action to promote effective measures for the prevention of disability, for rehabilitation and for the realization of the goals of full participation and equality for persons with disabilities. In its resolution 47/88 of 16 December 1992, the General Assembly encouraged the consideration by, inter alia, the International Conference on Population and Development, of disability issues relevant to the subject-matter of the Conference.

6.29. The objectives are:
(a) To ensure the realization of the rights of all persons with disabilities, and their participation in all aspects of social, economic and cultural life;
(b) To create, improve and develop necessary conditions that will ensure equal opportunities for persons with disabilities and the valuing of their capabilities in the process of economic and social development;
(c) To ensure the dignity and promote the self-reliance of persons with disabilities.

Actions
6.30. Governments at all levels should consider the needs of persons with disabilities in terms of ethical and human rights dimensions. Governments should recognize needs concerning, inter alia, reproductive health, including family planning and sexual health, HIV/AIDS, information, education and communication. Governments should eliminate specific forms of discrimination that persons with disabilities may face with regard to reproductive rights, household and family formation, and international migration, while taking into account health and other considerations relevant under national immigration regulations.
6.31. Governments at all levels should develop the infrastructure to address the needs of persons with disabilities, in particular with regard to their education, training and rehabilitation.
6.32. Governments at all levels should promote mechanisms ensuring the realization of the rights of persons with disabilities and reinforce their capabilities of integration.
6.33. Governments at all levels should implement and promote a system of follow-up of social and economic integration of persons with disabilities.

Chapter 7: REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

A. Reproductive rights and reproductive health Basis for action
7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.
7.3. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of
these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

Objectives
7.5. The objectives are:
(a) To ensure that comprehensive and factual information and a full range of reproductive health-care services, including family planning, are accessible, affordable, acceptable and convenient to all users;
(b) To enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so;
(c) To meet changing reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities.

Actions
7.6. All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breastfeeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes.
7.7. Reproductive health-care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services. Governments and other organizations should take positive steps to include women at all levels of the health-care system.

B. Family planning

Basis for action
7.12. The aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of services.
safe and effective methods. The success of population education and family-planning programmes in a variety of settings demonstrates that informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities. The principle of informed free choice is essential to the long-term success of family-planning programmes. Any form of coercion has no part to play. In every society there are many social and economic incentives and disincentives that affect individual decisions about child-bearing and family size. Over the past century, many Governments have experimented with such schemes, including specific incentives and disincentives, in order to lower or raise fertility. Most such schemes have had only marginal impact on fertility and in some cases have been counterproductive. Governmental goals for family planning should be defined in terms of unmet needs for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients. . .

Objectives
7.14. The objectives are:
(a) To help couples and individuals meet their reproductive goals in a framework that promotes optimum health, responsibility and family well-being, and respects the dignity of all persons and their right to choose the number, spacing and timing of the birth of their children;
(b) To prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality;
(c) To make quality family-planning services affordable, acceptable and accessible to all who need and want them, while maintaining confidentiality;
(d) To improve the quality of family-planning advice, information, education, communication, counselling and services. . .

Actions
7.15. Governments and the international community should use the full means at their disposal to support the principle of voluntary choice in family planning.
7.16. All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population. All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice. . .

7.19. As part of the effort to meet unmet needs, all countries should seek to identify and remove all the major remaining barriers to the utilization of family-planning services. Some of those barriers are related to the inadequacy, poor quality and cost of existing family-planning services. It should be the goal of public, private and non-governmental family-planning organizations to remove all programme-related barriers to family-planning use by the year 2005 through the redesign or expansion of information and services and other ways to increase the ability of couples and individuals to make free and informed decisions about the number, spacing and timing of births and protect themselves from sexually transmitted diseases.

7.20. Specifically, Governments should make it easier for couples and individuals to take responsibility for their own reproductive health by removing unnecessary legal, medical, clinical and regulatory barriers to information and to access to family-planning services and methods. . .
7.23. In the coming years, all family-planning programmes must make significant efforts to improve quality of care. Among other measures, programmes should:
(a) Recognize that appropriate methods for couples and individuals vary according to their age, parity, family-size preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods in order to enable them to exercise free and informed choice;
(b) Provide accessible, complete and accurate information about various family-planning methods, including their health risks and benefits, possible side effects and their effectiveness in the prevention of the spread of HIV/AIDS and other sexually transmitted diseases;
(c) Make services safer, affordable, more convenient and accessible for clients and ensure, through strengthened logistical systems, a sufficient and continuous supply of essential high-quality contraceptives. Privacy and confidentiality should be ensured;
(d) Expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communications and counselling;
(e) Ensure appropriate follow-up care, including treatment for side effects of contraceptive use;
(f) Ensure availability of related reproductive health services on site or through a strong referral mechanism;
(g) In addition to quantitative measures of performance, give more emphasis to qualitative ones that take into account the perspectives of current and potential users of services through such means as effective management information systems and survey techniques for the timely evaluation of services;
(h) Family-planning and reproductive health programmes should emphasize breast-feeding education and support services, which can simultaneously contribute to birth spacing, better maternal and child health and higher child survival.

C. Sexually transmitted diseases and prevention of human immunodeficiency virus (HIV)

Basis for action
7.27. The world-wide incidence of sexually transmitted diseases is high and increasing. The situation has worsened considerably with the emergence of the HIV epidemic. Although the incidence of some sexually transmitted diseases has stabilized in parts of the world, there have been increasing cases in many regions.
7.28. The social and economic disadvantages that women face make them especially vulnerable to sexually transmitted infections, including HIV, as illustrated, for example, by their exposure to the high-risk sexual behaviour of their partners. For women, the symptoms of infections from sexually transmitted diseases are often hidden, making them more difficult to diagnose than in men, and the health consequences are often greater, including increased risk of infertility and ectopic pregnancy. The risk of transmission from infected men to women is also greater than from infected women to men, and many women are powerless to take steps to protect themselves.
Objectives
7.29. The objective is to prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women.

7.30. Reproductive health programmes should increase their efforts to prevent, detect and treat sexually transmitted diseases and other reproductive tract infections, especially at the primary health-care level. Special outreach efforts should be made to those who do not have access to reproductive health-care programmes.
7.31. All health-care providers, including all family-planning providers, should be given specialized training in the prevention and detection of, and counselling on, sexually transmitted diseases, especially infections in women and youth, including HIV/AIDS.

7.32. Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.

D. Human sexuality and gender relations

Basis for action

7.34. Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour. Responsible sexual behaviour, sensitivity and equity in gender relations, particularly when instilled during the formative years, enhance and promote respectful and harmonious partnerships between men and women.

7.35. Violence against women, particularly domestic violence and rape, is widespread, and rising numbers of women are at risk from AIDS and other sexually transmitted diseases as a result of high-risk sexual behaviour on the part of their partners. In a number of countries, harmful practices meant to control women's sexuality have led to great suffering. Among them is the practice of female genital mutilation, which is a violation of basic rights and a major lifelong risk to women's health.

7.36. The objectives are:
(a) To promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals;
(b) To ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities.

7.38. In the light of the urgent need to prevent unwanted pregnancies, the rapid spread of AIDS and other sexually transmitted diseases, and the prevalence of sexual abuse and violence, Governments should base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behaviour.

7.39. Active and open discussion of the need to protect women, youth and children from any abuse, including sexual abuse, exploitation, trafficking and violence, must be encouraged and supported by educational programmes at both national and community levels. Governments should set the necessary conditions and procedures to encourage victims to report violations of their rights. Laws addressing those concerns should be enacted where they do not exist, made explicit, strengthened and enforced, and appropriate rehabilitation services provided. Governments should also prohibit the production and the trade of child pornography.

7.40. Governments and communities should urgently take steps to stop the practice of female genital mutilation and protect women and girls from all such similar unnecessary and dangerous practices. Steps to eliminate the practice should include strong community outreach programmes.
involving village and religious leaders, education and counselling about its impact on girls' and women's health, and appropriate treatment and rehabilitation for girls and women who have suffered mutilation. Services should include counselling for women and men to discourage the practice.

A. Primary health care and the health-care sector

Basis for action

8.1. One of the main achievements of the twentieth century has been the unprecedented increase in human longevity. In the past half century, expectation of life at birth in the world as a whole has increased by about 20 years, and the risk of dying in the first year of life has been reduced by nearly two thirds. Nevertheless, these achievements fall short of the much greater improvements that had been anticipated in the World Population Plan of Action and the Declaration of Alma Ata, adopted by the International Conference on Primary Health Care in 1978. There remain entire national populations and sizeable population groups within many countries that are still subject to very high rates of morbidity and mortality. Differences linked to socio-economic status or ethnicity are often substantial. In many countries with economies in transition, the mortality rate has considerably increased as a result of deaths caused by accidents and violence.

8.6. The role of women as primary custodians of family health should be recognized and supported. Access to basic health care, expanded health education, the availability of simple cost-effective remedies, and the reappraisal of primary health-care services, including reproductive health-care services to facilitate the proper use of women's time, should be provided.

C. Women's health and safe motherhood

Basis for action

8.19. Complications related to pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in many parts of the developing world. At the global level, it has been estimated that about half a million women die each year of pregnancy-related causes, 99 per cent of them in developing countries. The gap in maternal mortality between developed and developing regions is wide: in 1988, it ranged from more than 700 per 100,000 live births in the least developed countries to about 26 per 100,000 live births in the developed regions. Rates of 1,000 or more maternal deaths per 100,000 live births have been reported in several rural areas of Africa, giving women with many pregnancies a high lifetime risk of death during their reproductive years. According to the World Health Organization, the lifetime risk of dying from pregnancy or childbirth-related causes is 1 in 20 in some developing countries, compared to 1 in 10,000 in some developed countries. The age at which women begin or stop child-bearing, the interval between each birth, the total number of lifetime pregnancies and the socio-cultural and economic circumstances in which women live all influence maternal morbidity and mortality. At present, approximately 90 per cent of the countries of the world, representing 96 per cent of the world population, have policies that permit abortion under varying legal conditions to save the life of a woman. However, a significant proportion of the abortions carried out are self-induced or otherwise unsafe, leading to a large fraction of maternal deaths or to permanent injury to the women involved. Maternal deaths have very serious consequences within the family, given the crucial role of the mother for her children's health and welfare. The death of the mother increases the risk to the survival of her young children, especially if the family is not able to provide a substitute for the maternal role. Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion. Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality.
Objectives

8.20. The objectives are:
(a) To promote women's health and safe motherhood; to achieve a rapid and substantial reduction in maternal morbidity and mortality and reduce the differences observed between developing and developed countries and within countries. On the basis of a commitment to women's health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion.

Actions

8.21. Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. The realization of these goals will have different implications for countries with different 1990 levels of maternal mortality. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed.

8.22. All countries, with the support of all sections of the international community, must expand the provision of maternal health services in the context of primary health care. These services, based on the concept of informed choice, should include education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programmes, adequate delivery assistance that avoids excessive recourse to caesarean sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; post-natal care and family planning. All births should be assisted by trained persons, preferably nurses and midwives, but at least by trained birth attendants. The underlying causes of maternal morbidity and mortality should be identified, and attention should be given to the development of strategies to overcome them and for adequate evaluation and monitoring mechanisms to assess the progress being made in reducing maternal mortality and morbidity and to enhance the effectiveness of ongoing programmes. Programmes and education to engage men's support for maternal health and safe motherhood should be developed.

8.23. All countries, especially developing countries, with the support of the international community, should aim at further reductions in maternal mortality through measures to prevent, detect and manage high-risk pregnancies and births, particularly those to adolescents and late-parity women.

D. Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS)

Basis for action

8.28. The AIDS pandemic is a major concern in both developed and developing countries. WHO estimates that the cumulative number of AIDS cases in the world amounted to 2.5 million persons by mid-1993 and that more than 14 million people had been infected with HIV since the pandemic began, a number that is projected to rise to between 30 million and 40 million by the end of the decade if effective prevention strategies are not pursued. As of mid-1993, about four fifths of all persons ever infected with HIV lived in developing countries where the infection was being transmitted mainly through heterosexual intercourse and the number of new cases was
rising most rapidly among women. As a consequence, a growing number of children are becoming orphans, themselves at high risk of illness and death. In many countries, the pandemic is now spreading from urban to rural areas and between rural areas and is affecting economic and agricultural production.

Objectives
8.29. The objectives are:
(a) To prevent, reduce the spread of and minimize the impact of HIV infection; to increase awareness of the disastrous consequences of HIV infection and AIDS and associated fatal diseases, at the individual, community and national levels, and of the ways of preventing it; to address the social, economic, gender and racial inequities that increase vulnerability to the disease;
(b) To ensure that HIV-infected individuals have adequate medical care and are not discriminated against; to provide counselling and other support for people infected with HIV and to alleviate the suffering of people living with AIDS and that of their family members, especially orphans; to ensure that the individual rights and the confidentiality of persons infected with HIV are respected; to ensure that sexual and reproductive health programmes address HIV infection and AIDS;
(c) To intensify research on methods to control the HIV/AIDS pandemic and to find an effective treatment for the disease.

Actions
8.30. Governments should assess the demographic and development impact of HIV infection and AIDS. The AIDS pandemic should be controlled through a multisectoral approach that pays sufficient attention to its socio-economic ramifications, including the heavy burden on health infrastructure and household income, its negative impact on the labour force and productivity, and the increasing number of orphaned children. Multisectoral national plans and strategies to deal with AIDS should be integrated into population and development strategies. The socio-economic factors underlying the spread of HIV infection should be investigated, and programmes to address the problems faced by those left orphaned by the AIDS pandemic should be developed.
8.31. Programmes to reduce the spread of HIV infection should give high priority to information, education and communication campaigns to raise awareness and emphasize behavioural change.

8.32. Governments should mobilize all segments of society to control the AIDS pandemic, including non-governmental organizations, community organizations, religious leaders, the private sector, the media, schools and health facilities. Mobilization at the family and community levels should be given priority. Communities need to develop strategies that respond to local perceptions of the priority accorded to health issues associated with the spread of HIV and sexually transmitted diseases.

8.33. The international community should mobilize the human and financial resources required to reduce the rate of transmission of HIV infection. To that end, research on a broad range of approaches to prevent HIV transmission and to seek a cure for the disease should be promoted and supported by all countries. In particular, donor and research communities should support and strengthen current efforts to find a vaccine and to develop women-controlled methods, such as vaginal microbicides, to prevent HIV infection. Increased support is also needed for the treatment and care of HIV-infected persons and AIDS patients. The coordination of activities to combat the AIDS pandemic must be enhanced. Particular attention should be given to activities of the United Nations system at the national level, where measures such as joint programmes can improve coordination and ensure a more efficient use of scarce resources. The international
Community should also mobilize its efforts in monitoring and evaluating the results of various efforts to search for new strategies.

8.34. Governments should develop policies and guidelines to protect the individual rights of and eliminate discrimination against persons infected with HIV and their families. Services to detect HIV infection should be strengthened, making sure that they ensure confidentiality. Special programmes should be devised to provide care and the necessary emotional support to men and women affected by AIDS and to counsel their families and near relations.

8.35. Responsible sexual behaviour, including voluntary sexual abstinence, for the prevention of HIV infection should be promoted and included in education and information programmes. Condoms and drugs for the prevention and treatment of sexually transmitted diseases should be made widely available and affordable and should be included in all essential drug lists. Effective action should be taken to further control the quality of blood products and equipment decontamination.

B. Documented migrants Basis for action

10.9. Documented migrants are those who satisfy all the legal requirements to enter, stay and, if applicable, hold employment in the country of destination. In some countries, many documented migrants have, over time, acquired the right to long-term residence. In such cases, the integration of documented migrants into the host society is generally desirable, and for that purpose it is important to extend to them the same social, economic and legal rights as those enjoyed by citizens, in accordance with national legislation. The family reunification of documented migrants is an important factor in international migration. It is also important to protect documented migrants and their families from racism, ethnocentrism and xenophobia, and to respect their physical integrity, dignity, religious beliefs and cultural values. Documented migration is generally beneficial to the host country, since migrants are in general concentrated in the most productive ages and have skills needed by the receiving country, and their admission is congruent with the policies of the Government. The remittances of documented migrants to their countries of origin often constitute a very important source of foreign exchange and are instrumental in improving the well-being of relatives left behind.

Objectives
10.10.
The objectives are:
(a) To ensure the social and economic integration of documented migrants, especially of those who have acquired the right to long-term residence in the country of destination, and their equal treatment before the law;
(b) To eliminate discriminatory practices against documented migrants, especially women, children and the elderly.

Actions
10.11. Governments of receiving countries are urged to consider extending to documented migrants who meet appropriate length-of-stay requirements, and to members of their families whose stay in the receiving country is regular, treatment equal to that accorded their own nationals. Governments of receiving countries are further urged to take appropriate steps to avoid all forms of discrimination against migrants, including eliminating discriminatory practices concerning their nationality and the nationality of their children, and to protect their rights and safety. Women and children who migrate as family members should be protected from abuse or denial of their human rights by their sponsors, and Governments are asked to consider extending their stay should the family relationship dissolve, within the limits of national legislation.
10.13. Governments of countries of destination should respect the basic human rights of documented migrants as those Governments assert their right to regulate access to their territory and adopt policies that respond to and shape immigration flows. With regard to the admission of migrants, Governments should avoid discriminating on the basis of race, religion, sex and disability, while taking into account health and other considerations relevant under national immigration regulations, particularly considering the special needs of the elderly and children. . .

B. Population information, education and communication

1. Basis for action

1.11. Greater public knowledge, understanding and commitment at all levels, from the individual to the international, are vital to the achievement of the goals and objectives of the present Programme of Action. In all countries and among all groups, therefore, information, education and communication activities concerning population and sustainable development issues must be strengthened. This includes the establishment of gender- and culturally sensitive information, education and communication plans and strategies related to population and development . .

11.12. Effective information, education and communication are prerequisites for sustainable human development and pave the way for attitudinal and behavioural change. Indeed, this begins with the recognition that decisions must be made freely, responsibly and in an informed manner, on the number and spacing of children and in all other aspects of daily life, including sexual and reproductive behaviour. . .

11.13. Effective information, education and communication activities include a range of communication channels, from the most intimate levels of interpersonal communication to formal school curricula, from traditional folk arts to modern mass entertainment, and from seminars for local community leaders to coverage of global issues by the national and international news media. Multichannel approaches are usually more effective than any single communication channel. All these channels of communication have an important role to play in promoting an understanding of the interrelationships between population and sustainable development. Schools and religious institutions, taking into account their values and teachings, may be important vehicles in all countries for instilling gender and racial sensitivity, respect, tolerance and equity, family responsibility and other important attitudes at all ages. Effective networks also exist in many countries for non-formal education on population and sustainable development issues through the workplace, health facilities, trade unions, community centres, youth groups, religious institutions, women's organizations and other non-governmental organizations. Such issues may also be included in more structured adult education, vocational training and literacy programmes, particularly for women. These networks are critical to reaching the entire population, especially men, adolescents and young couples. Parliamentarians, teachers, religious and other community leaders, traditional healers, health professionals, parents and older relatives are influential in forming public opinion and should be consulted during the preparation of information, education and communication activities. The media also offer many potentially powerful role models.

11.14. Current information, education and communication technologies, such as global interlinked telephone, television and data transmission networks, compact discs and new multimedia technologies, can help bridge the geographical, social and economic gaps that currently exist in access to information around the world. They can help ensure that the vast majority of the world's people are involved in debates at the local, national and global levels
about demographic changes and sustainable human development, economic and social inequities, the importance of empowering women, reproductive health and family planning, health promotion, ageing populations, rapid urbanization and migration.

Objectives

The objectives are:
(a) To increase awareness, knowledge, understanding and commitment at all levels of society so that families, couples, individuals, opinion and community leaders, non-governmental organizations, policy makers, Governments and the international community appreciate the significance and relevance of population-related issues, and take the responsible actions necessary to address such issues within sustained economic growth in the context of sustainable development;
(b) To encourage attitudes in favour of responsible behaviour in population and development, especially in such areas as environment, family, sexuality, reproduction, gender and racial sensitivity;
(c) To ensure political commitment to population and development issues by national Governments in order to promote the participation of both public and private sectors at all levels in the design, implementation and monitoring of population and development policies and programmes;
(d) To enhance the ability of couples and individuals to exercise their basic right to decide freely and responsibly on the number and spacing of their children, and to have the information, education and means to do so.

Actions

Information, education and communication efforts should raise awareness through public education campaigns on such priority issues as: safe motherhood, reproductive health and rights, maternal and child health and family planning, discrimination against and valorization of the girl child and persons with disabilities; child abuse; violence against women; male responsibility; gender equality; sexually transmitted diseases, including HIV/AIDS; responsible sexual behaviour; teenage pregnancy; racism and xenophobia; ageing populations; and unsustainable consumption and production patterns.

Chapter XV* PARTNERSHIP WITH THE NON-GOVERNMENTAL SECTOR

A. Local, national and international non-governmental organizations

Basis for action

As the contribution, real and potential, of non-governmental organizations gains clearer recognition in many countries and at regional and international levels, it is important to affirm its relevance in the context of the preparation and implementation of the present Programme of Action. To address the challenges of population and development effectively, broad and effective partnership is essential between Governments and non-governmental organizations (comprising not-for-profit groups and organizations at the local, national and international levels) to assist in the formulation, implementation, monitoring and evaluation of population and development objectives and activities.

Despite widely varying situations in their relationship and interaction with Governments, non-governmental organizations have made and are increasingly making important contributions to both population and development activities at all levels. In many areas of population and development activities, non-governmental groups are already rightly recognized for their comparative advantage in relation to government agencies, because of innovative, flexible and responsive programme design and implementation, including grass-roots participation, and because quite often they are rooted in and interact with constituencies that are poorly served and hard to reach through government channels.
15.3. Non-governmental organizations are important voices of the people, and their associations and networks provide an effective and efficient means of better focusing local and national initiatives and addressing pressing population, environmental, migration and economic and social development concerns.

15.5. The experience, capabilities and expertise of many non-governmental organizations and local community groups in areas of direct relevance to the Programme of Action is acknowledged. Non-governmental organizations, especially those working in the field of sexual and reproductive health and family planning, women’s organizations and immigrant and refugee support advocacy groups, have increased public knowledge and provided educational services to men and women which contribute towards successful implementation of population and development policies... These diverse organizations can help in ensuring the quality and relevance of programmes and services to the people they are meant to serve. They should be invited to participate with local, national and international decision-making bodies, including the United Nations system, to ensure effective implementation, monitoring and evaluation of the present Programme of Action.

ICPD POA specifically called on Governments at all levels to eliminate discrimination against people with disabilities with regard to their sexual and reproductive rights and to ensure their participation in decision-making at all levels.


Prevention
Prevention of health conditions associated with disability is a development issue. Attention to environmental factors including nutrition, preventable diseases, safe water and sanitation, safety on roads and in workplaces can greatly reduce the incidence of health conditions leading to disability...

A public health approach distinguishes:
Primary prevention – actions to avoid or remove the cause of a health problem in an individual or a population before it arises. It includes health promotion and specific protection (for example, HIV education) (54).

Secondary prevention – actions to detect a health problem at an early stage in an individual or a population, facilitating cure, or reducing or preventing spread, or reducing or preventing its long-term effects (for example, supporting women with intellectual disability to access breast cancer screening) (55).

Tertiary prevention – actions to reduce the impact of an already established disease by restoring function and reducing disease-related complications (for example, rehabilitation for children with musculoskeletal impairment) (56).

Disability and human rights...

Article 3 of the CRPD outlines the following general principles:
1. respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;
2. non-discrimination;
3. full and effective participation and inclusion in society;
4. respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
5. equality of opportunity;
6. accessibility;
7. equality between men and women;
8. respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

States ratifying the CRPD have a range of general obligations. Among other things, they undertake to: adopt legislation and other appropriate administrative measures where needed; modify or repeal laws, customs, or practices that discriminate directly or indirectly; include disability in all relevant policies and programmes; refrain from any act or practice inconsistent with the CRPD; take all appropriate measures to eliminate discrimination against persons with disabilities by any person, organization, or private enterprise.

**Box 1.4. The Millennium Development Goals and disability**

The Millennium Development Goals (MDGs) – agreed on by the international community in 2000 and endorsed by 189 countries – are a unified set of development objectives addressing the needs of the world’s poorest and most marginalized people, and are supposed to be achieved by 2015. The goals are:

1. promote gender equality and empower women . . .
2. improve maternal health . . .

The MDGs are a compact between developing and developed nations. They recognize the efforts that must be taken by developing countries themselves, as well as the contribution that developed countries need to make through trade, development assistance, debt relief, access to essential medicines, and technology transfer.

While some of the background documents explicitly mention people with disabilities, they are not referred to in the MDGs, or in the material generated as part of the process to achieve them. The 2010 MDG report is the first to mention disabilities, noting the limited opportunities facing children with disabilities, and the link between disability and marginalization in education. The Ministerial Declaration of July 2010 recognizes disability as a cross-cutting issue essential for the attainment of the MDGs, emphasizing the need to ensure that women and girls with disabilities are not subject to multiple or aggravated forms of discrimination, or excluded from participation in the implementation of the MDGs (101). The United Nations General Assembly has highlighted the invisibility of persons with disabilities in official statistics (102).

**Global Estimates of disability prevalence**

... Across all countries, vulnerable groups such as women, those in the poorest wealth quintile, and older people had higher prevalences of disability. For all these groups the rate was higher in developing countries. The prevalence of disability in lower income countries among people aged 60 years and above, for instance, was 43.4%, compared with 29.5% in higher income countries. . .

About the prevalence estimates

[T]he sex ratio for disability differs greatly between the World Health Survey and the Global Burden of Disease (see Table 2.1 and Table 2.2). At the global level, the Global Burden of
Disease estimates of moderate and severe disability prevalence are 11% higher for females than males, reflecting somewhat higher age-specific prevalences in females, but also the greater number of older women in the population than older men. But the World Health Survey estimates give a female prevalence of disability nearly 60% higher than that for males. It is likely that the differences between females and males in the World Health Survey study result to some extent from differences in the use of response categories.

Demographics

Older persons
Higher disability rates among older people reflect an accumulation of health risks across a lifespan of disease, injury, and chronic illness (74). The disability prevalence among people 45 years and older in low-income countries is higher than in high-income countries, and higher among women than among men.

Needs and unmet needs
Disabled respondents from 51 countries reported seeking more inpatient and outpatient care than people without disabilities in the WHO 2002-2004 World Health Survey . . . . Women seek care more often than men, and so do respondents with disabilities in high-income countries compared with respondents in low-income countries across gender and age groups.

Health promotion and prevention
While some research indicates minimal differences in immunization rates . . . people with disabilities are generally less likely to receive screening and preventive services. Several studies found that women with disabilities receive less screening for breast and cervical cancer compared with women without disabilities . . . .

Sexual and reproductive health services
Sexual and reproductive health services include family planning, maternal health care, preventing and managing gender-based violence, and preventing and treating sexually transmitted infections including HIV/AIDS. While little information is available, it is widely held that people with disabilities have significant unmet needs. . . . Adolescents and adults with disabilities are more likely to be excluded from sex education programmes. . . . A national study in the United States showed that women with functional limitations were less likely to be asked about contraceptive use during visits to general practitioners.

Addressing barriers to service delivery
Medical equipment is often not accessible for people with disabilities, particularly those with mobility impairments. In the World Health Survey men with disabilities report health services provider’s equipment (including medication) to be inadequate across income settings (22.4% compared with 7.7% for men without disabilities); women with disabilities in high-income countries report similar difficulties . . . . For example, many women with mobility impairments are unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand . . . .

Communications difficulties between people with disabilities and service providers are regularly cited as an area of concern . . . . An investigation into Deaf women’s access to health care in the United States found that health-care workers often turn their heads down when talking, preventing deaf women from lip-reading.

. . . Perceptions of health status may influence health behaviours, including attendance at health care services, and how health needs are communicated. . . . An Australian study on women with
mental health conditions and physical, sensory, and intellectual impairment found that self-perceptions regarding sexuality, painful past experiences associated with reproductive screening, and memories of themselves before disability were all barriers to seeking health care.

Box 3.6. Sexual and reproductive rights of persons with disabilities
Despite legal prohibitions, there are many cases of involuntary sterilization being used to restrict the fertility of some people with a disability, particularly those with an intellectual disability, almost always women. . . . Involuntary sterilization of persons with disabilities is contrary to international human rights standards. Persons with disabilities should have access to voluntary sterilization on an equal basis with others. Furthermore, sterilization is almost never the only option for menstrual management or fertility control. . . . Nor does it offer any protection against sexual abuse or sexually transmitted diseases. Legal frameworks and reporting and enforcement mechanisms need to be put in place to ensure that, whenever sterilization is requested, the rights of persons with disabilities are always respected above other competing interests.

Understanding rehabilitation

Needs and unmet needs
Most of the available data on national supply and unmet needs are derived from disability-specific surveys on specific populations such as: . . . National studies on living conditions of people with disabilities conducted in Malawi, Mozambique, Namibia, Zambia, and Zimbabwe . . . revealed large gaps in the provision of medical rehabilitation and assistive devices. . . . Gender inequalities in access to assistive devices were evidence in Malawi (men 25.3% and women 14.1%) and Zambia (men 15.7% and women 11.9%). . . .

Increasing human resources for rehabilitation
The lack of women in rehabilitation professions, and the cultural attitudes towards gender, affect rehabilitation services in some contexts. The low number of women technicians in India, for example, may partly explain why women with disabilities were less likely than men to receive assistive devices. . . . Female patients in Afghanistan can be treated only by female therapists, and men only by men. Restrictions on travel for women prevent female psychotherapists from participating in professional development and training workshops and limit their ability to make home visits. . . .

Understanding support and assistance

Consequences for caregivers of unmet need for formal support services
Informal care can be an efficient and cost-effective way of supporting people with disabilities. But exclusive reliance on informal support can have adverse consequences for caregivers.

- Stress. The demands of caring often result in stress for families, particularly for women, who tend to be responsible for domestic labour, with care for family members with disability representing a significant share. . . .
- Fewer opportunities for employment. Where employment would otherwise be an option, caring for a family member with a disability is likely to result in lost economic opportunities, as caregivers either reduce their paid work or refrain from seeking it. . . . An analysis of the General Household Survey in the United Kingdom found that informal care reduced the probability of working by 13% for men and 27% for women. . . .
- Excessive demands on children. When adults acquire a disability, children are often asked to help. . . . Female children may be expected to contribute to domestic tasks or to help support the parent with a disability.
Provision of assistance and support

Limited data are available on the economic value of informal care, overwhelmingly performed by women. In 2005-2006 the estimated value of all unpaid care in Australia was A$41.4 billion, the major part of all “welfare services resources,” which amounted to A$72.6 billion. A Canadian study found that private expenditure, largely related to time costs for provision of assistance, accounted for 85% of total home-care costs, which escalated as activity limitations increased.

Lack of adequate human resources

Many support workers are economic migrants, lacking skills and a career ladder. They are vulnerable to exploitation, particularly given their precarious immigration status. The high demand for support workers in more affluent countries has led to an inflow of people, largely women, from neighboring countries.

Work and employment

Barriers to entering the labour market

Wages

If people with disabilities are employed, they commonly earn less than their counterparts without disabilities; women with disabilities commonly earn less than men with disabilities. The wage gaps between men and women with and without disabilities are thus as important as the difference in employment rates.

The way forward: Recommendations

Disability: a global concern

Diverse experiences

Women with disabilities experience gender discrimination as well as disabling barriers.

Vulnerable populations

Disability disproportionately affects vulnerable populations. There is a higher disability prevalence in lower-income countries than in higher-income countries. People from the poorest wealth quintile, women, and older people have a higher prevalence of disability.

The World Bank (26 January 2010), Poverty and Disability. Available at: http://go.worldbank.org/IMVL0SHUT0. [Note from Stephanie: This link leads to a page that itself offers links to a number of different documents so here look to see if there are useful documents on this topic we don’t already have and if useful, add them to the list and quote them.]


1. Introduction and background

Chronic poverty and disability in Uganda are inextricably linked. Despite impressive economic gains made by the country in the last 10 - 15 years, current evidence suggests that at least 2.4 million disabled people remain poor.
2. Disability feeds on poverty, and poverty on disability. Because of poverty many people become disabled. Such people have very limited access to health care and facilities (including immunisation); they have very rudimentary feeding and nutrition; they are exposed to a number of disabling conditions, etc. As a consequence chronically poor people are more likely to become disabled. On the other hand, many disabled people lack education and skills training. Hence they cannot easily access employment. The physically demanding nature of unskilled labour (a hallmark of most African economies) also makes it difficult for disabled people to be involved in labour intensive activities. This situation is made worse by outright social exclusion of disabled people that constrains disabled people’s participation in the job market.


**Box 1. The Convention on the Rights of Persons with Disabilities addresses sexual and reproductive health**

. . . Several articles of the Convention have direct relevance to SRH, reproductive rights, and gender-based violence (see Appendix A): Article 9 calls for accessibility, including access to medical facilities and to information. Article 16 requires states parties to take measures to protect persons with disabilities from violence and abuse, including gender-based violence and abuse. Article 22 asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information. Article 23 requires states to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life. . .

2.1 A significant constituency

. . . [T]he needs of persons with disabilities are often overlooked or neglected. Worse, many persons with disabilities are marginalized, they are deprived of freedom, and their human rights are violated.

(1). Historically, as part of this pattern, persons with disabilities have been denied information about sexual and reproductive health (SRH). Furthermore, they have often been denied the right to establish relationships and to decide whether, when, and with whom to have a family. Many have been subjected to forced sterilizations, forced abortions, or forced marriages (6). They are more likely to experience physical, emotional, and sexual abuse and other forms of gender-based violence. They are more likely to become infected with HIV and other sexually transmitted infections (STIs) (7). In crisis situations these risks are multiplied. . .

3.2.1 Gender and disability

While many issues faced by persons with disabilities apply equally to men and women, some issues are gender specific. Among the special issues more often faced by women with disabilities than by men are forced marriage, domestic violence, and other types of physical, emotional, and sexual abuse, the burdens of household responsibilities, and issues concerning pregnancy, labour, delivery, and childrearing. Nonetheless, men with disabilities are also at greater risk of sexual abuse than men who do not have disabilities.

Women and disability
It has been said that to be a woman and a person with a disability is to be doubly marginalized. Among obstacles faced particularly by women are the following:
Survival rates: In many societies the survival rate for women with disabilities is lower than that for men with disabilities. For example, Helander (11) reports that in Nepal the long-term survival rate of women who were disabled by polio is only half that of men who had polio.

Unstable relationships: Considered in some societies as less eligible marriage partners, women with disabilities are more likely to live in a series of unstable relationships, and thus have fewer legal, social and economic options should these relationships become abusive.

Maternal morbidity and mortality: Women with disabilities are not only less likely to receive general information on sexual and reproductive health and are less likely to have access to family planning services, but should they become pregnant, they are also less likely than their non-disabled peers to have access to prenatal, labour and delivery and post-natal services. Physical, attitudinal and information barriers frequently exist. Often community level midwifery staff will not see women with disabilities, arguing that the birthing process needs the help of a specialist or will need a Cesarean section - which is not necessarily the case. Of equal concern is the fact that in many places women with disabilities are routinely turned away from such services should they seek help, often also being told that they should not be pregnant, or scolded because they have decided to have a child (12).

Women without disabilities in households with family members with a disability: Parents of children with disabilities often find themselves socially isolated. Stigma, poverty, and lack of support systems take a toll on such families. The burdens often fall disproportionately on women in such households. Thus, support systems for care providers, as well as for persons with disabilities, are crucial – both formal systems, such as social security and health insurance, and informal social networks, such as community support groups. Furthermore, in a number of societies, if a child is born with a disability, it is assumed that the mother has been unfaithful or has otherwise sinned. She suffers significantly as a result of this assumption. Even without such stigma, the physical, mental and financial stresses, coupled with social isolation, result in rates of divorce and desertion often twice as high among mothers of children with disabilities as among their peers who do not have children with disabilities. There are a number of ramifications of this – most striking, a cycle of increasing poverty.

3.2.2 Life-cycle approach

Like everyone else, persons with disabilities have SRH needs throughout their lives, and these needs change over a lifetime. Different age groups face different challenges. For example, adolescents go through puberty and require information about the changes in their bodies and emotions, and about the choices they face concerning sexual and reproductive health related behavior (see Box 4). Adolescents with disabilities need to know all this information, but they also may need special preparation concerning sexual abuse and violence and the right to protection from it. It is important to assure that SRH services are friendly to youth with disabilities. On reaching the age for having a family, women and couples with disabilities, like everyone else, have the right to decide whether and when to have children and a right to sound, unbiased information on which to base these decisions. Health-care providers owe all clients, whether they have disabilities or not, encouragement, support, and appropriate services over the years – both when they want to have children and when they want to avoid pregnancy.

Box 6. WHO Task Force improves internal policies and practices

The WHO Task Force on Disability is an initiative launched by the Director-General to help mainstream disability issues across the Organization and to ensure that WHO responds to the challenge of the new Convention on the Rights of Persons with Disabilities. At the six-month mark of this two-year project, the response from across the Organization has been very gratifying: for example, improvements have been made in the accessibility of the WHO web site and of the buildings, development of a new human resources policy on disability, and ongoing work to address the needs of persons with disabilities in various technical programmes. In the
area of Reproductive Health, for instance, collaboration with the Department of Reproductive Health and Research and with UNAIDS has produced a policy brief on the intersections between HIV/AIDS and disability, improved technical guidance on contraceptive choices for women with disabilities, and, in partnership with UNFPA, this guidance note.

Appendix C.
Key recommendations to all humanitarian actors concerning persons with disabilities in emergency situations...
Set up a standard, centralized data collection system to collect disaggregated data on the number, age, gender and profile of displaced persons with disabilities in order to enhance their protection and assistance. Conduct community-based information and awareness-raising campaigns to promote greater tolerance, respect and understanding of persons with disabilities. Promote the inclusion of people with all types of disabilities in camp management structures, community decision-making processes and at all stages of the program cycle, ensuring age and gender diversity.


Overview
- In most OECD countries, women report higher incidents of disability than men.
- The World Bank estimates that 20 per cent of the world’s poorest people are disabled, and tend to be regarded in their own communities as the most disadvantaged.
- Women with disabilities are recognized to be multiply disadvantaged, experiencing exclusion on account of their gender and their disability.
- Women and girls with disabilities are particularly vulnerable to abuse. A small 2004 survey in Orissa, India, found that virtually all of the women and girls with disabilities were beaten at home, 25 per cent of women with intellectual disabilities had been raped and 6 per cent of disabled women had been forcibly sterilized.

Education
- The global literacy rate for adults with disabilities is as low as 3 per cent, and 1 per cent for women with disabilities, according to a 1998 UNDP study


An estimated 10% of the world’s population – 650 million people – live with a disability. Persons with disabilities have the same sexual and reproductive health (SRH) needs as other people. Yet they often face barriers to information and services. The ignorance and attitudes of society and individuals, including health-care providers, raise most of these barriers – not the disabilities themselves. In fact, existing services usually can be adapted easily to accommodate persons with disabilities. Increasing awareness is the first and biggest step. Beyond that, much can be accomplished through resourcefulness and involving persons with disabilities in programme design and monitoring. . .

This guidance note addresses issues of SRH programming for persons with disabilities. It is intended for SRH experts and advocates within UNFPA and WHO as well as those in other development organizations and partners.
Those who address issues of family planning, maternal health, HIV and AIDS, adolescence, and gender-based violence (GBV) may find this information particularly helpful. SRH, in particular, deserves attention because these needs have been so widely and so deeply neglected. At the same time, however, the approaches discussed here apply broadly to all aspects of health programming for persons with disabilities. This note outlines a general approach to programming and does not address specific protocols for the SRH care and treatment of persons with disabilities.

Often already marginalized, persons with disabilities become even more vulnerable when humanitarian crises occur. Between 2.5 and 3.5 million of the world’s 35 million displaced persons also live with disabilities, according to a 2008 report by the Women’s Commission for Refugee Women and Children (4, 5).

Despite these large numbers, the needs of persons with disabilities are often overlooked or neglected. Worse, many persons with disabilities are marginalized, they are deprived of freedom, and their human rights are violated.

Historically, as part of this pattern, persons with disabilities have been denied information about sexual and reproductive health (SRH). Furthermore, they have often been denied the right to establish relationships and to decide whether, when, and with whom to have a family. Many have been subjected to forced sterilizations, forced abortions, or forced marriages (6). They are more likely to experience physical, emotional, and sexual abuse and other forms of gender-based violence. They are more likely to become infected with HIV and other sexually transmitted infections (STIs) (7). In crisis situations these risks are multiplied. The United Nations system and its partners seek to clarify their roles and strengthen their capacity and collaborative efforts to support the implementation of the new Convention as a matter of human rights. Furthermore, a world that neglects 20% of the poor in developing countries cannot achieve the Millennium Development Goals (MDGs) and other international agendas, including the Programme of Action of the International Conference on Population and Development (ICPD).

Disability concerns must be integrated into all the programmatic and policy goals associated with SRH and reproductive rights...

2.2 Sexual and reproductive health needs largely unmet

All too often, the SRH of persons with disabilities has been overlooked by both the disability community and those working on SRH. This leaves persons with disabilities among the most marginalized groups when it comes to SRH services. Yet persons with disabilities have the same needs for SRH services as everyone else. In fact, persons with disabilities may actually have greater needs for SRH education and care than persons without disabilities due to their increased vulnerability to abuse. The challenges to SRH faced by persons with disabilities are not necessarily part of having a disability, but instead often reflect lack of social attention, legal protection, understanding and support. Persons with disabilities often cannot obtain even the most basic information about SRH. Thus they remain ignorant of basic facts about themselves, their bodies, and their rights to define what they do and do not want. (They may have little experience relating to and negotiating with potential partners.) Persons with disabilities may be denied the right to establish relationships, or they may be forced into unwanted marriages, where they may be treated more as housekeepers or objects of abuse than as a member of the family. As a group, persons with disabilities fit the common pattern of structural risks for HIV/AIDS and other sexually transmitted infections – e.g. high rates of poverty, high rates of illiteracy, lack of access to health resources, and lack of power when negotiating safer sex. (For further guidance concerning HIV, see Disability and HIV. UNAIDS, WHO and OHCHR policy brief, April 2009.)
Persons with disabilities are up to three times more likely than non-disabled persons to be victims of physical and sexual abuse and rape. Persons with intellectual and mental disabilities are the most vulnerable. Persons with disabilities are sometimes placed in institutions, group homes, hospitals, and other group living situations, where they not only may be prevented from making informed and independent decisions about their SRH, but where they may also face an increased risk of abuse and violence. Violence against persons with disabilities is compounded by the fact that the victims may be physically and financially dependent on those who abuse them. Furthermore, when they come forward to report such abuse, the medical (both physical and mental), legal, and social service systems are often unresponsive and inaccessible.

Persons with disabilities face many barriers to care and information about SRH, GBV and other violence, and abuse. First is the frequent assumption that persons with disabilities are not sexually active and therefore do not need SRH services. Research shows, however, that persons with disabilities are as sexually active as persons without disabilities (9). Despite this, too often their sexuality has been ignored and their reproductive rights, denied. At best, most existing policies and programmes concentrate on the prevention of pregnancy but ignore the fact that many persons with disabilities will eventually have children of their own. At worst, forced sterilization and forced abortion often have been imposed on persons with disabilities. Furthermore, SRH services are often inaccessible to persons with disabilities for many reasons, including physical barriers, the lack of disability-related clinical services, and stigma and discrimination. In many situations barriers to health services include:

- lack of physical access, including transportation and/or proximity to clinics and, within clinics, lack of ramps, adapted examination tables, and the like;
- lack of information and communication materials (e.g. lack of materials in Braille, large print, simple language, and pictures; lack of sign language interpreters);
- health-care providers’ negative attitudes;
- providers’ lack of knowledge and skills about persons with disabilities;
- lack of coordination among health care providers;
- lack of funding, including lack of health-care insurance.

3.1 Multiple challenges

All efforts to include fully persons with disabilities, their needs, and their concerns in health policy and programmes must confront multiple challenges. People’s impairments are not the source of these challenges. Instead, these are the challenges that the world imposes on persons with disabilities:

- Lack of awareness, knowledge, and understanding. Although one person in every 10 has a disability, persons with disabilities are often “invisible”. Policy-makers and providers often greatly underestimate the number of persons with disabilities. If they think there are few persons with disabilities, they may assign them low priority among groups needing attention. Also, they may assume incorrectly that persons with disabilities are not sexually active and so do not need SRH services.
Prejudice and stigma. Public attitudes differ from place to place and among different types of disability. The great majority of persons with disabilities face prejudice and stigma in their daily lives. This prejudice underlies the deprivation of a wide range of human rights, from freedom of movement and association to health and education and pursuit of a livelihood.

Physical and attitudinal barriers to health services. Physical barriers to access may reflect simple lack of awareness and forethought or else the assumption that “it costs too much” to remove these barriers. Changing misperceptions and prejudiced attitudes, however, may be more difficult to address than removing physical barriers.

Exclusion of persons with disabilities from decision-making. Too often even programmes with the best intentions have treated persons with disabilities as a “target” – passive recipients of services. In fact, persons with disabilities constitute a significant stakeholder group that should have a place at the table whenever health programmes are planned and decisions are made. Their involvement is the best assurance that programmes will meet needs effectively.

3.2 Issues requiring special attention

Meeting these challenges to the SRH of persons with disabilities involves some specific considerations. Many of these considerations apply to the SRH of all people, but they can take on a new light from the perspective of persons with disabilities.

3.2.1 Gender and disability

While many issues faced by persons with disabilities apply equally to men and women, some issues are gender specific. Among the special issues more often faced by women with disabilities than by men are forced marriage, domestic violence, and other types of physical, emotional, and sexual abuse, the burdens of household responsibilities, and issues concerning pregnancy, labour, delivery, and childrearing. Nonetheless, men with disabilities are also at greater risk of sexual abuse than men who do not have disabilities. Women and disability. It has been said that to be a woman and a person with a disability is to be doubly marginalized. Among obstacles faced particularly by women are the following:

Survival rates: In many societies the survival rate for women with disabilities is lower than that for men with disabilities. For example, Helander reports that in Nepal the long-term survival rate of women who were disabled by polio is only half that of men who had polio.

Unstable relationships: Considered in some societies as less eligible marriage partners, women with disabilities are more likely to live in a series of unstable relationships, and thus have fewer legal, social and economic options should these relationships become abusive.

Maternal morbidity and mortality: Women with disabilities are not only less likely to receive general information on sexual and reproductive health and are less likely to have access to family planning services, but should they become pregnant, they are also less likely than their non-disabled peers to have access to prenatal, labour and delivery and post-natal services. Physical, attitudinal and information barriers frequently exist. Often community level midwifery staff will not see women with disabilities, arguing that the birthing process needs the help of a specialist or will need a Cesarean section - which is not necessarily the case. Of equal concern is the fact that in many places women with disabilities are routinely turned away from such services should they seek help, often also being told that they should not be pregnant, or scolded because they have decided to have a child (12).
Women without disabilities in households with family members with a disability: Parents of children with disabilities often find themselves socially isolated. Stigma, poverty, and lack of support systems take a toll on such families. The burdens often fall disproportionately on women in such households. Thus, support systems for care providers, as well as for persons with disabilities, are crucial − both formal systems, such as social security and health insurance, and informal social networks, such as community support groups. Furthermore, in a number of societies, if a child is born with a disability, it is assumed that the mother has been unfaithful or has otherwise sinned. She suffers significantly as a result of this assumption. Even without such stigma, the physical, mental and financial stresses, coupled with social isolation, result in rates of divorce and desertion often twice as high among mothers of children with disabilities as among their peers who do not have children with disabilities. There are a number of ramifications of this − most striking, a cycle of increasing poverty…

4.3 Ensure that all sexual and reproductive health programmes reach and serve persons with disabilities. Review all current programmes to ensure that persons with disabilities have access to all programmes and services offered to the community. With modest adaptations broad-based SRH programmes can fully serve most persons with disabilities… .

4.3.1 Types of programme
Mainstreaming in all programmes. Existing programmes can meet the SRH needs of most persons with disabilities. Modest adaptations can accommodate a wide range of disabilities, and these adaptations usually can be identified easily with the help of persons with disabilities. Persons with disabilities are a crucial constituency in all programmes. Therefore, persons with disabilities need to be consulted, and the needs of persons with disabilities should be addressed in all programmes at all levels − international, regional, national, and local…

4.3.2
Activities to raise awareness and address misconceptions, stigma, and lack of knowledge. Many health professionals, partner organizations, and communities will need training or awareness-raising on how to address the SRH of persons with disabilities. Although there are some special considerations for persons with disabilities concerning SRH, most of the impediments to providing good-quality services are related to providers’ attitudes and basic lack of general knowledge about disabilities. The required information can easily be integrated into existing training strategies and curricula. Training about persons with disabilities and their needs should be addressed both in in-service SRH training for current providers and in pre-service training offered in medical, nursing, midwifery, public health, and hospital administration programmes. Persons with disabilities themselves should be co-facilitators or presenters of such training whenever possible. Raising awareness about SRH for persons with disabilities requires fighting misconceptions, stigma, and discrimination in communities. . . A key message is that negative attitudes and barriers in societies are often more disabling than the actual impairments. Another key message at all levels is that persons with disabilities are entitled to self-determination, privacy, respect, and dignity in all situations. It is also important to promote awareness of the capabilities and contributions of persons with disabilities. In particular, persons with disabilities, their families, the health and development community, and members of the general public need education about rights and about harmful practices such as forced sterilization, forced abortion, and forced marriage. Furthermore, people need to know whom to contact and where to go to obtain protection against such abuses.

Chronic Poverty and Disability in Uganda (2003), Charles Lwanga-Ntale, Development Research & Training at Chronic Poverty Research Center

1. Introduction and background
Chronic poverty and disability in Uganda are inextricably linked. Despite impressive economic gains made by the country in the last 10 - 15 years, current evidence suggests that at least 2.4 million disabled people remain poor. . .

2. Disability feeds on poverty, and poverty on disability. Because of poverty many people become disabled. Such people have very limited access to health care and facilities (including immunisation); they have very rudimentary feeding and nutrition; they are exposed to a number of disabling conditions, etc. As a consequence chronically poor people are more likely to become disabled. On the other hand, many disabled people lack education and skills training. Hence they cannot easily access employment. The physically demanding nature of unskilled labour (a hallmark of most African economies) also makes it difficult for disabled people to be involved in labour intensive activities. This situation is made worse by outright social exclusion of disabled people that constrains disabled people's participation in the job market. Understanding the processes that underpin the poverty-disability dynamic, and the reasons that prevent disabled people from participating in, or benefiting from, development opportunities is, therefore, a pre-requisite for suggesting pro-disabled people’s policy interventions, hence this research.

6.4. What are the “drivers” of chronic poverty among disabled people. . .

6.4.2. Exclusion, isolation, fear and neglect:
Exclusion, isolation and neglect were observed to be among the leading causes of marginalisation, failure to access resources, and hence chronic poverty among disabled people. There is fundamental ignorance around disability at all levels of society. In Mukono and Iganga witchcraft was blamed, especially if mental illness was involved, in which case individuals and their families were likely to be rejected by both their families and by communities. Widespread fear of disability, especially of mentally ill individuals, is based on a common perception that disability and mental illness are contagious. The perception is even more deep-rooted for epilepsy. Evidence from Mulago in Kampala revealed that even within the medical profession, disability is given little time in training and negligible allocation of resources hence ignorance is very widespread outside of the tiny number of people that are trained specifically in this area. Approaches that are used by traditional practitioners in dealing with disability follow the “curative medical model”, but often lend themselves to physical and sexual abuse in “treatment”. Awareness raising appears to be an urgent need for all community members and professionals. . .

Disabled teenagers on the other hand, especially as they explore and discover their sexuality, find it extremely difficult to find boyfriends or girlfriends, which in turn makes them vulnerable to “any willing sexual partners”, sometimes carrying with them the risk of HIV/AIDS. Several reports, however, also mentioned men who only want to “explore” the sexuality of a disabled person but have no intention of entering into long-term relationships. Adult disabled persons, also, neither had genuine friendships nor fully participated in social activities. . .

Most disabled women were observed to be particularly vulnerable because:
•They lack permanent marriage partners
•They are unable to defend themselves in case they are attacked sometimes raped.
• They may themselves be seeking to have a child at any cost and with anybody able and willing to father the child.

• They are unable to make firm decisions on matters of sexuality due to powerlessness resulting from various forms of social discrimination.

• Many are made to believe that they are “simply being helped to satisfy their sexual desires”.

• Communication materials that are prepared on important health messages such as HIV/AIDS are either inaccessible or the mode in which they are transmitted unfriendly.

• They lack sensitisation on reproductive issues.

The implications of social exclusion ranged from missed opportunities in education, to seclusion and non-participation in development activities. Many disabled persons also missed out on development-oriented information in health, governance, etc. which further marginalized them from participation in mainstream activities . . .

6.4.3. Feminisation of disability:
(a) Disability a “curse” to the family:
Among some people in three out of four districts (Mbarara, Mukono and Iganga) disability was considered to be “a curse” brought to the family through the woman (mother of the disabled child). Thus it was evident in these districts that if disabled children are borne to a family, not only does the burden of care fall on the shoulders of the woman, but she too is often blamed for bringing “kisirani” (a curse) to the family. In Mbarara and Iganga disability was believed to be “transmitted” by a mother, who was sometimes blamed for failing to perform some marital rites or simply “looking at the wrong people” during the course of pregnancy. The common remedy when a woman, therefore, produces a disabled child, is for the man to “find another wife (woman) who does not produce disabled children.”

(b) Disability diminishes a woman’s chances to marry:
Disability for female children, it was observed, created additional challenges. Communities’ expectation that girl children will be married off at puberty to start their own life - working for their husbands and bringing forth babies - was noted not to hold for disabled girls. Having a disability often meant that one was unable to cultivate, prepare food for self and others, do household chores or even have personal care. This tended to “reduce the value of disabled girls” which further condemned them to exclusion and poverty. For such young women no marriage meant no livelihood and hence very marginal survival. Since access to prime resources for survival, such as land, are through a husband or male relative, being a disabled girl meant at the outset that there would be no access at all to any important resources.

(c) Disabled co-wives more resented than other women: In Iganga District it was revealed that disabled women who are married as second or third wives faced particular resentment from “first wives” who could not come to terms with a disabled person being their co-wife. Such disabled women, once they came to the household, faced intra-household exclusion and were at times discriminated against. The situation was not, however, the same for all disabled co-wives, especially those who were successful in business . . .

6.4.6. Women with Disabilities
Ugandan society is still very patriarchal and discriminatory. Although attitudes are changing, women’s social role is primarily defined through motherhood and homemaking. With little or no opportunity to live up to the demanding ideals of womanhood that are imposed by society, disabled women experience more discrimination than other women. As a result of exclusion, disabled women are more likely to be poor or destitute and also have a lesser chance of founding a family or benefiting from social capital and protection that are often associated with family relationships. Thus the stigma of disability, its myths and fears are likely to increase women’s social isolation in society, and hence poverty. But women with disabilities, especially widows, are also more vulnerable to poverty because in addition to having to look after their children single-handedly, such children have fewer opportunities for inheriting properties since they would be considered to have been borne out of wedlock.

[Note from Stephanie: Please include the direct quote from the above document.]

Section 1.01 Vision

FIGO has a vision that women of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives.

Section 1.02 Mission

FIGO is a professional organisation that brings together obstetrical and gynecological associations from all over the world.

FIGO is dedicated to the improvement of women’s health and rights and to the reduction of disparities in healthcare available to women and newborns, as well as to advancing the science and practice of obstetrics and gynecology.

The organisation pursues its mission through advocacy, programmatic activities, capacity strengthening of Member Associations, education and training.

(a) FIGO’s overall goals are:

- to improve the health and wellbeing of women and newborn children worldwide;
- to raise the status of women and enable their active participation to achieve their reproductive and sexual rights with access to efficient education and services throughout their life cycle;
- and to upgrade the practice of obstetrics and gynecology through education, training and research to maintain a high standard of professionalism and ethical adherence

FIGO’s considerable global achievements include a staging system for gynecologic tumours (used in hospitals worldwide); ethical guidelines; harmonisation of scientific terminology; numerous General Assembly resolutions; and various major maternal and newborn health initiatives funded by major global donor bodies.

Section 1.03 Commitments
1. Encouraging all efforts for raising the status of women and for advancing their role in all issues related to women’s health
2. Promoting sexual and reproductive health and rights and services through education, research and advocacy, as well as through the provision of accessible, efficient, affordable, sustainable and comprehensive reproductive health services
3. Emphasising the importance of achieving the Millennium Development Goals by 2015 - FIGO is committed to accelerating its efforts and activities to reach MDG targets, especially in the area of safe motherhood and newborn health
4. Continually upgrading the practice of gynecology and obstetrics through research, education and training, and by maintaining the highest levels of professionalism and scientific and ethical standards
5. Improving communication with and between Member Associations and building the capacities of those from low-resource countries through strengthening leadership, management, good practice and the promotion of policy dialogues
6. Strengthening capacities to enable societies to play a pivotal role in the development and implementation of sustainable programmes aimed at the improvement of care available to women and newborns, especially for poor and underserved populations
7. Recognising the importance of collaborative efforts for advancing women’s health and rights - FIGO is committed to strengthening partnerships with other international professional organisations, UN agencies, and the public/private sector to achieve its objectives

**International Federation of Gynecology and Obstetrics, Female Contraceptive Sterilization.** (2011), Available at: [http://www.wwda.org.au/FIGOGuidelines2011.pdf](http://www.wwda.org.au/FIGOGuidelines2011.pdf). ‘Forced/involuntary sterilization’ refers to the performance of a procedure which results in sterilization in the absence of the free and informed consent of the individual who undergoes the procedure, including instances in which sterilization has been authorized by a third party, without that individual’s consent. This is considered to have occurred if the procedure is carried out in circumstances other than where there is a serious threat to life. Coerced sterilization occurs when financial or other incentives, misinformation, misrepresentation, undue influences, pressure, and/or intimidation tactics are used to compel an individual to undergo the procedure. Coercion includes conditions of duress such as fatigue or stress. Undue influences include situations in which the person concerned perceives there may be an unpleasant consequence associated with refusal of consent. Any sterilization of a child, unless performed as a life-saving measure, is considered a forced sterilization.


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