International Disability Alliance (IDA)

Disabled Peoples' International, Down Syndrome International, Inclusion International,
International Federation of Hard of Hearing People,
Rehabilitation International, World Blind Union,
World Federation of the Deaf, World Federation of the DeafBlind,
World Network of Users and Survivors of Psychiatry,
Arab Organization of Disabled People, European Disability Forum, Pacific Disability Forum,
Red Latinoamericana de Organizaciones no Gubernamentales de Personas con
Discapacidad y sus familias (RIADIS)

IDA submission to the Committee on Economic, Social and Cultural Rights
Day of General Discussion on Sexual and Reproductive Health Rights
15 November 2010

The International Disability Alliance (IDA) is the network of global and regional organisations of persons with disabilities (DPOs) currently comprising nine global and four regional DPOs, with two other regional DPOs having observer status. With member organisations around the world, IDA represents the estimated 650 million people worldwide living with a disability, the world's largest – and most frequently overlooked – minority group. IDA's mission is to promote the effective implementation of the UN Convention on the Rights of Persons with Disabilities, as well as compliance with the CRPD within the whole UN system including in the work of other treaty bodies.

IDA welcomes the initiative of the Committee on Economic, Social and Cultural rights (*hereinafter* "CESCR Committee") to hold a Day of General Discussion on the right to sexual and reproductive health and encourages the drafting and adoption of a General Comment on this subject. IDA believes that such a General Comment will serve as a comprehensive update of General Comments of the treaty bodies which touch upon the issue such as CESCR Committee's General Comment no 5 on persons with disabilities adopted in 1994, CEDAW General Recommendation on disabled women adopted in 1991, and others (see Annex).

The sexual and reproductive health rights of persons with disabilities have traditionally been denied, ignored or at best misunderstood by medical and health professionals, policy makers, and wider society. The medical model continues to reign in which persons with all types of disabilities (physical, sensory, and psychosocial disabilities) are viewed as unable or unfit to engage in sexual activity, and unable or unfit to exercise parental rights and responsibilities, and deemed unworthy to be informed and educated about their right to sexual and reproductive health.

As a result of this long standing and continuing discrimination, adolescents and adults with disabilities have frequently been considered genderless or asexual. In the case of institutional settings, staff often reject the idea that patients/residents are interested in engaging in intimate relationships, and any display of sexual interest or conduct is

considered as a treatable consequence of their condition. Due to widespread attitudes of neglect and psychiatrisation in institutional settings and in society, the right to sexual autonomy is prohibited, and no efforts are taken to provide information or education about healthy sexual relationships and reproductive health. The failure to address these important issues increases the risk of sexual abuse and exploitation, and the transmission of HIV and other sexually transmitted infections (STIs).

Persons with disabilities are also subject to discrimination and violation of their right to found a family when they are denied access to fertility treatment. This could be for a variety of reasons, all of which are entrenched in the medical model of disability which views the bodies and minds of persons with disabilities as unsuitable or undesirable for reproduction. For example, persons with psychosocial disabilities who have trouble conceiving and require fertility treatment, can be withheld such treatment if they are deemed unfit to become parents on the basis of a psychiatric history or a medical opinion; they are denied the right to found a family on an equal basis with others because the authoritative view is that they cannot amount to anything else but their condition or perceived condition. The same obstacles exist for persons with developmental disabilities who are most often automatically deemed unfit to be parents and hence denied fertility treatment. For persons with spinal cord injuries, it is often the case that fertility treatments are inaccessible due to the costs for such treatments. When it is one's disability which is the cause of infertility, treatments and their costs should be within reach to ensure that persons with disabilities have opportunities to conceive on an equal basis with others. And where a disability is genetically transferable, such as muscular dystrophy or cystic fibrosis, fertility treatments may offer a way to have children but break the genetic chain of the disability. However, such solutions are rarely explored. In general, the inaccessibility of fertility treatments for persons with disabilities has a negative impact on research and development to explore and find new opportunities for persons with disabilities who face challenges in conceiving or who are infertile.

Women and girls with disabilities experience double discrimination which places them at a higher risk of gender based violence, sexual abuse, neglect, maltreatment, harassment and exploitation. They suffer violence both within and outside the home including rape (also marital rape), forced marriages, female genital mutilation (FGM) and other harmful traditional practices, and most often health and community professionals are not trained to treat the negative reproductive health consequences of FGM and other harmful traditional practices such as infections, obstructed labour, perineal tears, fistula and infertility bearing upon them. Women and girls with disabilities are also subjected to forced abortion, forced contraception (including pills, injections and intrauterine devices –IUDs), and forced sterilisation (hysterectomy, tubal ligation, essure). Boys and men with disabilities have also been subjected to forced sterilisation (vasectomy) or chemical castration. They have been equally neglected in being informed about their rights and as a consequence are often ill-equipped to take on the responsibility of their own reproductive and sexual behavior and health. The Platform for Action of the Fifth World Conference for Women in 1995 in Beijing recognised the need for men's participation in sexual and reproductive health when it stated that '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." Nonetheless, in general, awareness by persons with disabilities of their sexual and reproductive health rights is hampered by high rates of illiteracy, unemployment and poverty; 90% of children with

disabilities in developing countries do not attend school and 80% of persons with disabilities live in developing countries.

With the entry into force of the CRPD came the important paradigm shift from the outdated medical model of disability, viewing persons with disabilities as objects of treatment, to persons with disabilities emerging as subjects of their own rights. Several rights of the CRPD uphold the sexual and reproductive rights of persons with disabilities:

- Article 25 - Right to health

Article 25 on the right to the enjoyment of the highest attainable standard of health makes explicit reference of sexual and reproductive health and the obligation to provide persons with disabilities the same range, quality and standard of free or affordable health care and programmes as provided to other persons on the basis of free and informed consent. The requirement of free and informed consent therefore prohibits any coercion in medical treatment including forced abortion, forced contraception, forced sterilisation, and administration of all other non-consensual medical treatment. The provision supports access to consensual treatments, such as fertility treatment, on an equal basis with others. Implicit in this right is the availability of trained professionals who are aware of the sexual and reproductive health needs of women and men with disabilities and who are able to effectively communicate and render information accessible.

- Article 17 – Protecting the integrity of the person

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others. Involuntary treatment is a clear violation of an individual's integrity.

- Article 16 – Freedom from violence, exploitation and abuse

This provision requires States Parties to take all appropriate legislative, administrative, social, education 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. This includes all non-consensual medical interventions, sexual violence, forced marriages, FGM, both perpetrated by private and public actors.

- Article 22 – Respect for privacy

The confidential nature of information relating to personal information, health and rehabilitation is particularly pertinent for persons with disabilities. This provision ensures that such information must be accessible to the individual concerned and is not to be shared without prior approval with doctors, family members and other third parties to the ends of non-consensual treatment.

- Article 23 – Respect for the home and family

This provision requires States Parties to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships to ensure that persons with disabilities exercise their right to

- marry and found a family on the basis of free and full consent,
- 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 and the means necessary to enable them to exercise these rights are provided,

- retain their fertility on an equal basis with others (including children with disabilities)
- adopt and receive appropriate assistance in the performance of their child-rearing responsibilities,
- receive early and comprehensive information, services and support for children with disabilities and their families,
- not be separated from their child on the basis of a disability of either the child or one or both parents,
- ensure that, where the immediate family is unable to care for a child with disabilities, every effort is undertaken to provide alternative care within the wider family and failing that within the community in a family setting.

▪ Article 6 – Women with disabilities

Recognising the multiple discrimination to which women and girls with disabilities are subjected, this provision guarantees that measures are to be taken to guarantee their full and equal enjoyment of all human rights and fundamental freedoms, naturally including their right to sexual and reproductive health.

▪ Article 7 – Children with disabilities

Children with disabilities have the right to express their views freely on all matters affecting them, with 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 realise this right. Children with disabilities must have the same rights to information and education on sexual and reproductive health rights, and to access services and assistance with respect to this right in accordance with their age and maturity.

▪ Article 21 – Freedom of expression and opinion, and access to information

This provision requires States Parties to take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the right to seek, receive and impart information and ideas on an equal basis with others with others and through all forms of communication of their choice[1] including by:

- providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost,
- accepting and facilitating the use of sign languages, Braille, augmentative and alternative communication, and all other accessible means, modes and formats of communication of their choice by persons with disabilities in official interactions;
- urging private entities that provide services to the general public, including through the Internet, to provide information and services in accessible and usable formats for persons with disabilities;
- encouraging the mass media, including providers of information through the Internet, to make their services accessible to persons with disabilities;
- recognising and promoting the use of sign languages.

[1] As defined under Article 2 of the CRPD, communication includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology.

This provision requires States to make available and accessible information on sex education including protective measures against STIs, contraceptive measures, family planning options and services to children and adults with disabilities.

- Article 8 – Awareness-raising

Article 8 requires States Parties to adopt immediate effective and appropriate measures to

- raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities;
- combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
- promote awareness of the capabilities and contributions of persons with disabilities.

This provision promotes greater social awareness and positive perceptions about persons with disabilities including their sexual autonomy and reproductive rights, the fostering of an attitude of respect for these rights, and promoting awareness-training programmes regarding persons with disabilities in this area which would necessarily include training programmes for all medical and health professionals, educators and others working in the field of sexual and reproductive health. Training must ensure that information, advice and treatment are provided to persons with disabilities in a respectful and professional manner which does not exert pressure or threats, or amount to judgments on the sexuality and family planning choices of persons with disabilities.

- Article 9 – Accessibility

This provision provides for the elimination of barriers of accessibility in the physical and environment, including explicitly medical facilities, and accessibility of information, communications and other services. Article 9 reinforces the independence and participation of persons with disabilities by ensuring that information and services on sexual and reproductive health is made accessible, hence for information to be available in different formats which respond to the needs of persons with disabilities, for example information in Braille or easy to read formats, availability of sign language interpreters in related services and by providing appropriate training for medical professionals, educators, service providers and others to understand the rights of persons with disabilities concerning sexual and reproductive health, to foster respect for their decisions and to ensure the provision of support for their choices, instead of curtailing them.

- Article 12 – Equal recognition before the law

Article 12 reflects the paradigm shift of the CRPD which recognises that persons with disabilities enjoy legal capacity in all aspects of life on an equal basis with others. Whereas many decisions leading to infringements of the sexual and reproductive health rights of persons with disabilities have been considered valid on the grounds that they were taken by an individual's legal guardian or family member, Article 12 prohibits the deprivation of an individual's capacity to exercise their rights and obliges the State to make available support, where it may be required, for decision making and exercise of rights in accordance with an individual's wills and preferences. This provision prohibits health care decisions such as the use of contraception, abortion, sterilisation, etc to be taken by a third party against the will of the individual concerned. Equally, the right to marry, family planning decisions and the exercise of parental rights cannot be taken away or restricted on the basis of disability, and

appropriate support is made available to persons with disabilities, where it may be required (and so long as it is accepted by the person concerned), for the full enjoyment of these rights.

The CRPD therefore obliges States to respect, protect and fulfill the sexual freedom and choices of persons with disabilities, the right to make their own decisions about their reproductive health, and to make available and accessible all information and services related to the exercise of this right.

On the basis of the CRPD provisions, IDA makes the following recommendations to the CESCR Committee:

- To elaborate and adopt a General Comment on the right to sexual and reproductive health which comprehensively addresses the situation and concerns of children and adults with disabilities by upholding the rights inscribed in the CRPD, including to consult closely with DPOs (organisations run by persons with disabilities, especially membership-based organisations of persons with disabilities) in the drafting process of the General Comment (Article 4(3), CRPD: "In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organisations").

- To call on states to adopt a comprehensive national policy on sexual and reproductive health in which the rights and needs of children and adults with disabilities figure as an integral part of every aspect, including in awareness-raising such as through an inclusive public health campaign, provision of information and services, education and training, and that persons with disabilities and DPOs participate and play a central role in the elaboration, implementation and monitoring of the policy and related campaigns.

- To call on states to adopt measures which ensure that all sexual and reproductive health care and services provided to persons with disabilities are respectful of the dignity and integrity of persons with disabilities and are therefore based on the free and informed consent of the individual concerned, and that consensual treatment such as the administration of contraception, or fertility treatments are not denied, while all non-consensual treatment, including that for which consent is given by a third party, is not permitted by law (including *inter alia* forced abortions, forced contraception, and forced sterilisation). Further, to ensure that the law provides for both criminal and civil remedies for victims whose sexual and reproductive health rights and integrity have been violated through involuntary treatment.

- To call on states to take steps to effectively prohibit in the law sexual violence and abuse including rape (also marital rape), forced marriage, FGM and other harmful traditional practices which violate sexual and reproductive health rights and the right not to be subjected to ill-treatment, and to ensure effective protection of women and girls with disabilities who are at a heightened risk due to discrimination and their marginalisation in society.

- To call on states to ensure information and services related to sexual and reproductive health, including counseling, family planning, maternal health, testing, treatment and counseling for HIV and other STIs, and those available for victims of abuse and exploitation, are available and accessible to children and adults with disabilities. This includes ensuring both that facilities and equipment are available and physically accessible, in both urban and rural areas, and accessibility of communications regarding information and services (making communications and information accessible by having them available in age appropriate and easy to read formats, different languages including sign language and sign language interpretation, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology such as through websites and phone lines). A central component in upholding this right is the availability of trained medical, health and social professionals who are aware of the sexual and reproductive health needs of women and men with disabilities and are able to effectively communicate with them (using the methods described above or through alternative forms of communication) in the provision of advice, information and treatment services.

- To call on states to ensure that support mechanisms and services, should they be solicited, are accessible and available to children and adults with disabilities which are respectful of the wills and preferences of children and adults with disabilities to exercise their sexual autonomy and reproductive health rights including *inter alia*: support to make informed choices, support to engage in sexual activity, support to families of parent(s) with disabilities, and support to families with children with disabilities.

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Annex: Extracts of General Comments/Recommendations related to the sexual and reproductive health rights of persons with disabilities

CESCR General Comment No. 14 (2000), The right to the highest attainable standard of health, Article 12

8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

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:
(i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
(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.

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)) 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, emergency obstetric services and access to information, as well as to resources necessary to act on that information.

16. "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular

HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States' individual and joint efforts to, *inter alia*, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunisation programmes and other strategies of infectious disease control.

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

35. Obligations to *protect* include, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. 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.

CESCR General Comment No. 5 (1993), Persons with disabilities

30. In the case of persons with disabilities, the Covenant's requirement that "protection and assistance" be rendered to the family means that everything possible should be done to enable such persons, when they so wish, to live with their families. Article 10 also implies,

subject to the general principles of international human rights law, the right of persons with disabilities to marry and have their own family. These rights are frequently ignored or denied, especially in the case of persons with mental disabilities. In this and other contexts, the term "family" should be interpreted broadly and in accordance with appropriate local usage. States parties should ensure that laws and social policies and practices do not impede the realisation of these rights. Persons with disabilities should have access to necessary counselling services in order to fulfil their rights and duties within the family.

31. Women with disabilities also have the right to protection and support in relation to motherhood and pregnancy. As the Standard Rules state, "persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood". The needs and desires in question should be recognized and addressed in both the recreational and the procreational contexts. These rights are commonly denied to both men and women with disabilities worldwide. Both the sterilisation of, and the performance of an abortion on, a woman with disabilities without her prior informed consent are serious violations of article 10 (2).

CEDAW General Recommendation No. 14 (1990), Female circumcision

Noting with grave concern that there are continuing cultural, traditional and economic pressures which help to perpetuate harmful practices, such as female circumcision,

Recommends that States parties:

(a) Take appropriate and effective measures with a view to eradicating the practice of female circumcision. Such measures could include:

(iv) The introduction of appropriate educational and training programmes and seminars based on research findings about the problems arising from female circumcision;

(b) Include in their national health policies appropriate strategies aimed at eradicating female circumcision in public health care. Such strategies could include the special responsibility of health personnel, including traditional birth attendants, to explain the harmful effects of female circumcision;

(c) Invite assistance, information and advice from the appropriate organisations of the United Nations system to support and assist efforts being deployed to eliminate harmful traditional practices;

(d) Include in their reports to the Committee under articles 10 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women information about measures taken to eliminate female circumcision.

CEDAW General Recommendation No. 18 (1991), Disabled 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.

CEDAW General Recommendation No.19 (1992), Violence against Women

6. The Convention in article 1 defines discrimination against women. 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.

19. States parties are required by article 12 to take measures to ensure equal access to health care. Violence against women puts their health and lives at risk.

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.

22. Compulsory sterilisation 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.

(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;

(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;

(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;

CEDAW General Recommendation No. 24 (1999), Women and Health, Article 12

5. The Committee refers also to its earlier general recommendations on female circumcision, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), disabled women, violence against women and equality in family relations, all of which refer to issues which are integral to full compliance with article 12 of the Convention.

6. While biological differences between women and men may lead to differences in health status, there are societal factors which are determinative of the health status of women and men and which can vary among women themselves. For that reason, special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities.

25. Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation. States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity.

CEDAW General Comment no. 21, Equality in marriage and family relations, Article 16,

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 sterilisation. 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.

23. There is general agreement that where there are freely available appropriate measures for the voluntary regulation of fertility, the health, development and well-being of all members of the family improves. Moreover, such services improve the general quality of life and health

of the population, and the voluntary regulation of population growth helps preserve the environment and achieve sustainable economic and social development.

CRC General Comment no. 9 (2006), The rights of children with disabilities

42. Children with disabilities are more vulnerable to all forms of abuse be it mental, physical or sexual in all settings, including the family, schools, private and public institutions, inter alia alternative care, work environment and community at large. It is often quoted that children with disabilities are five times more likely to be victims of abuse. In the home and in institutions, children with disabilities are often subjected to mental and physical violence and sexual abuse, and they are also particularly vulnerable to neglect and negligent treatment since they often present an extra physical and financial burden on the family. In addition, the lack of access to a functional complaint receiving and monitoring mechanism is conducive to systematic and continuing abuse. School bullying is a particular form of violence that children are exposed to and more often than not, this form of abuse targets children with disabilities. Their particular vulnerability may be explained inter alia by the following main reasons:
(a) Their inability to hear, move, and dress, toilet, and bath independently increases their vulnerability to intrusive personal care or abuse;
(b) Living in isolation from parents, siblings, extended family and friends increases the likelihood of abuse;
(c) Should they have communication or intellectual impairments, they may be ignored, disbelieved or misunderstood should they complain about abuse;
(d) Parents or others taking care of the child may be under considerable pressure or stress because of physical, financial and emotional issues in caring for their child. Studies indicate that those under stress may be more likely to commit abuse;
(e) Children with disabilities are often wrongly perceived as being non-sexual and not having an understanding of their own bodies and, therefore, they can be targets of abusive people, particularly those who base abuse on sexuality.

47. The Committee has often expressed its concern at the high number of children with disabilities placed in institutions and that institutionalisation is the preferred placement option in many countries. The quality of care provided, whether educational, medical or rehabilitative, is often much inferior to the standards necessary for the care of children with disabilities either because of lack of identified standards or lack of implementation and monitoring of these standards. Institutions are also a particular setting where children with disabilities are more vulnerable to mental, physical, sexual and other forms of abuse as well as neglect and negligent treatment (see paragraphs 42-44 above). The Committee therefore urges States parties to use the placement in institution only as a measure of last resort, when it is absolutely necessary and in the best interests of the child. It recommends that the States parties prevent the use of placement in institution merely with the goal of limiting the child's liberty or freedom of movement. In addition, attention should be paid to transforming existing institutions, with a focus on small residential care facilities organized around the rights and needs of the child, to developing national standards for care in institutions, and to establishing rigorous screening and monitoring procedures to ensure effective implementation of these standards.

76. Children with disabilities, specifically physical disabilities, often end up on the streets for a variety of reasons, including economic and social factors. Children with disabilities living and/or working on the streets need to be provided with adequate care, including nutrition, clothing, housing, educational opportunities, life-skills training as well as protection from the different dangers including economic and sexual exploitation. In this regard an individualized approach is necessary which takes full account of the special needs and the capacities of the child. The Committee is particularly concerned that children with disabilities are sometimes

exploited for the purpose of begging in the streets or elsewhere; sometimes disabilities are inflicted on children for the purpose of begging. States parties are required to take all necessary actions to prevent this form of exploitation and to explicitly criminalize exploitation in such manner and take effective measures to bring the perpetrators to justice.

77. The Committee has often expressed grave concern at the growing number of child victims of child prostitution and child pornography. Children with disabilities are more likely than others to become victims of these serious crimes. Governments are urged to ratify and implement the Optional Protocol on the sale of children, child prostitution and child pornography (OPSC) and, in fulfilling their obligations to the Optional Protocol, States parties should pay particular attention to the protection of children with disabilities recognizing their particular vulnerability.

79. Certain disabilities result directly from the conditions that have led some individuals to become refugees or internally displaced persons, such as human-caused or natural disasters. For example, landmines and unexploded ordnance kill and injure refugee, internally displaced and resident children long after armed conflicts have ceased. Refugee and internally displaced children with disabilities are vulnerable to multiple forms of discrimination, particularly refugee and internally displaced girls with disabilities, who are more often than boys subject to abuse, including sexual abuse, neglect and exploitation. The Committee strongly emphasizes that refugee and internally displaced children with disabilities should be given high priority for special assistance, including preventative assistance, access to adequate health and social services, including psychosocial recovery and social reintegration. The Office of the United Nations High Commissioner for Refugees (UNHCR) has made children a policy priority and adopted several documents to guide its work in that area, including the Guidelines on Refugee Children in 1988, which are incorporated into UNHCR Policy on Refugee Children. The Committee also recommends that States parties take into account the Committee's general comment No. 6 (2005) on the treatment of unaccompanied and separated children outside of their country of origin.

CRC General Comment no. 4 (2003): Adolescent health and development in the context of the Convention on the Rights of the Child

10. The Convention defines the civil rights and freedoms of children and adolescents in its articles 13 to 17. These are fundamental in guaranteeing the right to health and development of adolescents. Article 17 states that the child has the right to "access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health". The right of adolescents to access appropriate information is crucial if States parties are to promote cost-effective measures, including through laws, policies and programmes, with regard to numerous health-related situations, including those covered in articles 24 and 33 such as family planning, prevention of accidents, protection from harmful traditional practices, including early marriages and female genital mutilation, and the abuse of alcohol, tobacco and other harmful substances.

12. States parties must take effective measures to ensure that adolescents are protected from all forms of violence, abuse, neglect and exploitation (arts. 19, 32-36 and 38), paying increased attention to the specific forms of abuse, neglect, violence and exploitation that affects this age group. In particular, they should adopt special measures to ensure the physical, sexual and mental integrity of adolescents with disabilities, who are particularly vulnerable to abuse and neglect. States parties should also ensure that adolescents affected

by poverty who are socially marginalized are not criminalized. In this regard, financial and human resources need to be allocated to promote research that would inform the adoption of effective local and national laws, policies and programmes. Policies and strategies should be reviewed regularly and revised accordingly. In taking these measures, States parties have to take into account the evolving capacities of adolescents and involve them in an appropriate manner in developing measures, including programmes, designed to protect them. In this context, the Committee emphasizes the positive impact that peer education can have, and the positive influence of proper role models, especially those in the worlds of arts, entertainment and sports.

20. The Committee is concerned that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS. Both the legal minimum age and actual age of marriage, particularly for girls, are still very low in several States parties. There are also non-health-related concerns: children who marry, especially girls, are often obliged to leave the education system and are marginalized from social activities. Further, in some States parties married children are legally considered adults, even if they are under 18, depriving them of all the special protection measures they are entitled under the Convention. The Committee strongly recommends that States parties review and, where necessary, reform their legislation and practice to increase the minimum age for marriage with and without parental consent to 18 years, for both girls and boys. The Committee on the Elimination of Discrimination against Women has made a similar recommendation (general comment No. 21 of 1994).

31. Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents. Young mothers, especially where support is lacking, may be prone to depression and anxiety, compromising their ability to care for their child. The Committee urges States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.

35. In accordance with article 23 of the Convention, adolescents with mental and/or physical disabilities have an equal right to the highest attainable standard of physical and mental health. States parties have an obligation to provide adolescents with disabilities with the means necessary to realize their righs States parties should
(a) ensure that health facilities, goods and services are available and accessible to all adolescents with disabilities and that these facilities and services promote their self-reliance and their active participation in the community;
(b) ensure that the necessary equipment and personal support are available to enable them to move around, participate and communicate;
(c) pay specific attention to the special needs relating to the sexuality of adolescents with disabilities; and
(d) remove barriers that hinder adolescents with disabilities in realizing their rights.

39. In exercising their obligations in relation to the health and development of adolescents, States parties shall always take fully into account the four general principles of the Convention. It is the view of the Committee that States parties must take all appropriate legislative, administrative and other measures for the realization and monitoring of the rights of adolescents to health and development as recognized in the Convention. To this end, States parties must notably fulfil the following obligations:
(a) To create a safe and supportive environment for adolescents, including within their family, in schools, in all types of institutions in which they may live, within their workplace and/or in the society at large;
(b) To ensure that adolescents have access to the information that is essential for their health and development and that they have opportunities to participate in decisions affecting their health (notably through informed consent and the right of confidentiality), to acquire life skills, to obtain adequate and age-appropriate information, and to make appropriate health behaviour choices;
(c) To ensure that health facilities, goods and services, including counselling and health services for mental and sexual and reproductive health, of appropriate quality and sensitive to adolescents' concerns are available to all adolescents;
(d) To ensure that adolescent girls and boys have the opportunity to participate actively in planning and programming for their own health and development;
(e) To protect adolescents from all forms of labour which may jeopardize the enjoyment of their rights, notably by abolishing all forms of child labour and by regulating the working environment and conditions in accordance with international standards;
(f) To protect adolescents from all forms of intentional and unintentional injuries, including those resulting from violence and road traffic accidents;
(g) To protect adolescents from all harmful traditional practices, such as early marriages, honour killings and female genital mutilation;
(h) To ensure that adolescents belonging to especially vulnerable groups are fully taken into account in the fulfilment of all aforementioned obligations;
(i) To implement measures for the prevention of mental disorders and the promotion of mental health of adolescents.

41. In accordance with articles 24, 39 and other related provisions of the Convention, States parties should provide health services that are sensitive to the particular needs and human rights of all adolescents, paying attention to the following characteristics:
(a) *Availability*. Primary health care should include services sensitive to the needs of adolescents, with special attention given to sexual and reproductive health and mental health;
(b) *Accessibility.* Health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all adolescents, without discrimination. Confidentiality should be guaranteed, when necessary;
(c) *Acceptability.* While fully respecting the provisions and principles of the Convention, all health facilities, goods and services should respect cultural values, be gender sensitive, be respectful of medical ethics and be acceptable to both adolescents and the communities in which they live;
(d) *Quality.* Health services and goods should be scientifically and medically appropriate, which requires personnel trained to care for adolescents, adequate facilities and scientifically accepted methods.