CHAPTER 1

THE SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF WOMEN WITH DISABILITIES IN AFRICA: LINKAGES BETWEEN THE CRPD AND THE AFRICAN WOMEN'S PROTOCOL

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Summary

Despite efforts made to address discriminatory practices against women in the last twenty years, women still encounter challenges with regard to their sexual and reproductive health and rights. In many African countries, women's autonomy to exercise sexual and reproductive health choices is often undermined by cultural and religious practices as well as social attitudes and beliefs about the sexuality of women. Women with disabilities experience more barriers as exacerbated by social attitudes and systemic responses to disability which tend to diminish the sexual needs of persons with disabilities. Both the UN Convention on the Rights of Persons with Disabilities (CRPD) and the Protocol to the African Charter on the Rights of Women in Africa (African Women's Protocol) have provisions which are relevant to sexual and reproductive health rights. Both instruments also recognise the increased vulnerability of women with disabilities to abuse or denial of their rights as a result of the intersection of disability and gender.

While there are some differences in the approach to sexual and reproductive health and rights, the two instruments underscore the need for non-discrimination and for purposive measures to enable women with disabilities to exercise and benefit from sexual and reproductive health services on a basis of equality with other women in the communities in which they live. The provisions of the CRPD would seem to build upon a bold path charted by the African Women's Protocol in the recognition of the sexual and reproductive health and rights of women. Cumulatively, both instruments, along with other international and regional human rights instruments provide a solid basis for the protection of the sexual and reproductive health rights of women with disabilities.

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1 Introduction

Generally, sexual and reproductive rights are some of the most controversial, underdeveloped, and least understood spheres of rights, especially in Africa. The sexual and reproductive rights of women with disabilities are even more susceptible to abuse fuelled by negative social attitudes and beliefs. Indeed, women with disabilities experience multiple barriers in the exercise of their rights due to the intersection of age, gender, disability, and in some cases other factors of vulnerability such as displacement or social and economic marginalisation. It is therefore significant that the African Women's Protocol lays a foundation for the protection of sexual and reproductive rights of women. The provisions of the Protocol on sexual and reproductive rights of women in Africa are a strong starting point for enhanced protection of such rights. The Protocol specifically led the way in the recognition of sexual and reproductive rights as part of the right to health.

The CRPD builds upon the gains of the African Women's Protocol through a number of provisions that enhance the protection of women's sexual and reproductive rights. In its preamble, the Convention recognises the inherent dignity and worth of every human being as a basis for the rights contained therein. The CRPD establishes a strong basis for the protection of the sexual and reproductive health of women and girls with disabilities in a number of ways. First, it takes special cognisance of the higher risk of abuse that women and girls with disabilities face in access to their rights and therefore calls for special measures to be taken to ensure equality of access to rights. Secondly, the CRPD sets out general principles on the interpretation and implementation of disability rights. These principles have an impact on the kind of measures necessary to ensure sexual and reproductive health rights. The principles are anchored in the social model of thinking about disability which demands a shift in attitudes towards disability in all areas of rights including sexuality and reproduction.[1] In addition, while the CRPD does not specifically address the sexual rights of persons with disabilities, it does call for equal access to 'sexual and reproductive health programmes' for persons with disabilities on a basis of equality with all other people.

This article seeks to establish the extent to which the standards set out in the African Women's Protocol and the CRPD promote and protect the sexual and reproductive rights of women with disabilities in Africa. This is important because the sexual and reproductive needs of people with disabilities, particularly women with disabilities, are often treated lightly. By critically evaluating the standards set out in both instruments as well as the resulting approach to sexual and reproductive health and rights, the

1 See generally C Barnes *Understanding the social model of disability* (2009) for a discussion of the social model of disability.

article identifies the linkages and synergies between the African Women's Protocol and the CRPD in the protection of sexual and reproductive rights of women in Africa.

2 Evolution of sexual and reproductive health as human rights

Sexual and reproductive health and rights as currently recognised developed from the right to the highest attainable standard of mental and physical health guaranteed in numerous human rights instruments. The first recognition of the right to health was contained in the preamble to the Constitution of the World Health Organization in 1946, where it was noted that the enjoyment of the right to health is a fundamental right of all individuals.[2] Thereafter, attempts have been made to give recognition to this right in other human rights instruments such as the Universal Declaration on Human Rights,[3] which despite being a non-binding human rights instrument, is widely accepted as an authoritative human rights instrument worldwide. In fact, the UDHR has almost attained the status of customary international law due to its influence in the drafting of many national constitutions.[4]

However, the most authoritative recognition of the right to health is found in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[5] Article 12 of the ICESCR recognises the right of everyone to the enjoyment of the highest attainable standard of mental and physical health. The Committee on Economic, Social and Cultural Rights in its General Comment No 14 has explained that the right to health necessarily includes the right to sexual and reproductive health care services.[6]

Attempts at recognising sexual and reproductive health and rights as human rights gained momentum during the 1990s mainly due to the

2 The Constitution of the WHO was adopted by the International Health Conference, New York, 19-22 June 1945; opened for signature on 22 July 1946 by the representatives of 61 states; 14 UNTS 185.

3 See art 25 of the Universal Declaration of Human Rights, GA Res 217 A (III), UN Doc A/810 (10 December 1948).

4 JP Humphrey 'The Universal Declaration of Human Rights: Its history, impact and juridical character' in BG Ramcharam (ed) *Human rights: Thirty years after the Universal Declaration* (1979) 21 28.

5 International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).

6 UN Committee on Economic, Social and Cultural Rights (Committee on ESCR) 'The Right to the Highest Attainable Standard of Health' General Comment No 14, UN Doc E/C/12/2000/4 para 21.

activism of women's and gay rights groups.[7] In 1993, at the International Conference on Human Rights, the international community affirmed that acts of violence against women constituted a violation of their rights.[8] More importantly, it was affirmed that women's rights are human rights and that all human rights – civil, political and economic, social and cultural rights – are universal, interrelated, interdependent and indivisible.[9] Subsequently, during the International Conference on Population and Development Cairo 1994[10] and the Fourth World Conference on Women,[11] issues affecting women's health and reproductive well-being were discussed from a human rights perspective. At these meetings the international community recognised that sexual and reproductive health needs of women are human rights imperatives necessary to ensure their well-being and advance their rights. Also, these meetings, addressed keys issues affecting the well-being of women and sought to: advance gender equality; equity; women's empowerment; eliminate violence against women; promote reproductive freedom; and assist women to control their own fertility without external coercion.[12]

At Cairo, the international community broadly addressed the health needs of women and girls by declaring that:

> Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care which includes family planning and sexual health … All couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have information, education and means to do so.[13]

In Chapter 7 of the Platform of Action, an attempt was made to define reproductive health and rights. According to the ICDP, reproductive rights:[14]

> 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

7 C Ngwena 'Sexuality rights as human rights in Southern Africa with particular reference to South Africa' (2002) 17 *South African Public Law* 1; see also RG Parker 'Sexual rights: Concepts and action' (1997) 2 *Health and Human Rights* 31.
8 Vienna Programme of Action UN Doc A/CONF 157/24 Part 1 chap III.
9 As above.
10 Programme of Action of the International Conference on Population and Development (ICPD) adopted in Cairo 5-13 September 1994, UN Doc A/CONF 171/13 1994.
11 Beijing Declaration Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF 177/20 (1995) and A/CONF 177/20/Add 1 (1995).
12 See for instance Principle 4 of ICPD (n 10 above).
13 Chap VII.
14 Chap VIII.

childbirth and provide couples with the best chance of having a healthy infant.

It is clear from the above that the right to sexual and reproductive health includes the ability of an individual to make choices about his/her reproduction, to be entitled to information and education about his/her sexuality and to be free from all acts of gender-based violence.[15] It is also clear that the recognition and realisation of sexual and reproductive health and rights is contingent upon the recognition and protection of other rights such as the right to dignity, non-discrimination, or protection from violence. Furthermore, both the ICPD and the FWCW recognised that sexual and reproductive rights are rights already guaranteed in different human rights instruments. In other words, human rights such as rights to life, privacy, dignity and non-discrimination guaranteed in international and regional human rights instruments can be invoked to advance the sexual and reproductive rights of individuals.[16] Thus, human rights recognised in human rights instruments adopted by the United Nations such as the Convention on Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Right to Child (CRC), the Convention Elimination of Racial Discrimination (CERD), and the Convention on the Rights of People with Disabilities (CRPD), are relevant in advancing sexual and reproductive rights of individuals.

3 Development of sexual and reproductive health and rights in Africa

At the regional level, building on the long established essence and role of the African Charter on Human and Peoples' Rights (the African Charter),[17] the African Women's Protocol[18] was adopted in 2003 and came into force in 2005. The Women's Protocol supplements the African Charter and compliments CEDAW on matters relating to the protection and recognition of women's rights in Africa. Both the African Charter and African Women's Protocol draw inspiration from international human rights law.[19] In article 16, the African Charter recognises the right to the highest attainable state of physical and mental health. However, it was the African Women's Protocol that expounded on the right to health to include sexual and reproductive health.

15 See RJ Cook & M Fathalla 'Advancing reproductive rights beyond Cairo and Beijing' (1996) 22 *International Family Planning Perspective* 115; see also L Freedman & I Stephens 'Human rights and reproductive choice' (1993) 24 *Studies in Family Planning* 18.

16 See P Hunt & JB Mesquita *The rights to sexual and reproductive health* (2006).

17 African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

18 Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November 2005.

19 Art 60 of the African Charter.

In recognition of the indivisibility of rights, the African Charter guarantees both civil-political and socio-economic rights of individuals. As highlighted above, the other rights guaranteed in the Charter including the rights to life, dignity, privacy, non-discrimination, information and health are relevant in advancing the sexual and reproductive health and rights of individuals. Indeed, as noted earlier, the right to health guaranteed in the Charter should be interpreted to embrace sexual and reproductive health and rights.[20]

Article 18(4) of the Charter recognises the rights of person with disabilities to special measures and treatment in accordance with their physical and moral needs. The African Commission is yet to clarify what physical and moral needs refer to (such as through a general comment); but it is arguable that the promotion and protection of the sexual and reproductive health needs of persons with disabilities is crucial to their physical and moral needs.

It is important to emphasise that whereas it is acknowledged that 'women' include girls below the age of 18, and therefore that the general provisions relevant to the rights of women apply to girls as well, child specific considerations need to be taken into account when assessing their access to and exercise of sexual and reproductive health and rights. Accordingly, the provisions of the African Children's Charter are relevant to the protection of the rights of girls and young women below the age of 18. The African Children's Charter recognises a number of civil-political and socio-economic rights of children that are important in advancing the sexual and reproductive health and rights of children. More specifically, article 14 of the Charter recognises the right to health of children, which based on the interpretation of the right to health highlighted above, necessarily includes their sexual and reproductive health and rights. Moreover, in a language similar to the African Charter, article 13 of the African Children's Charter provides that special measures should be adopted to protect children with disabilities in a manner that is consistent with their physical and moral needs, giving due regard to their dignity. In as far as the SRHRs are central to the dignity of an individual, the provision is basis for the protection of the SRHRs of adolescents with disabilities.[21]

3.1 The African Women's Protocol

By far, however, the African Women's Protocol is the most emphatic and forthright instrument dealing with sexual and reproductive health and

20 See V Balogun & E Durojaye 'The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive rights (2011) *African Human Rights Law Journal* 368.

21 E Durojaye & LN Murungi 'The African Women's Protocol and sexual rights' (2014) 18 *International Journal of Human Rights* 893.

rights in Africa, particularly the rights of women in this regard.[22] The Protocol explicitly guarantees a woman's right to sexual and reproductive health, and contains important provisions such as the rights to non-discrimination and dignity that are useful in addressing discriminatory practices against women and girls, including those with disabilities.

The Protocol has been hailed as a pacesetter in the articulation of women's sexual and reproductive rights.[23] It has further been described as a progressive home grown human rights instrument that captures the lived experiences of African women.[24] The Protocol breaks new ground on sexual and reproductive health and rights in a number of ways, not least of which are the recognition of women's vulnerability to HIV as a human rights issue, the explicit recognition of women's sexual and reproductive health as human rights and the provisions allowing for abortion on limited grounds.[25] The Protocol affirms women's reproductive choice and autonomy to make sexual and reproductive decisions. Such decisions include the right to abortion when pregnancy results from a sexual attack, incest, rape or when it endangers a woman's life. In addition to recognising the rights of women with disabilities, the Women's Protocol explicitly articulates women's reproductive rights as human rights. It also expressly guarantees a woman's right to control her fertility without being coerced into making any decision that may undermine her sexual and reproductive autonomy.[26]

The African Women's Protocol addresses the rights of women with disabilities in a specific provision, thereby recognising the dual marginalisation that women with disabilities face.[27] The provision specific to women with disabilities however fails to sufficiently address the challenges experienced in exercising sexual and reproductive rights by women with disabilities.[28] Instead, the provision only calls for protection of women with disabilities from violence including sexual abuse. This approach is merely protectionist, and fails to embrace the fullness of the sexual and reproductive needs of women with disabilities. The approach fails to recognise the systemic barriers such as routine denial of

22 Durojaye & Murungi (n 21 above) 894.
23 F Banda 'Blazing a trail: The African Protocol on Women's Rights comes into force' (2006) 50 *Journal of African Law* 72; see also E Durojaye 'Advancing gender equity in access to HIV treatment through the Protocol to the Rights of Women' (2006) 6 *African Human Rights Law Journal* 187.
24 RS Mukasa *The African Women's Protocol: Harnessing a potential force for positive change* (2009) 5.
25 C Ngwena & E Durojaye 'Strengthening the protection of sexual and reproductive health and rights in the African Region through human rights: An introduction' in C Ngwena & E Durojaye (eds) *Strengthening the protection of sexual and reproductive health and rights in the African Region through human rights* (2014).
26 African Women's Protocol, art 14.
27 As above, art 23.
28 See SA Kamga 'A call for a protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa' (2013) 2 *African Journal of International and Comparative Law* 242.

contraceptive and abortion services that could undermine the exercise of sexual rights by women with disabilities. Implicitly, the provision fails to acknowledge the existence of such sexual and reproductive needs in a similar manner as in article 14.

Nevertheless, the second General Comment of the African Commission on Health and Reproductive Rights (hereafter GC No 2) made some attempts to extend the protections of sexual and reproductive health and rights under article 14 of the Protocol to women with disabilities.[29] Along with General Comment No 1, GC No 2 provides interpretive guidance on the overall and specific obligations of state parties for effective domestication and implementation of article 14 of the African Women's Protocol.

GC No 2 specifically highlights the constraints experienced by women with disabilities in access to family planning and contraceptive or safe abortion services.[30] The GC calls for action to eliminate barriers that women with disabilities face in access to family planning services[31] as well as family planning education.[32] Arguably however, the GC's failure to dedicatedly consider the challenges that women with disabilities face in the exercise of their sexual and reproductive health and rights, despite recognition of the unique vulnerability, diminishes its potential to address disability specific challenges.

The African Commission is yet to address communications directly related to the sexual and reproductive rights of women in its decisions. However, some of the decisions of the Commission based on other aspects of rights could have implications for the enjoyment of SRHRs. For instance in the *Doebeller* case[33] the African Commissioned condemned as a violation of the right to dignity the provision of the Sharia penal code in Sudan that permitted caning in public of school girls mingling with their male counter parts. The Commission reasoned that subjecting school girls to caning in public undermines their fundamental rights to dignity and to be free from inhuman and degrading treatment. In the Commission's view, subjecting any individual to physical or mental torture could amount to inhuman and degrading treatment.

In a more recent decision, the Commission has held in the *Egyptian Initiative* case[34] that acts of violence and sexual harassment against four

29 ACmHPR, General Comment No 2 on the article 14(1)(a), (b), (c) and (f) and article 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2014).
30 ACmHPR, General Comment No 2 (n 29 above) para 53.
31 ACmHPR, General Comment No 2 (n 29 above) para 61.
32 ACmHPR, General Comment No 2 (n 29 above) para 28(d).
33 *Curtis Doebbler v Sudan* (2003) AHRLR 153 (ACHPR 2003).
34 *Egyptian Initiative for Personal Rights and INTERIGHTS v Egypt* Communication 323/06 decided during the 10th Extraordinary session of the of African Commission on Human and Peoples' Right held between 12-16 December 2011.

women journalists constituted a violation of the rights to dignity and non-discrimination guaranteed in the African Charter. In arriving at this decision, the Commission drew inspiration from international human rights standards such as the UN Declaration on Violence against Women, the International Conference on Population and Development, and the Beijing Platform for Action.[35]

Whereas not directly emanating from or based on a violation of sexual and reproductive rights, these decisions significantly highlight the Commission's interpretation of African Charter provisions to cover sexual and reproductive health and rights including protection from sexual and gender based discrimination and abuse. By these decisions, the Commission would seem to be acknowledging the lived experiences of women, who are daily subjected to different forms of discriminatory practices, including acts of violence. Discriminatory practices against women not only violate their rights to equality but more importantly, undermine women's rights to dignity and to exercise choices about their sexuality free from violence and coercion. The reasoning of the Commission further shows willingness to affirm the rights of vulnerable groups, including women, girls and people with disabilities. This is important because it allows the extrapolation of existing provisions to promote and protect the rights of women with disabilities.

The Commission's application of other international standards in this regard also shows the potential of existing provisions of the African Charter and the African Women's Protocol to protect women with disabilities in the context of the exercise of sexual and reproductive health and rights. This is important because women and girls with disabilities are vulnerable to sexual abuse and acts of violence, including involuntary sterilisation all in a bid to 'protect' them. Such practices are a serious abuse of human rights.[36] The ability to rely on other instruments such as the CRPD and the interpretation of its provisions by the CRPD Committee has the potential to expand the protection of women and girls with disabilities in Africa in the exercise of their sexual and reproductive health and rights.

The African Commission has also issued important resolutions relevant to advancing sexual and reproductive health and rights in the region. For instance, in 2001 the Commission issued a resolution addressing the human rights issues raised by the HIV/AIDS epidemic in the region. The Resolution urged African governments to adopt a rights-based approach to addressing the HIV epidemic, particularly by protecting

35 Beijing Declaration and Platform for Action (1995).

36 ACmHPR, General Comment 2 (n 29 above) para 47; ACm HPR *Resolution on Involuntary Sterilization and the Protection of Human Rights in Access to HIV Services* adopted on 5 November 2013 at the 54th Ordinary Session of the Commission.

the rights of infected persons from discriminatory practices.[37] In another resolution on reproductive rights of women in Africa, the Commission called on African government to strive towards eliminating Female Genital Mutilation/Cutting, reducing the incidence of maternal mortality, and ensuring access to reproductive health care, including abortion, services to women.[38] Also in 2008 the Commission adopted two resolutions relating to sexual and reproductive health and rights. The first one deals with maternal mortality in Africa, where the Commission calls for a human rights-based approach to maternal mortality in the region.[39] The Commission noted that high maternal mortality in the region should be declared a state of emergency. In addition, the Commission noted that maternal mortality constitutes a gross violation of women's rights to health, life, dignity and non-discrimination. The second resolution in the same year deals with access to medicines as a human right.[40] Through the resolution, the Commission urges African government to prioritise access to life-saving medicines as a human rights issue by committing resources towards it. The Resolution further enjoins African governments to ensure that any trade agreements entered into do not undermine access to life saving medications to the people.

More recently, the Commission issued a resolution on the human rights issue raised by involuntary sterilisation.[41] The Commission reasoned that involuntary sterilisation constitutes a violation of the rights to autonomy, dignity and non-discrimination of women. It was also noted that forced and involuntary sterilisation could amount to acts of violence against women. The Commission noted that sterilisation must only be done with the informed consent of women given freely devoid of duress or undue influence.

While none of the foregoing resolutions are specifically targeted at persons with disabilities, they can no doubt be invoked to address their sexual and reproductive rights. The issue of forced sterilisation in particular, which has emerged as one of the more recent and pervasive abuses of the sexual and reproductive health and rights, is discussed in greater detail below. It is important to note that despite the various developments in the articulation of sexual and reproductive health and rights, misconception and prejudices remain barriers to their full

37 Resolution on the HIV/AIDS Pandemic –Threat against Human Rights and Humanity adopted at the 29th Ordinary Session of the African Commission held in Tripoli, Libya ACHPR Res 53 (XXIX) 01.

38 Adopted at the 41st Ordinary Session in Accra, Ghana from 16-30 May 2007 reproduced in E Durojaye & G Mirugi-Mukundi *Compendium of documents and cases on the right to health under the African human rights system* (2013) Community Law Centre, Cape Town.

39 ACHPR/Res 135 (XXXXIIII) 08: Resolution on Maternal Mortality in Africa.

40 ACHPR/Res 141 (XXXXIIII) 08: Resolution on Access to Health and Needed Medicines in Africa.

41 The resolution is available on the Commission's website: http://www.achpr.org/ (accessed 7 September 2014).

realisation.[42] Indeed this set of rights, especially sexual rights, remains highly contested at national and international levels.[43]An examination of the contestations and controversies around the recognition of sexual and reproductive health and rights is beyond the scope of this article. Nevertheless, it is imperative to highlight the fact that the foregoing resolutions and their relevance to sexual and reproductive health and rights re-affirms the argument that existing human rights such as the rights to life, privacy, non-discrimination, health and freedom from torture, inhumane and degrading treatment are all relevant in affirming the sexual and reproductive health and rights of individuals, especially for vulnerable groups such as people with disabilities.

Evidently, a lot of the African Commission's interpretative guidance and calls for action in the context of sexual and reproductive health and rights discussed above are anchored in the African Women's Protocol. Thus, even though the Protocol is a regional and women specific treaty, its potential to advance sexual and reproductive rights of women is highly significant and goes beyond the African continent.

3.2 The draft Protocol on the Rights of Persons with Disabilities in Africa

In 2003, the African Union initiated a process of developing a protocol on the protection of the rights of persons with disabilities and the elderly. Though the process of the development of the Protocol encountered a number of challenges,[44] the Commission's Working Group on the Rights of Older Persons and Persons with Disabilities presented a draft Protocol for public comment in April 2014.[45]

The draft Protocol contains a number of provisions that are relevant to the sexual and reproductive health and rights of women with disabilities. In particular, the draft Protocol recognises that the right to health includes sexual and reproductive health. The draft Protocol calls for effective implementation of the right to health including 'ensuring that health-care services are provided using accessible formats and that communication between service providers and persons with disabilities is effective'.[46] The draft Protocol further addresses the rights of women with disabilities

42 African Commission on Human and Peoples' Rights, General Comment on article 14(1)(d) & (e) of the African Women's Protocol reproduced in Durojaye & Mirugi-Mukundi (n 38 above).
43 Durojaye & Murungi (n 21 above) 881.
44 Kamga (n 28 above) 219-220.
45 See 'Comments invited on Draft Protocol on the Rights of Persons with Disabilities in Africa' available at http://www.achpr.org/news/2014/04/d121 (accessed 28 March 2015). Comments on the draft were considered by the Working Group in a meeting in March 2015. The draft Protocol will be submitted for the consideration of the African Commission at its 56th Ordinary Session in May 2015.
46 Draft Protocol on the Rights of Persons with Disabilities in Africa, art 12.

specifically, and calls upon states parties to ensure that 'the sexual and reproductive health rights of women with disabilities are guaranteed, and women with disabilities have the right to retain and control their fertility'.[47]

The bold approach of the draft Protocol to sexual and reproductive health and rights is a commendable improvement on the approach of the African Women's Protocol which despite having a specific provision of women with disabilities does not specifically address the unique challenges of these women in the exercise of sexual and reproductive rights. It is argued that specific reference to the challenges faced by women with disabilities helps to increase visibility of the challenges and hence influences duty bearers to adopt measures to address them.[48]

4 The CRPD and sexual and reproductive health and rights of women with disabilities

Whereas persons with disabilities generally experience discrimination on a range of grounds, the CRPD recognises that certain groups of people, such as women and children find themselves at the intersection of various vulnerabilities and hence are subject to dual or multiple forms of discrimination.[49] This recognition is significant in the context of sexual and reproductive health because, the recognition of the sexual and reproductive health and rights of women is itself a nascent area of rights, especially in the African context.[50] Hence, for women with disabilities, access to sexual and reproductive health entails dealing with gender based barriers as well as disability based discrimination. Recognition of the impact of the intersection of multiple vulnerabilities accounts for the CRPD's specific provisions on women and children.[51]

The CRPD's protection of sexual and reproductive health and rights is twofold, drawn from broad provisions such as those contained in the general principles of the Convention, as well specific articles directed at women with disabilities as a particularly vulnerable group or to areas of rights.

47 As above, art 19.
48 S Arnade & S Haefner 'Gendering the draft comprehensive and integral international convention on the protection and promotion of the rights and dignity of persons with disabilities' (2006) available at www.nw3.de/un-konv/doku/papier-02.rtf (accessed 25 March 2015).
49 C Frohmader & S Ortoleva 'The sexual and reproductive rights of women and girls with disabilities' Issue Papers International Conference on Human Rights (2013) 3.
50 Durojaye & Murungi (note 21 above) 881.
51 World Health Organization *World Report on Disability* (2011) 8; CPRD Committee 'Draft General Comment on Article 6: Women with Disabilities' CRPD/C/14/R.1 (May 2015) para 2.

4.1 General principles

The CRPD is the first human rights treaty to set out the General principles applicable to the rights contained therein in the text of the Treaty.[52] Whereas all of the general principles have a critical role in guiding the interpretation and implementation of the rights under discussion, some are of particular relevance to the sexual and reproductive health and rights of women with disabilities. For instance, respect for the inherent dignity, autonomy and choice of persons with disabilities in matters of their sexual and reproductive health is a fundamental aspect of respect for the integrity of their being. The link between the right to dignity and sexual and reproductive rights is discussed further below. Further, the question of the 'individual autonomy including the freedom to make one's own choices' is a solid basis for the protection of women with disabilities from forced sterilisation or abortion which are routinely practiced in some countries both as a matter of policy or in the full purview of complicit family members and public authorities.[53] Such practices undermine the dignity and humanity of the women with disabilities.[54]

The principle of reasonable accommodation calls for adjustments to be made to ensure that persons with disabilities enjoy their rights and freedoms on an equal basis with others.[55] The CRPD Committee has indicated that provision of reasonable accommodation is a necessity for the protection of the inherent dignity of persons with disabilities.[56] Ensuring reasonable accommodation means that positive action has to be taken, including providing the resources to ensure that women with disabilities not only access but also meaningfully benefit from sexual and reproductive health services. The CRPD Committee has indicated in this regard that reasonable accommodation is a means of ensuring accessibility for persons with disabilities by taking into account the individual access needs of the person in question.[57]

In practice, ensuring access to sexual and reproductive health and rights demands practical measures to guarantee the rights, including ensuring accessibility of premises where sexual and reproductive health services are offered, provision of information on sexual and reproductive

52 CRPD, art 3.
53 In draft General Comment on article 6 (note 51 above) para 3, the CRPD Committee highlights the prevalence of sexual violence against women and girls with disabilities based on information in state party reports as well as various submissions during its Day of General Discussion in 2013. Sexual violence against women and girls with disabilities manifests in various forms including forced sterilisation.
54 African Commission GC 2 (n 29 above) para 24; Frohmader & Ortoleva (n 49 above) 4 highlight the fact that forced sterilisation of persons with disabilities constitutes cruel, inhuman and degrading treatment.
55 CRPD, art 2.
56 CRPD Committee, General Comment on article 9 'Accessibility' CRPD/C/GC/2 (2014) para 24.
57 As above, para 22-23.

health in accessible format and flexibility to enable reasonable adjustments where necessary to ensure that persons with disabilities benefit from the services. Health workers also ought to be able to communicate with women with disabilities, or to avail support services where necessary to enable such communication.[58] The CRPD Committee notes the importance of taking 'into account the gender dimension of accessibility when providing health care, particularly reproductive healthcare for women and girls with disabilities'.[59] It is unfortunate the General Comment of the CRPD Committee does not outline in specific or illustrative terms the services necessary to ensure accessibility of the substance of healthcare services alongside accessibility of the premises. The CRPD's definition of discrimination to include denial of reasonable accommodation[60] means that it is not enough to merely recognise the equal right of women with disabilities to access sexual and reproductive health services. Such recognition has to be coupled with positive measures intended to ensure that the women disabilities with can access services.

4.2 Specific articles

Several specific provisions of the CRPD are relevant to the protection of the rights of women with disabilities. They include provisions specific to the right of women with disabilities, protection of dignity, equal protection of the law, right to family, and the right to health.

4.2.1 Article 6: The rights of women with disabilities

The starting point for the protection of the rights of women with disabilities is article 6 of the CRPD which recognises that women experience multiple forms of discrimination and therefore calls upon states parties to ensure that they enjoy the rights and freedoms fully and on a basis of equality with others in the society in which they live.[61] Whereas sexual and reproductive health is relevant to both men and women, women bear the bulk of the reproductive health burden and responsibilities. This is exacerbated by social attitudes that elevate women's reproductive role (almost as the sole subject of women's health) at the expense of other aspects of health, especially non-reproductive sexual expression. The emphasis on the right of women with disabilities to access these rights on the basis of equality with others in their societies is therefore very instrumental to surmounting the dual challenge of gender and disability based discrimination.

58 As above, para 6.
59 As above, para 36.
60 CPRD, art 5(3).
61 CRPD, art 6.

In May 2015, the CRPD Committee published a draft General Comment on article 6 of the CRPD for public comment.[62] The draft Comment underscores the dual discrimination experienced by women with disabilities and the need for states parties to adopt measures that take into account the intersection of gender and disability discrimination in the implementation of the CRPD.[63] The draft Comment further acknowledged 'restriction of sexual and reproductive rights of women with disabilities, including the right to motherhood and child-rearing responsibilities' as one of the issues of concern to the CRPD Committee in relation to the rights of women and girls with disabilities based on information received from several countries. Arguably, the draft General Comment pays a great deal of attention to the reproductive dimension of sexual and reproductive health and rights of women and girls, while de-emphasising the non-reproductive sexual expression. Also the draft Comment fails to address the link between article 6 and article 25 of the CRPD, yet the latter explicitly calls for the provision of sexual and reproductive health services without discrimination. Nevertheless, the draft Comment significantly increases the visibility of the plight of women and girls with disabilities in the context of access to sexual and reproductive health and rights.

The CRPD also calls for measures to ensure that children with disabilities benefit from all rights and freedoms on an equal basis with other children, including the right to express their views freely on all matters affecting them, and for such views to be given due weight in accordance with the age and maturity of the children on an equal basis with all other children.[64] Adolescents' access to sexual and reproductive health information and services is often controversial. In most cases, parents and caregivers are wary of the capacity of adolescents to consent to reproductive health procedures such as contraceptive and abortion services. The capacity of girls with disabilities, particularly intellectual disabilities, is even more denied. Hence, the call for the recognition of the capacity of children with disabilities on an equal basis with all other children underscores the need for an individualised approach to the assessment of the child's capacity to consent in the exercise of their sexuality and reproductive rights.

4.2.2 Article 9: Accessibility

The CRPD further calls upon states parties to ensure accessibility of information, facilities, and services open or provided to the public through the elimination of barriers.[65] This provision is important as access to

62 CRPD Committee Draft General Comment (n 51 above).
63 As above, para 12.
64 CRPD, art 7.
65 CRPD, art 9.

information is central to the full exercise of sexual and reproductive health and rights. The kind of barriers that affect access to health care services include geographic proximity of healthcare facilities, physical accessibility of facilities particularly in respect of women with physical disabilities, economic accessibility, and the skill to communicate with women with disabilities as in the case of the hearing impaired. Also, access to sexual and reproductive health information requires that the information given should be in accessible formats including brail and audio to ensure equal access to women with disabilities. The CRPD Committee has indicated that article 9 calls for access to facilities and equipment for sexual and reproductive health services including access to contraceptive information, adapted equipment such as gynaecological examination beds and mammography equipment, amongst others.[66]

In the view of the Committee on ESCR, accessibility of healthcare entails: non-discrimination in access, especially for the most vulnerable or marginalised sections of the population; physical accessibility meaning that health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups such as persons with disabilities; economic accessibility (affordability); and that healthcare information should be accessible.[67]

Evidently, ensuring equality of access to health care and health services calls for more than just legislation against exclusion from access to such services. It also includes taking positive measures to ensure that persons with disabilities are indeed able to benefit from the services.

4.2.3 Article 12: Equal recognition before the law

The CRPD calls for the recognition of the legal capacity of persons with disabilities to, amongst other things, exercise their will and preferences without undue influence of conflict of interests.[68] The CRPD Committee has interpreted this provision to include implementation of supported-decision making as opposed to substituted-decision making.[69] This is especially relevant in relation to forced sterilisation and control of the reproductive health and decision making of women with disabilities, the assumption being that they are incapable of consenting to sex.[70]

66 CRPD Committee Draft General Comment (n 51 above) para 39.
67 ESCR Committee, General Comment No 14 'The right to the highest attainable standard of health (Art 12 of the Covenant)' E/C.12/2000/411 (August 2000) para 12(b).
68 CRPD, art 12(4).
69 CRPD Committee, General Comment on article 12 'Equal recognition before the law' CRPD/C/GC/1 (19 May 2014) para 22.
70 As above, para 31.

4.2.4 Article 23: Family life

Article 23 provides for matters of the family and home, including the rights of persons with disabilities to freely and responsibly decide the number and spacing of their children.[71] The provision calls upon states to provide the means to enable the exercise of these rights. Further, the provision calls upon states to adopt measures to ensure that persons with disabilities retain their fertility on an equal basis with others.[72] Article 23 largely draws from the Standard Rules on Equalization of Opportunities for Persons with Disabilities which call for 'the full participation of persons with disabilities in family life' and urges states to promote the right to personal integrity for persons with disabilities and to ensure that laws do not discriminate against them with respect to sexual relationships, marriage and parenthood.[73]

In Rule 9, the Standard Rules further state that:

> Persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood. Taking into account that persons with disabilities may experience difficulties in getting married and setting up a family, States should encourage the availability of appropriate counseling. Persons with disabilities must have the same access as others to family-planning methods, as well as to information in accessible form on the sexual functioning of their bodies. States should promote measures to change negative attitudes towards marriage, sexuality and parenthood of persons with disabilities, especially of girls and women with disabilities, which still prevail in society. The media should be encouraged to play an important role in removing such negative attitudes.

The foregoing is, in the most simplistic way, a restatement of the centrality of sexual and reproductive health and rights, to the fulfillment of the right to family life and a testimony to the indivisibility of these rights.

4.2.5 Article 25: Right to health

Article 25 of the CRPD provides that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability, and that states parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive. In addition, the provision requires states parties to provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as

71 CRPD, art 23(1)(b).
72 CRPD, art 23(1)(c).
73 Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993), rule 9.

provided to other persons, including in the area of sexual and reproductive health.[74]

Notably, the initial draft of article 25 contained no references to reproductive rights. Instead, reproductive rights were discussed under the provision on privacy, home and family along with a right to sexuality and to form intimate relationships.[75] In fact, as shown above, some aspects of reproductive rights are still contained in article 23, such as the rights to determine the number and spacing of children and to retain one's fertility. It is reported that the inclusion of sexual and reproductive health and rights of persons with disabilities in article 25 was highly contested.[76] Supporting the retention of the provision, the Ad Hoc Committee noted that the statement 'including sexual and reproductive health services' was intended 'as a statement on the right to be free from discrimination and its effect was that persons with disabilities would need to be treated on an equal basis with others in this area'.[77]

The CRPD Committee argues that article 25 includes the right to health care on the basis of free and informed consent.[78] Hence, decisions relating to a person's physical and mental integrity must only be taken with the free and informed consent of the person involved. The Committee further argues that health and medical personnel should ensure appropriate consultation that directly engages the person with disabilities, taking care not to allow substituted decision making by guardians or caregivers.[79] The foregoing interpretation should be read alongside the understanding that the right to the 'highest attainable standard of health' has been interpreted to include measures to improve sexual and reproductive health services such as access to family planning, pre and post-natal care, emergency and obstetric services and access to information.[80]

Cumulatively, the above interpretations of the right under article 25 mean that the sexual and reproductive health and rights of women with disabilities must be guaranteed on the basis of equal access, reasonable

74 CRPD, art 25(a).
75 See 'Report of the third session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities – Article 14 – Respect for privacy, the home and the family' http://www.un.org/esa/socdev/enable/rights/ahc3reporte.htm#footnote47 (accessed 30 September 2014).
76 M Schulze 'Understanding the UN Convention on the Rights of Persons with Disabilities' 95.
77 Ad Hoc Committee Report of the 6th Session http://www.un.org/esa/socdev/enable/rights/ahc6reporte.htm (accessed 20 September 2014) para 85.
78 CRPD General Comment on art 12 (n 69 above), para 37; CRPD Committee Draft General Comment (note 51 above) para 17.
79 As above.
80 Committee on Elimination of Discrimination against Women (CEDAW Committee), General Comment No 21 – Equality in marriage and family relations (art 16) (1994), para 16.

accommodation, and respect for their dignity and integrity. The protection of the integrity of the person which is a component of the right to health[81] entails the protection of their physical and mental integrity on an equal basis with others.[82] Essentially therefore, neither forced sterilisation, abortion, contraceptive use on women with disabilities, nor can arbitrary restrictions on the exercise of their sexuality be justified. The protection of dignity and integrity also emphasises the need for individualised approaches to each woman with disabilities in their access to sexual and reproductive health and services. This means that blanket measures such as general sterilisation of women with disabilities can also not be justified.

Article 25 calls for gender sensitive health services. It has already been highlighted that the need for gender sensitivity in healthcare services was recognised by the Committee on ESCR in General Comment No 14. It was stated in this regard that

> a gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.[83]

The CRPD Committee has further noted that

> it is especially important to take into account the gender dimension of accessibility when providing healthcare, particularly reproductive healthcare for women and girls with disabilities.[84]

Accessibility is one of the more elaborated components of the right to health. Access to sexual and reproductive health and rights demands equality of access to the full range and quality standard of free or affordable healthcare. Equal access should be evaluated in light of the non-discrimination principle and purpose of the CRPD. Safeguards against exclusion of women with disabilities from access to population-based public health programmes purely on the basis of disabilities ought to be put in place. In the view of the Committee on ESCR, accessibility requires that health facilities, goods and services have to be accessible to everyone in the state without discrimination.

81 Committee on CESCR, General Comment No 14: The right to health (2000) para 4.
82 CRPD art 17; CRPD Committee Draft General Comment (n 51 above) para 17.
83 General Comment No 14 (n 81 above) para 20.
84 CRPD Committee General Comment on art 9 (n 56 above) para 36.

5 The relationship between CRPD and the African Women's Protocol in advancing the SRHRs of women with disabilities

The African Women's Protocol and the CRPD provisions that can be applied to advance the sexual and reproductive rights and needs of persons with disabilities have already been highlighted. This section examines the points of convergence between the provisions of the Protocol and the CRPD that are relevant to advancing the sexual and reproductive rights of women with disabilities.

5.1 Non-discrimination in access to SRHRs and services

It would seem that the largest area overlap of the two instruments is the prohibition of discrimination against specific members of society – women and persons with disabilities. The right to non-discrimination is crucial in realising access to sexual and reproductive health services for marginalised and disadvantaged groups such as women and persons with disabilities. In this regard, article 1 of the African Women's Protocol, drawing inspiration from CEDAW, adopts a substantive approach to equality by defining discrimination against women broadly in this manner:[85]

> Any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their mental status, of human rights and fundamental freedoms in all spheres of life

The Protocol addresses all forms of discrimination against women and girls, including those in the private sphere. The focus on the private sphere is deliberate and aimed at protecting women and girls who are often subjected to inhuman and degrading cultural practices and acts of violence within the family. While the African Commission is yet to clarify the nature of obligation imposed by article 1 of the Protocol, it has explained that the non-discriminatory provision of the African Charter is fundamental to the enjoyment of all other rights in the Charter.[86]

Article 5 of the CRPD reaffirms the substantive notion of equality when it provides that 'States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law'. It further urges states to 'prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds'. Moreover, article 5(3) enjoins states to

85 See art 1 of the African Women's Protocol above.
86 *Legal Resources Foundation v Zambia* (2001) *AHRLR* 84 (ACHPR 2001).

adopt appropriate measures that reasonable accommodation is provided. This provision should be interpreted purposively to require targeted measures that will ensure the realisation of the sexual and reproductive health and rights of women with disabilities.

The combined reading of article 5 of the CRPD with articles 1 and 14 of the African Women's Protocol reinforces the point that women with disabilities deserve tailored responses to guarantee their enjoyment of sexual and reproductive health and rights. Therefore, negative attitudes and practices that hinder access to sexual and reproductive health services to women with disabilities need to be addressed. Often, women with disabilities in particular tend to experience attitudinal challenges in the exercise of sexual and reproductive health and rights compared to their male counterparts,[87] which makes it essential for states to take positive measures in order to facilitate access to sexual health services to person with disabilities.

The Canadian Supreme court decision in the *Eldridge* case[88] illustrates the measures that are necessary to actualise the protections contained in the right. The case dealt with the legality of regulations that failed to require hospitals to provide interpretation services for deaf patients. The Court held that the failure to make money available for sign-language interpretation that would equip hearing-impaired patients to communicate with health-service providers in the same way that unimpaired patients can, constituted discrimination in violation of the Canadian Charter on Rights and Freedoms.

The Court explained that:

> In the present case the adverse effects suffered by deaf persons stem not from the imposition of a burden not faced by the mainstream population, but rather from a failure to ensure that deaf persons benefit equally from a service offered to everyone. Once it is accepted that effective communication is an indispensable component of the delivery of a medical service, it is much more difficult to assert that the failure to ensure that deaf persons communicate effectively with their health care providers is not discriminatory. To argue that governments should be entitled to provide benefits to the general population without ensuring that disadvantaged members of society have the resources to take full advantage of those benefits bespeaks a thin and impoverished vision of s 15(1). It is belied, more importantly, by the thrust of this Court's equality jurisprudence.[89]

The reasoning of the Court in the case underscores the need for states to not only claim that they are providing services to all including women with

87 CRPD Committee Draft General Comment (n 51 above) para 8. See also SE Ahumuza et al 'Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda' (2014) 11 *Reproductive Health Journal* 4.
88 *Eldridge v British Columbia (Attorney-General)* 1977 151 DLR (4th) 577.
89 As above.

disabilities, but rather demonstrate that they have taken additional measures to prioritise the sexual and reproductive health needs of vulnerable and marginalised groups such as women with disabilities.[90]

5.2 The protection of dignity

The protection of human dignity is at the core of fundamental rights, and even more relevant in the context of human rights that deal with the basic rights of persons. Indeed, the common denominator of all human beings is the recognition of their worth as human deserving to be treated with respect and dignity. Article 3 of the African Women's Protocol provides that every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights. In a more radical and progressive manner, the African Women's Protocol declares that 'every woman shall have the right to respect as a person and to the free development of her personality'. It enjoins states parties to implement appropriate measures to prohibit exploitation or degradation of women.[91] In addition, the African Commission has noted that states must ensure that 'women are not treated in an inhumane, cruel or degrading manner when they seek to benefit from reproductive health services such as contraception/family planning services or safe abortion care'.[92]

When a woman is made to undergo medical procedures merely based on her disability and without informed consent, there is no doubt that her right to dignity as guaranteed under the Protocol is undermined.

A provision in the CRPD similar to article 3 of the African Women's Protocol and relevant in advancing the sexual and reproductive rights of persons with disabilities is article 12. This article provides, *inter alia*, that states parties should ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, and are free of conflict of interest and undue influence.

One of the challenges facing people living with disabilities is the fact that they are often treated with indignity by health care providers. In a number of cases, medical decisions are made on their behalf by health care providers with little regard for human rights principles and standards such as autonomy and dignity. This practice raises the question as to whether people with disabilities can make informed decisions about their reproductive choices. This was the subject of contention in the Indian case of *Suchita Srivastava v Chandigarh Administration.*[93]

90 See E Durojaye 'Realising equality in access to HIV treatment for vulnerable and marginalised groups in Africa' (2012) *Potchefstroom Electronic Law Journal* 214.
91 Art 3 of the Women's Protocol.
92 General Comment No 2 (n 29 above) para 36.
93 2009 (11) SCALE 813 N.

In that case, a 20-year old woman who suffered from a 'mild' intellectual disability got pregnant and a medical board was set up to assess the condition of the woman with a view to ascertaining the consequences of continuation of the pregnancy and the capability of the victim to cope with the same. Subsequently, the board recommended that her pregnancy be aborted. As there was no clear basis in law for proceeding with the termination, the Chandigarh administration approached the Punjab and Haryana High Court seeking approval for medical termination of the pregnancy, keeping in mind that the woman had intellectual disability, was an orphan, and did not have a parent or guardian who could look after her and her prospective child. Relying on expert evidence which indicated that the woman in question was unable to fully comprehend and appreciate the implications of her pregnancy, the High Court granted the application for the termination of the pregnancy.

On appeal to the Supreme Court, it was held that based on the Medical Termination Act of 1971 consent is crucial to any termination of pregnancy. According to the court, while the state could claim to be the guardian of the woman in question since she was an orphan and had been in state-owned welfare institution, that claim could not be used as the basis for making a decision about her pregnancy on her behalf. Since the woman in question was an adult and was merely classified as 'mildly mentally retarded' and not 'mentally ill' her consent should have been sought before any decision is made about her pregnancy. The court further explained that a woman's right to make reproductive choices is a dimension of 'personal liberty', as understood under article 21 of the Indian Constitution, and that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration was held to be a woman's rights to privacy, dignity and bodily integrity. Thus, restrictions could not be placed on the exercise of reproductive choice such as a woman's right to refuse participation in sexual activity or, alternatively, her insistence on the use of contraceptive methods. This case clearly shows that intellectual disability should not be use an excuse to undermine the human rights of persons with disabilities

It should be noted that article 25 of the Convention guarantees the right to the highest attainable standard of health of persons with disabilities without discrimination. Given that this provision is similar to article 12 of the ICESCR, and considering that the Committee on CRPD is yet to issue any interpretative guidance on the article, the interpretation provided by the Committee on ESCR in its General Comment 14 ought to apply. In General Comment 14, the Committee explains that the realisation of the right to health also includes the enjoyment of sexual and reproductive health and rights. More importantly, the Committee observes that the enjoyment of the right to health, including sexual and reproductive rights should be accorded to vulnerable and marginalised groups such as women, children, adolescents, people living with HIV and persons with disabilities. This statement along with its earlier General Comment 5, in which the

Committee had observed that persons with disabilities should be protected from all forms of discrimination and human rights abuse, anchor the equal right to sexual and reproductive health and rights for women with disabilities.

The Committee further notes that persons with disabilities are entitled to the enjoyment of the right to highest attainable standards of mental and physical health, including the right to have access to, and to benefit from, those medical and social services.[94] And that all services provided in this regard should be respectful of the rights to dignity of persons with disabilities.[95] This statement can be interpreted to include the rights of persons with disabilities to enjoy access to sexual and reproductive health care services. However, it should be pointed out that the ESCR Committee's approach to the health needs of persons with disabilities tended to be therapeutic and failed to appreciate their sexual and reproductive needs. This would seem to reinforce the general misconception about persons with disabilities that they are asexual and should be discourage from expressing their sexual needs.

5.3 Addressing intersectionality

People who find themselves at the intersection of various factors of vulnerability such as race, religion, class, gender or disability often experience dual or multiple forms of discrimination and hence barriers to the exercise of their rights. Vulnerability is a contested concept the nuances of which are beyond the ambit of this article. In the most simplistic way, factors of vulnerability are those that influence a person's susceptibility to abuse or denial of rights. Such factors of vulnerability vary from one community to another. Women with disabilities are at the intersection of gender and disability, which are factors of discrimination and marginalisation in a majority of societies. In some cases, women with disabilities may experience further marginalisation such as living in rural or marginalised areas, displacement or sexual orientation. Both the CRPD and the African Women's Protocol recognise the negative consequences of the intersection of gender and disability in access to SRHRs for women with disabilities. The CRPD Committee has in fact identified sexual and reproductive health and rights, violence against girls and women, as well as the intersection of gender and discrimination as areas for priority action.[96] It is argued in this regard that

94 CESCR Committee General Comment No 5 – The rights of persons with disabilities (1995) para 34.

95 As above.

96 CRPD Committee, Half Day of General Discussion on Women and Girls with Disabilities http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGD17April2013.aspx (accessed 25 March 2015).

> although women with disabilities experience the same forms of discrimination [that] all women experience, when gender and disability intersect, discrimination takes on unique forms, has unique causes, and results in unique consequences.[97]

Both instruments approach the multiple vulnerabilities of women with disabilities, including in the context of access to sexual and reproductive health and rights by having a sub-group specific but general provision within the treaty. The core purpose of these provisions, however, is to reaffirm the applicability of the treaties to the particular group. In both cases, the specific provisions do not address sexual and reproductive health and rights, thereby limiting their effectiveness in this regard. Nevertheless, the approach of having a dedicated provision on women with disabilities enhances the visibility of their plight in accessing all rights, hence raising the likelihood that their unique challenges will be taken into account in the implementation of the other rights in the treaty.

6 Implications of the CRPD for the protection of the SRHRs of Women with Disabilities

6.1 Does the CRPD introduce any new rights in the context of the SRHRs of women with disabilities?

In the words of the Chair of ad hoc committee for the drafting of the CRPD, 'without creating for the most part new rights, the [CRPD] sets out a detailed code of implementation and spells out *how* individual rights should be put into practice'.[98] This position notwithstanding, there is no consensus in the disability rights field on whether the final text of the CRPD in fact creates new rights. In its preamble, the CRPD reiterates the continuing exclusion of persons with disabilities from participation as equal members of society and violations of their human rights in all parts of the world despite the existence of various instruments and undertakings.[99] The preamble also recognises that children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children, particularly those obligations that have already been undertaken by state parties to the CRC.[100] These assertions suggest that one of the purposes of the Convention is to correct the inequality in the application of existing rights.

97 Frohmader & Ortoleva (n 49 above) 8.

98 United Nations Information Service 'Committee Negotiating Convention on Rights of Disabled Persons Concludes Current Session' SOC/4680 15 August 2005 http://www.unis.unvienna.org/unis/pressrels/2005/soc4680.html (accessed 20 September 2014). Anna Lawson 'The UN Draft International Convention on the Rights of Persons with Disabilities: Purpose progress and potential' Paper delivered at London School of Economics, School of Law and Centre for Disability Studies, 9 March 2006.

99 CRPD, Preamble, para (k).

100 Para (r).

The CRPD is part of a general trend in international human rights law that entails adoption of human rights instruments specific to certain social groups. The trend entails acceptance of the fact that 'certain groups do need separate restatements of how rights apply to them, either because they have specific needs to enjoy their rights, different versions of the same rights, or possibly even slightly different rights'.[101]

In the context of sexual and reproductive health and rights, the CRPD does not in fact introduce any new rights. Instead, and as indicated in the preceding part, the Convention focuses on making the already existing right to sexual and reproductive health rights relevant to persons with disabilities, and women with disabilities in particular. Indeed, during the negotiation of article 25 of the CRPD, it was specifically argued that:

> The Ad Hoc Committee notes that the use of the phrase 'sexual and reproductive health services' would not constitute recognition of any new international law obligations or human rights. The Ad Hoc Committee understands draft paragraph (a) to be a non-discrimination provision that does not add to, or alter, the right to health as contained in article 12 of the International Covenant on Economic, Social and Cultural Rights or article 24 of the Convention on the Rights of the Child. Rather, the effect of paragraph (a) would be to require States Parties to ensure that where health services are provided, they are provided without discrimination on the basis of disability.[102]

In comparative terms, article 25 elaborates much more on the right to health, and gives much more attention to sexual and reproductive health rights. Indeed, unlike the ICESCR which minimally addresses sexual and reproductive health by calling for 'the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child',[103] article 25 of the CRPD expressly refers to sexual and reproductive health and rights.

101 F Megret 'The disabilities convention: human rights of persons with disabilities or disability rights' (2008) 30 2 *Human Rights Quarterly* 497. B Byrne 'Minding the gap? Children with disabilities and the United Nations Convention on the Rights of Persons with Disabilities' in M Freeman *Law and childhood studies* (2012) 419 argues that the development of the CRPD as a thematic convention is indicative of the increasing recognition of the complexity of disability issues, and the fact that the difference of disability is such that it has not and cannot be effectively addressed by mainstream human rights instruments. See also L Mute 'Domesticating the International Convention on the Rights if Persons with Disabilities: Key considerations for Kenya' (Undated) (not paginated) on file with the authors.

102 Ad Hoc Committee on the CRPD 'Report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its seventh session' New York, 16 January - 3 February 2006 http://www.un.org/esa/socdev/enable/rights/ahc7report-e.htm#fn4 (accessed 30 September 2014).

103 ICESCR, art 12(2)(a).

The previous experiences of persons with disabilities (such as involuntary sterilisation of women with disabilities)[104] in the context of sexual and reproductive health and rights doubtlessly had a role in the explicit approach of the provisions of the CRPD.

6.2 CRPD and the 'how' to make SRHRs work for women with disabilities

As above indicated, the core contribution of the CRPD to the rights of persons with disabilities is the 'how' to make the rights relevant to them. It was stated in respect of the CRPD that it is an 'implementation convention' and that

> the lack of effective implementation is the underlying reason for having this convention. The rights of persons with disabilities are recognized by the other human rights conventions, but we need to actually implement these rights.[105]

The foregoing differentiates the CRPD from the African Women's Protocol which merely recognizes the right. Article 25 of the CRPD, as read together with the other provisions of the Convention, therefore mainly give direction on measures that ought to be put in place to make the exercise of sexual and reproductive health and rights, possible for women with disabilities such as ensuring accessibility, gender sensitivity and equality.

7 Conclusion

The right to health, including reproductive health and rights, is recognised under various provisions in a range of human rights instruments. However, the African Women's Protocol made the boldest attempt to address sexual and reproductive health and rights in a binding legal instrument. In this way, the Protocol paved a way for similar recognition of these rights in other instruments. The African Women's Protocol also highlighted the unique challenges experienced by women with disabilities in accessing these rights, but failed to adequately elaborate on challenges related to sexual and reproductive health and rights, or how these rights would be implemented to deliver the rights to women with disabilities.

104 These concerns are reflected in the negotiation archives. See Report of the third session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities http://www.un.org/esa/socdev/enable/rights/ahc3reporte.htm#footnote47 (accessed 30 September 2014).

105 Statement by Chairperson of the Drafting Committee on the CRPD http://www.unis.unvienna.org/unis/pressrels/2005/soc4680.html (accessed 20 September 2014).

The CRPD recognises the peculiar circumstances and vulnerabilities of women and children and hence provides a basis for special measures to be adopted to enable their access to sexual and reproductive health and rights. The general principles of the Convention enhance the effectiveness of measures taken to ensure rights by calling for both universal measures such as universal design to facilitate accessibility, as well as individualised measures under reasonable accommodation. It is arguable that whereas the CRPD does not create new rights in relation to sexual and reproductive health and rights, its provisions in this regard provide considerable guidance on how to ensure that the rights are in fact feasible for women with disabilities. The CRPD enhances the implementability and enforceability of the right to health and of sexual and reproductive health rights in general.

There are certainly a number of areas of convergence between the African Women's Protocol and the CRPD in addressing the sexual and reproductive health and rights of women with disabilities. There is also no doubt that the CRPD indeed contributes to better recognition and protection of the sexual and reproductive rights of women with disabilities in Africa. In the African context however, the CRPD is more significant for the purpose of furthering the recognition of sexual and reproductive health rights under the African Women's Protocol, and adding clarity on the measures necessary to implement the recognised rights. The draft Protocol on the Rights of Persons with Disabilities in Africa builds even further on the foundation of the African Women Protocol, and if adopted, has the potential to bolster the protection of the sexual and reproductive health rights of women with disabilities in Africa.