Women With Disabilities Australia (WWDA)



Dehumanised:

The Forced Sterilisation of Women and Girls with Disabilities in Australia

Publishing Information

*‘Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia’*

WWDA Submission to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia

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About Women With Disabilities Australia (WWDA)

Women With Disabilities Australia (WWDA)[[1]](#footnote-1) is the peak non-government organisation (NGO) for women with all types of disabilities in Australia. WWDA is run by women with disabilities, for women with disabilities, and represents more than 2 million disabled women in Australia. WWDA’s work is grounded in a rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. Promoting the reproductive rights of women and girls with disabilities, along with promoting their rights to freedom from violence and exploitation, and to freedom from torture or cruel, inhuman or degrading treatment are key policy priorities of WWDA.[[2]](#footnote-2)



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*Winner, National Human Rights Award 2001*

*Winner, National Violence Prevention Award 1999*

*Winner, Tasmanian Women's Safety Award 2008*

*Certificate of Merit, Australian Crime & Violence Prevention Awards 2008*

*Nominee, French Republic's Human Rights Prize 2003*

*Nominee, UN Millennium Peace Prize for Women 2000*

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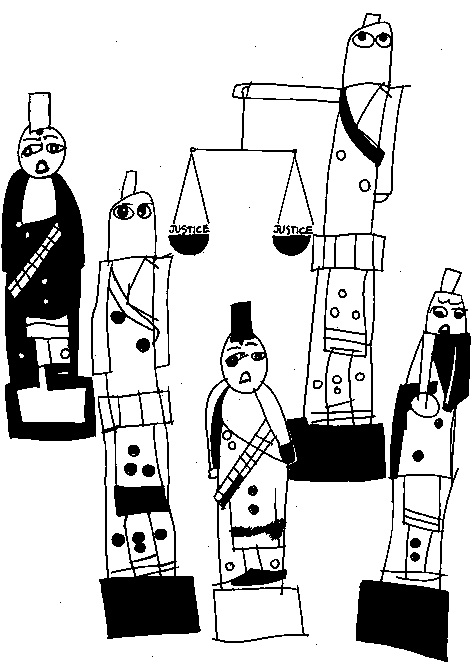
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Acknowledgment

*In presenting this Submission to the Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia, WWDA wishes to acknowledge and thank all the women who have been involved with Women with Disabilities Australia (WWDA).*

*We dedicate this work to all those who have suffered discrimination and the devastating life-long impact of forced or coerced sterilisation and other violations of their reproductive health rights. Although we can never take away the pain and trauma of those women and girls affected, we trust that our work will ensure that this gross violation of the human rights of women and girls with disabilities will never be allowed to occur again.*

*To our sisters in other countries who are also continuing the fight to stop the practice of forced and coerced sterilisation of women and girls, we hope our work can contribute in some small way to your efforts.*



“I think there should be an Act that should go through Parliament, it must be a Sterilisation Act that stops girls and women with intellectual disabilities being sterilised.”

Participant, STAR Conference on Sterilisation, 1990[[3]](#footnote-3)

Overview

1. Australia is a country that prides itself on values and principles which provide the basis for a free and democratic society, including for example: the equal worth, dignity and freedom of the individual; equality under the law; equality of opportunity; equality of men and women; and the right of its citizens to participate fully in the economic, political and social life of the nation.[[4]](#footnote-4) However, these entitlements remain a distant goal for many women and girls with disabilities. In contemporary Australia, many are denied the most fundamental rights and freedoms, they are not treated with dignity and respect, they remain profoundly more disadvantaged than their male counterparts; are systematically denied opportunities to develop, gain an education and live a full and meaningful life. They experience multiple forms of discrimination, and widespread, serious violation of their human rights.
2. Denial of these rights and freedoms is predicated on the assumption - usually implicit - that there are degrees of being human, and that only the "fully human" are entitled to enjoy the advantages of our society and the full protection of its laws. Since ability and intelligence are highly valued in our society, they are closely associated with being human. ‘Diminished ability and intelligence’, on the other hand, is equated with lower forms of life. Women with disabilities have typically been perceived as sub-human - lacking such basic human needs as the need for love, intimacy, identity and freedom. Dehumanising conditions - such as those which still pervade many of our state institutions - have been rationalised on the basis that women with disabilities do not have the same needs and feelings as the "fully human", and hence that they do not need privacy, personal property, recognition, intimacy or freedom of choice. Viewed as "undesirable" and as potential threats to society, women with disabilities have often been isolated in institutions and otherwise prevented from fully participating in society.[[5]](#footnote-5)
3. The right to bodily integrity and bodily autonomy, including the right of a woman to make her own reproductive choices, are enshrined in a number of international human rights treaties and instruments to which Australia is a party. However, women and girls with disabilities in Australia have failed to be afforded, or benefit from, these provisions in international human rights law. Instead, systemic prejudice and discrimination against them continues to result in widespread denial of their right to make decisions about their own bodies, experience their sexuality, have sexual relationships, and found and maintain families. In Australia there are women and girls with disabilities who have been and continue to be, denied these and other fundamental human rights through the ongoing Government sanctioned practice of ‘forced/involuntary’ and ‘coerced’ sterilisation.[[6]](#footnote-6)
4. Forced sterilisation – that is, sterilisation in the absence of the free and informed consent of the individual concerned - including instances in which sterilisation has been authorised by a third party, without that individual’s consent[[7]](#footnote-7) - is an act of violence,[[8]](#footnote-8) a form of social control, and a clear and documented violation of the right to be free from torture.[[9]](#footnote-9) Forced sterilisation of girls and women with disabilities is internationally recognised as a harmful practice based on tradition, culture, religion or superstition.[[10]](#footnote-10) Perpetrators[[11]](#footnote-11) are seldom held accountable and women and girls with disabilities who have experienced this violent abuse of their rights are rarely, if ever, able to obtain justice. Successive Australian Governments have not acknowledged this pervasive practice, nor expressed regret, nor offered redress to the women and girls affected.
5. Forced sterilisation constitutes torture.[[12]](#footnote-12) The right to be free from torture is one of the few absolute and non-derogable human rights, a matter of *jus cogens*,[[13]](#footnote-13) a peremptory norm of customary international law, and as such is binding on all States, irrespective of whether they have ratified specific treaties.[[14]](#footnote-14) A State cannot justify its non-compliance with the absolute prohibition of torture, under any circumstances. The UN Special Rapporteur on Torture has recently clarified:

*Forced interventions [including involuntary sterilization], often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.[[15]](#footnote-15)*

1. Forced sterilisation breaches every international human rights treaty to which Australia is a party. Legal authorisation of forced sterilisation procedures directly implicate the Australian Government in the perpetration of torture against disabled women and girls. Any law which authorises forced sterilisation is a law which authorises violence against women, the consequence of which is severe pain and suffering,[[16]](#footnote-16) including *‘drastic and emotionally painful consequences that are un-ending’*.[[17]](#footnote-17)
2. The UN Special Rapporteur on Torture has made it clear that the failure of the State to exercise due diligence to intervene to prevent torture and provide remedies to victims of torture *‘facilitates and enables non-state actors to commit acts impermissible under [the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment] with impunity*,’ and its indifference or inaction provides a form of encouragement and/or de facto permission.[[18]](#footnote-18) The UN Committee Against Torture has also confirmed that States have a heightened obligation to protect vulnerable and/or marginalised individuals from torture and cruel inhuman and degrading treatment and to:

*‘adopt effective measures to prevent public authorities and other persons acting in an official capacity from directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in acts of torture.’*[[19]](#footnote-19)

1. For more than twenty years, women with disabilities and their allies have been demanding successive Australian Governments show national leadership and undertake wide ranging reforms to stop the forced and coerced sterilisation of women and girls with disabilities, and develop policies and programs that enable disabled women and girls to realise their human rights on an equal basis as others. These recommendations to the Australian Government for action have been strongly echoed, supported and re-iterated by several international human rights treaty monitoring bodies and mechanisms since 2005.[[20]](#footnote-20) That Australian Governments have chosen to ignore the voices of disabled women, as well as clear recommendations from the United Nations and international medical bodies, clearly demonstrates that disabled women and girls are not considered by our Governments as worthy of all that it means to be fully human.
2. No group has ever been as severely restricted, or negatively treated, in respect of their reproductive rights, as women with disabilities.[[21]](#footnote-21) The practice of forced sterilisation is itself part of a broader pattern of denial of human and reproductive rights of Australian disabled women and girls which also includes systematic exclusion from appropriate reproductive health care and sexual health screening, forced contraception and/or limited contraceptive choices, a focus on menstrual suppression, poorly managed pregnancy and birth, selective or coerced abortion and the denial of rights to parenting.[[22]](#footnote-22) These practices are framed within traditional social attitudes that continue to characterise disability as a personal tragedy, a burden and/or a matter for medical management and rehabilitation.[[23]](#footnote-23)
3. This Submission from Women With Disabilities Australia (WWDA) to the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* supplements many of the submissions, reports, articles, and letters previously provided by WWDA to successive Australian Governments on this issue over the last twelve years. This Submission does not intend to replicate all that work,[[24]](#footnote-24) but instead seeks to highlight key issues for consideration, in recognition that women and girls with disabilities have the right to experience full and effective enjoyment of their human rights on an equal basis as others. Indeed, the right to be fully human.[[25]](#footnote-25)
4. This Submission examines the background to the issue of forced and coerced sterilisation of women and girls with disabilities in Australia and highlights the status of the issue in Australia today. It examines the rationale used to justify the forced sterilisation of disabled women and girls, including themes such as eugenics/genetics; for the good of the State, community or family; incapacity for parenthood; incapacity to develop and evolve; prevention of sexual abuse; and discourses around “best interest”. In doing so, this Submission analyses Australian Court and Tribunal applications and authorisations for sterilisation of disabled women and girls, and demonstrates that in reality, applications and authorisations for sterilisation have very little to do with the ‘best interests’ of the individual concerned, and more to do with the interests of others. This Submission demonstrates that the Australian Government’s current justification of the “best interest approach” in the sterilisation of disabled women and girls, has in effect, been used to perpetuate discriminatory attitudes against women and girls with disabilities, and has only served to facilitate the practice of forced sterilisation.
5. The impact of forced sterilisation on women and girls with disabilities is also highlighted in this Submission, and reaffirms that forced and coerced sterilisation has long-lasting physical, psychological and social effects and causes severe mental pain and suffering, extreme psychological trauma, including depression and grief. It also demonstrates that for women with disabilities, the issue of forced sterilisation encompasses much broader issues of reproductive health, including for example: support for choices and services in menstrual management, contraception, abortion, sexual health management and screening, pregnancy, birth, parenting, menopause, sexuality, violence and sexual assault prevention and more.
6. This Submission looks in detail at forced sterilisation as a violation of human rights and provides an analysis of how the practice contravenes every international human rights treaty to which Australia is a party. It examines the human rights treaty monitoring bodies responses to the practice of forced sterilisation around the world and clearly demonstrates that Australia’s apathy and indifference to the issue sees it lagging behind the rest of the developed world, at the expense of the human rights of disabled women and girls.
7. The Submission provides examples of several recent legal cases to highlight that the issue of forced and coerced sterilisation of women and girls is increasingly being recognised in Courts around the world, as a violation of women’s fundamental human rights. Importantly, WWDA’s Submission also examines redress and transitional justice for women and girls with disabilities who have been sterilised in the absence of their fully informed and free consent. In doing so, the Submission looks at the necessary components of redress and transitional justice, including for example: measures of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery.
8. Given the magnitude of the issue of forced sterilisation of women and girls with disabilities, in that it represents just one element of a much broader pattern of denial of human and reproductive rights of Australian disabled women and girls, it is outside the scope of this Submission to address in detail the wide-ranging and extensive raft of actions required to address the breadth and scope of issues involved. This Submission has, however, endeavoured to identify key recommendations for consideration, whilst acknowledging that much more intensive work is required. Critically, any work in this area, must be based on the understanding that women and girls with disabilities must be at the forefront of any and all consultative and decision-making processes.
9. Forced sterilisation of women and girls with disabilities, and the inadequacy of Australian Governments’ responses to it, represent grave violations of multiple human rights. The Australian Government is obliged to exercise due diligence to: prevent the practice of forced and coerced sterilisation from taking place; investigate promptly, impartially and effectively all cases of forced sterilisation of women and girls with disabilities; remove any time limits for filing complaints; prosecute and punish the perpetrators, and, provide adequate redress to all victims of forced or coerced sterilisation. Meeting these obligations requires the Australian Government to take into account the marginalisation of disabled women and girls, whose rights are compromised due to deeply rooted power imbalances and structural inequalities, and to take all appropriate measures, including focused, gender-specific measures to ensure that disabled women and girls experience full and effective enjoyment of their human rights on an equal basis as others. Nothing less is acceptable.
10. Whilst WWDA welcomes the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* as a long-overdue initiative and commends the Senate for recognising the imperative to address this long neglected yet urgent human rights issue, we re-iterate that there are absolutely no grounds or excuses which can be used to justify the torture of women and girls with disabilities by forced sterilisation.

Key Recommendations

Based on the information provided in this Submission, coupled with WWDA’s extensive and dedicated work on this issue for more than twelve years, WWDA makes the following 18 Key Recommendations to the Australian Government through the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*:

**Recommendation 1**

As an immediate action, in keeping with the human rights treaties to which Australia is a party, and consistent with the recommendations to the Australian Government from the United Nations *Committee on the Elimination of Discrimination Against Women* (CEDAW/C/AUS/CO/7), the *Committee on the Rights of the Child* (CRC/C/15/Add.268; CRC/C/AUS/CO/4), the *Human Rights Council* (A/HRC/17/10), along with the *International Federation of Gynecology and Obstetrics (FIGO) Guidelines on Female Contraceptive Sterilization* (2011); recommendations of the *World Medical Association (WMA)* (2011) and the *International Federation of Health and Human Rights Organisations (IFHHRO)* (2011), and the February 2013 Recommendations of the *UN Special Rapporteur on Torture* (A/HRC/22/53) **enact national legislation prohibiting, except where there is a serious threat to life, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.** Such legislation must prohibit the removal of a child or adult with a disability from Australia with the intention of having a forced sterilisation procedure performed.

**Recommendation 2**

In consultation with women with disabilities, and as a matter of urgency, establish and adequately resource a National Task Force[[26]](#footnote-26) to develop a **Policy and Framework for Transitional Justice and Redress** to address the forced and coerced sterilisation of women and girls with disabilities in Australia. Such a policy and framework must be consistent with the *United Nations Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law* (A/RES/60/147), the *Convention on the Rights of Persons With Disabilities* (A/RES/61/106) and other relevant international standards and frameworks.[[27]](#footnote-27) The following elements as articulated under the *Convention Against Torture [and Other Cruel, Inhuman or Degrading Treatment or Punishment]*, must be included: measures of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery.

**Recommendation 3**

In developing measures of **rehabilitation and recovery** for those affected by forced sterilisation practices and other violations of their reproductive rights and freedoms, women and girls with disabilities must be actively consulted to identify the full range of rehabilitation and recovery measures required, which may include for example:

* specialised counselling, psychological, and social programs, services and supports;
* provision of legal services, supports and assistance for survivors;
* specialised women’s health, allied health and medical programs, services and supports;
* specialised and targeted violence and sexual assault prevention services, programs and support;
* specialised reproductive and sexual health education and training services and programs;
* processes for memorialising and documenting the experiences, stories and histories of those affected.

**Recommendation 4**

Issue a **formal apology** that identifies the discriminatory actions, policies, culture and attitudes that result in forced and coerced sterilisation of people with disabilities and that acknowledges, on behalf of the nation, the harm done to those who have been forcibly sterilised and experienced other violations of their reproductive rights. The formal apology must be developed in consultation with those affected and their allies, and satisfy the five criteria for formal apologies as articulated by the Canadian Law Commission, which include:

* acknowledgment of the wrong done or naming the offence.
* accepting responsibility for the wrong that was done.
* the expression of sincere regret and profound remorse.
* the assurance or promise that the wrong done will not recur.
* reparation through concrete measures.

**Recommendation 5**

Provide **financial reparation** to women and girls with disabilities who have been forcibly sterilised. In establishing a scheme for financial reparation, the Australian Government should examine similar models used in Canada, Sweden and the US, including the *North Carolina Justice for Sterilization Victims Foundation*, established in 2010.

**Recommendation 6**

In consultation with people with disabilities and their allies, and consistent with the *Convention on the Rights of Persons With Disabilities*, act to undertake the following **legislative reforms**:

* enact national legislation that replaces regimes of substitute decision making for people with disabilities with supported decision-making;
* repeal any laws, policies and practices which permit guardianship and trusteeship for adults (and replace regimes of substitute decision-making with supported decision making);
* ensure that the requirement for prior, full and informed consent in all interventions and treatments concerning people with disabilities is enshrined in relevant legal frameworks at national and state/territory levels;
* ensure that criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent is clarified in the law, and that no distinction between persons with or without disabilities is made; and,
* ensure that any law or policy which restricts in any way, a disabled woman’s [and girls] right to full enjoyment of her sexual and reproductive health rights and freedoms, is amended as a matter of urgency.[[28]](#footnote-28)

**Recommendation 7**

In keeping with recommendations from the *Committee on the Elimination of Discrimination Against Women* (CEDAW/C/AUS/CO/7), act to adopt urgent measures to ensure that women with disabilities are better represented in decision-making and leadership positions, and that structures, mechanisms and initiatives are established to enable and foster their participation and engagement. Inherent in this is the need for the Australian Government to undertake an **immediate and** **urgent review** of the level and adequacy of the annual funding provided by the Australian Government to Women With Disabilities Australia (WWDA) ($163,000) including its staffing levels (1 EFT).

**Recommendation 8**

Act immediately to commission and adequately resource a **National Public Inquiry** into the removal and/or threat of removal of babies and children from parents with disabilities. Such an Inquiry must investigate reasons why in Australia today, a parent with a disability is up to ten times more likely than other parents to have a child removed from their care.[[29]](#footnote-29) The Inquiry must also address the over-representation of parents with intellectual disabilities in care and protection proceedings.

**Recommendation 9**

Act immediately on the urgent recommendation of the *Committee on the Elimination of Discrimination Against Women* (CEDAW/C/AUS/CO/7), to address the violence, abuse, neglect and exploitation experienced by women and girls with disabilities living in institutions or supported accommodation. Inherent in this is the need to develop and resource targeted, gendered initiatives to build capacity of individuals and organisations to prevent violence against people with disabilities and to ensure appropriate responses when it does occur.

**Recommendation 10**

As a matter of urgency, and consistent with recommendations from other key Australian disabled people’s organisations, establish and adequately resource an independent, statutory, **national protection mechanism** for ‘vulnerable’ and/or ‘targeted’ adults, where the requirement for mandatory reporting is legislated.

**Recommendation 11**

Commission and fund a three year **national research study** on women and girls with disabilities’ right to reproductive freedom which:

* investigates models of best practice in the delivery of sexual and reproductive health programs and services for women and girls with disabilities, including on all matters relating to parenthood and relationships;
* addresses the effects, including long-term effects, of forced and coerced sterilisation for all women and girls with disabilities, including those with psychiatric, cognitive, sensory and physical disabilities;
* investigates the practice of menstrual suppression of girls and women with disabilities, including those in group homes and other forms of institutional care. Research into menstrual suppression practices must include:
  + - investigation into the non-consensual and coerced administration of Depo-Provera and other injectable contraceptives, the contraceptive pill, and other forms of contraception to women and girls with disabilities;
    - investigation into the use of contraception as a form of social control of girls and women with disabilities;
    - investigation into the long term physical, psychological, and social effects of menstrual suppression practices.

**Recommendation 12**

In consultation with women with disabilities and their allies, **commission specific work** to assist women and girls with disabilities and their families and support persons to access appropriate reproductive health care. Work in this area would need to include:

* Researching and implementing the specific supports required by carers/support persons to better assist them in managing the menstruation and reproductive health needs of women and girls with intellectual and/or cognitive disabilities;
* Investigating the feasibility of establishing a national scheme (similar to schemes such as the Continence Aids Payment Scheme), which provides funding for all women and girls with disabilities and their families and support persons/carers to access appropriate reproductive health care;
* Developing national sexual health protocols for women and girls with disabilities that incorporate options for menstrual management and contraception.

**Recommendation 13**

Establish, and recurrently fund a **National Resource Centre for Parents with Disabilities**, focusing on pregnancy and birthing, adoption, custody, assisted reproduction, adaptive baby-care equipment, as well as general parenting issues. In establishing such a Resource Centre, the Australian Government should examine similar Centres available in other countries, such as the US organisation ‘Through the Looking Glass’.[[30]](#footnote-30)

**Recommendation 14**

Recognise, **support and strengthen** the role of women with disabilities organisations, groups and networks in efforts to fulfil, respect, protect and promote their human rights, and to support and empower women with disabilities, both individually and collectively, to claim their rights. This includes the need to create an environment conducive to the effective functioning of such organisations, groups and networks, including adequate and sustained resourcing. Inherent in this, is the need for financial and political support to enable the establishment and recurrent funding of a peak NGO for women with disabilities in each State and Territory.

**Recommendation 15**

Ensure that information on women and girls with disabilities is provided in all human rights treaties **Periodic Reports** as a matter of course. This would include information on the situation of women with disabilities under each right, including their current de-facto and de jure situation, measures taken to enhance their status, progress made and difficulties and obstacles encountered. Inherent in this is the need to ensure disaggregated data is included in information provided under each right.

**Recommendation 16**

Act to separate disability policy and disability support from family carer policy and support in order to **increase the autonomy** of women and girls with disabilities and challenge the stereotype of women and girls with disabilities as burdens of care.

**Recommendation 17**

Through the National Registration and Accreditation Scheme for the Health Professions (NRAS),[[31]](#footnote-31) act to ensure that **accreditation of the training of health professionals** covered under the *Health Practitioner Regulation National Law Act 2009*, is contingent on disability, gender and human rights specific curriculum components.

**Recommendation 18**

Develop specific measures to ensure a **gender perspective** is incorporated into any national, state/territory initiatives undertaken as part of the domestic implementation of Article 8 [Awareness Raising] of the CRPD.

Terminology

1. *‘Sterilisation’* refers to the performance of a medical procedure which permanently removes an individual’s ability to reproduce, and/or the administration of medication to suppress menstruation. *‘Forced/involuntary sterilisation’* refers to the performance of a procedure which results in sterilisation in the absence of the free and informed consent of the individual who undergoes the procedure. This is considered to have occurred if the procedure is carried out in circumstances other than where there is a serious threat to life. *Coerced sterilisation* occurs when financial or other incentives, misinformation, misrepresentation, undue influences, pressure, and/or intimidation tactics are used to compel an individual to undergo the procedure. Coercion includes conditions of duress such as fatigue or stress. Undue influences include situations in which the person concerned perceives there may be an unpleasant consequence associated with refusal of consent.[[32]](#footnote-32)
2. In considering issues of sterilisation (whether referred to as non-therapeutic, involuntary, coerced) - it is important to be clear that any sterilisation carried out without the free and informed consent of the individual concerned, is a forced sterilisation.[[33]](#footnote-33) This includes instances in which sterilisation has been authorised by a third party, such as a parent, legal guardian, court, tribunal, or judge, without the individual’s consent.[[34]](#footnote-34)
3. The practices that law makers and health care providers call ‘unlawful,’ ‘unauthorised,’ ‘non-consensual,’ ‘involuntary’, or ‘non-therapeutic’ sanitises the picture of what really happens to disabled women and girls in their reproductive choices. For many, the experience is about being denied access to suitable services, forced against their will, coerced, intimidated, pressurised, deceived, compelled, raped and even unknowingly deprived of their human rights to bodily integrity and control over their reproductive health. In the case of sterilisation, the fact that a procedure may be deemed ‘authorised’ or ‘lawful’ does not in any way obviate the reality that a woman with a disability, often a very young woman or girl, undergoes a medical procedure to remove non-diseased parts of her body which are essential to her ongoing health and well-being.[[35]](#footnote-35)
4. Whilst there may be instances where disabled men and boys are subject to sterilisation procedures, sterilisation disproportionately affects women and girls and is clearly a gendered issue. Women and girls with disabilities are at particular risk of forced sterilisations performed under the auspices of legitimate medical care or the consent of others in their name.[[36]](#footnote-36) The majority of cases that have come to the attention of relevant authorities in Australia (including Courts and Guardianship Tribunals) have involved the sterilisation of girls with intellectual disabilities.[[37]](#footnote-37) Similarly, there have been no instances in Australia where authorisations to sterilise have been sought for children without disabilities in the absence of a threat to life or health.[[38]](#footnote-38) In this context, this Submission focuses on women and girls with disabilities, whilst acknowledging that disabled men and boys who may be subject to forced or coerced sterilisation are entitled to the same protection against violations of their human rights as disabled women and girls. As recently highlighted by the Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health:

*Women are generally more likely to experience infringements of their right to sexual and reproductive health given the physiology of human reproduction and the gendered social, legal and economic context in which sexuality, fertility, pregnancy and parenthood occur. Persistent stereotyping of women’s roles within society and the family establish and fuel societal norms.[[39]](#footnote-39)*

1. In discussing sterilisation of people with disabilities, it must also be understood that adult women with disabilities and men with disabilities have the same rights as their non-disabled counterparts to choose sterilisation as a means of contraception. In this context, safeguards to prevent forced sterilisation should not infringe the rights of disabled women and men to choose sterilisation voluntarily and be provided with all necessary supports to ensure that they can make and communicate such a choice based on their free and informed consent.

Background and Status of the Issue in Australia

1. There is a historical precedent in several countries including for example the USA (until the 1950s), in Canada and Sweden (until the 1970s), and Japan (until 1996) indicating that torture of women and girls with disabilities by sterilisation occurred on a collective scale – that is, mass forced sterilisation. This policy was rationalised by a pseudo-scientific theory called eugenics – the aim being the eradication of a wide range of social problems by preventing those with ‘physical, mental or social problems’ from reproducing.[[40]](#footnote-40)
2. Although eugenic policies have now been erased from legal statutes in most countries, vestiges still remain within some areas of the legal and medical establishments and within the attitudes of some sectors of the community:

*“Disabled people should not have babies.” [[41]](#footnote-41)*

*“We neuter our dogs and cats for the perfectly ethical reasons such as their health, to lessen the natural biological impact it causes to their bodies and to ensure that they don't breed unnecessarily….. If she* [re Angela] *were a cat, dog, horse, hamster we would do what we could to alleviate her burdens and to make sure she enjoyed the best quality of life she can have.” [[42]](#footnote-42)*

*“She* [re Angela] *doesnt have the skills necessary to raise a child herself (who will most likely be disabled too), so what use is a reproductive system anyway. Our health system is under enough pressure with the aging population without the addition to any more disabled people.” [[43]](#footnote-43)*

*"Disabled children cost the council too much money and should be put down." [[44]](#footnote-44)*

1. In Australia the issue of sterilisation of disabled women and girls has been the subject of debate since the early 1980s when it became clear that many women with disabilities had been and were being sterilised without their consent and in many cases without their knowledge. It was clear this was happening with the informal consent of family, carers or doctors and without public scrutiny or accountability.[[45]](#footnote-45) This was in keeping with the legacy of the coercive and government sanctioned mass sterilisation of women with disabilities in pre-war Australia.[[46]](#footnote-46)
2. In 1992, in a case now known as *Marion's Case,*[[47]](#footnote-47) an application was made to the High Court of Australia on appeal from the Family Court in relation to a teenage girl with an intellectual disability. The application was for a 'non-therapeutic'[[48]](#footnote-48) surgical sterilisation in order to manage the young girl’s menstruation and prevent pregnancy. The High Court found that fundamental questions of human rights such as the right to reproduce should be decided by the courts rather than by parents, carers or medical practitioners.[[49]](#footnote-49) While this decision leant support to the rights of people with disabilities and has since assumed symbolic importance, subsequent judicial decisions and social practices have failed to give full effect to the promise of *Marion's Case*.[[50]](#footnote-50) In reality considerations about forced sterilisation in Australia have remained effectively bogged down in an ongoing legalistic debate about who can authorise sterilisation, for whom, under what circumstances and within which jurisdiction.[[51]](#footnote-51) The main concern of public policy in the area has focused on piecemeal development of mechanisms, protocols and guidelines in an attempt to *‘minimise the risk of unauthorised sterilisations occurring’.*[[52]](#footnote-52) Additionally, the legal question essentially addressed in the debates around forced sterilisation of women and girls with disabilities has been constructed as a decision about whether to sanction a ‘medical procedure.’[[53]](#footnote-53) This has resulted in the narrow conception of forced sterilisation as a legal and medical matter when it is clearly an issue of fundamental human rights.
3. In 2003, Chief Justice Alastair Nicholson (Chief Justice of the Family Court of Australia from 1988-2004) reflected on the apathy of successive Australian Governments in addressing the issue of sterilisation of disabled women and girls:

*“I have no real knowledge of why successive governments of both federal and state haven't taken a greater degree of interest in this area. It does concern me that the issue hasn't been taken up in any real sense. I know the Federal Government has made some attempts to draw attention to it through the Attorney General's department from time to time but that seems to be about as far as it's gone.” [[54]](#footnote-54)*

1. In August 2003, Australian Governments, through the [then] *Standing Committee of Attorneys-General* (SCAG)[[55]](#footnote-55) agreed that a nationally consistent approach to the authorisation procedures required for the lawful sterilisation of minors was appropriate. From 2003-2007, despite strong opposition from disability and human rights advocates, the SCAG pushed ahead with a proposal to develop legislation aimed to regulate authorisation of sterilisation of minors with a ‘decision-making disability’ rather than prohibit this form of violence.[[56]](#footnote-56) In November 2006, the SCAG released for consultation with selected stakeholders, a draft Bill (*Children with Intellectual Disabilities (Regulation of Sterilisation*) Bill 2006).[[57]](#footnote-57) The Bill set out the procedures that jurisdictions could adopt in authorising the sterilisation of children who have an intellectual disability.[[58]](#footnote-58)
2. The SCAG disbanded its work on the Draft Bill in 2008, declaring that *‘there would be limited benefit in developing model legislation’ [[59]](#footnote-59)* and instead, its Ministers agreed to *‘review current arrangements to ensure that all tribunals or bodies with the power to make orders concerning the sterilisation of minors with an intellectual disability are required to be satisfied that all appropriate alternatives to sterilisation have been fully explored and/or tried before such an order is made’.[[60]](#footnote-60)* There is no evidence to date that these reviews were conducted, and in fact, in 2009, one State Government Attorney-General advised WWDA in writing that no such review had been undertaken in that particular State and nor was there any intention to undertake such a review.[[61]](#footnote-61)
3. In 2009, WWDA formally recommended to the Australian Government/s that the issue of sterilisation of girls and women with disabilities remain as a standing item on the SCAG agenda until such time that national legislation had been developed which prohibited forced sterilisation. Despite the fact that the Australian Government had conceded that: a) girls with disabilities continue to be sterilised in Australia,[[62]](#footnote-62) and b) *‘unrecorded and unauthorised non-therapeutic sterilisations of young women with intellectual disabilities [are] being undertaken in Australia’*,[[63]](#footnote-63) WWDA’s recommendation was rejected, with the [then] Federal Attorney-General, Hon Robert McClelland advising WWDA that:

*'While appreciating your organisation's long advocacy on this issue……..I do not propose at this time to develop Commonwealth legislation or to pursue the issue further through SCAG.’ [[64]](#footnote-64)*

1. In 2009 the Australian Government formally asserted to the United Nationsthat:

*‘a comprehensive review … indicated that sterilisations of children with an intellectual disability had declined since the 1997 report[[65]](#footnote-65) - to very low numbers. Evidence also indicated that alternatives to surgical procedures to manage the menstruation and contraceptive needs of women are increasingly available and seem to be successful in the most part. Further, while it was not possible to be definitive due to limitations in the available information, the review concluded that existing processes to authorise sterilisation procedures appeared to be working adequately due to improvements in treatment options and wider community awareness.’[[66]](#footnote-66)*

1. There was however, no evidence to support that a ‘comprehensive review’ (including *‘evidence and information gathered relating to the issue’)*[[67]](#footnote-67) had been undertaken. No report was ever made available to stakeholders who participated in the consultations on the SCAG 2006 draft legislation, and repeated requests by WWDA to the Australian Government for the report of the ‘comprehensive review’ were ignored.[[68]](#footnote-68)
2. Forced sterilisations continue to occur in Australia,[[69]](#footnote-69) despite the Australian Government’s assertion that only ‘very low numbers’ of children with an intellectual disability are sterilised. A documentary by ABC TV program *‘Four Corners’* in 2003 into sterilisation of people with disabilities, reported on a number of girls and women with disabilities who had been illegally sterilised. Four Corners also *‘made contact with families who have had their daughters sterilised illegally…..they would not come on camera for fear of prosecution’.*[[70]](#footnote-70) The Program identified that *‘some parents, frustrated by the system, are now seeking out illegal sterilisations or finding ways to get around the system’*. The program interviewed a couple who had their 15 year old disabled daughter *‘secretly sterilised in hospital’*. The doctor booked the young girl into the hospital in the mother’s name. The mother explained:

*‘no one questioned me. No one, none of the nurses, no one. We were in a private room, we were on our own, and I stayed with her and then I brought her home and nursed her and she was fine…… It's something we have to do behind closed doors because people don't understand.’ [[71]](#footnote-71)*

1. In another case, a couple had their 15 year old disabled daughter sterilised in the United States. The parents wanted their daughter sterilised for menstrual management purposes and also to prevent a possible pregnancy in the future. The mother was of the view that, for her daughter to be sterilised in Australia would have been ‘virtually impossible’ and ‘we’d have to break the law’. She explained:

*‘I've got many friends that have been down the line and been knocked back, some friends going through the process at the moment, some friends that it will come up in the next couple of years. The motivation for a parent to get an illegal sterilisation would be they're doing the best for their child. Health and hygiene would be the utmost. And they would be desperate. And, yeah, I'd go down that track if we were not able to get a hysterectomy for Laura in the States.’ [[72]](#footnote-72)*

1. Although forced sterilisation breaches every international human rights treaty to which Australia is a party, and is a practice that constitutes torture, successive Australian Governments have consistently taken the view that there are instances in which forced sterilisation can and should be authorised, as evidenced for example, in the current Australian Government’s 2009 Report to the United Nations under the *Convention on the Rights of the Child* (CRC):

*A blanket prohibition on the sterilisation of children could lead to negative consequences for some individuals. Applications for sterilisation are made in a variety of circumstances. Sometimes sterilisation is necessary to prevent serious damage to a child’s health, for example, in a case of severe menstrual bleeding where hormonal or other treatments are contraindicated. The child may not be sexually active and contraception may not be an issue, but the concern is the impact on the child’s quality of life if they are prevented from participating to an ordinary extent in school and social life.[[73]](#footnote-73)*

1. In June 2011, WWDA lodged a formal complaint with four of the United Nations Special Rapporteurs, requesting urgent intervention from each of their offices simultaneously.[[74]](#footnote-74) The Special Rapporteurs[[75]](#footnote-75) wrote to the Australian Government on 18 July 2011 seeking a formal response in relation to the alleged ongoing practice of forced sterilisation of girls and women with disabilities in Australia (see Appendix 2). The Government’s response, provided to the UN on 16 December 2011 (see Appendix 3), outlined the different laws governing sterilisation in Australia; and stated that *‘sterilisations are authorised only where they are the last resort, as less invasive options have failed or are inappropriate, and where they are in a person’s best interests’*. The response demonstrates that the Australian Government does not currently have a coherent national approach to sterilisation of women and girls with disabilities and indicates that the Australian Government remains of the view that there are instances in which forced sterilisation of disabled girls and women, can and should be authorised.
2. Since 2005, United Nations treaty monitoring bodies have consistently and formally recommended that the Australian Government enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.[[76]](#footnote-76)
3. In June 2012, the Committee on the Rights of the Child (CRC), in its *Concluding Observations*[[77]](#footnote-77) to the Fourth periodic report of Australia,[[78]](#footnote-78) expressed its serious concern that the absence of legislation prohibiting non-therapeutic sterilisation of girls and women with disabilities *“is discriminatory and in contravention of article 23(c) of the Convention on the Rights of Persons with Disabilities………..”*. The Committee urged the State party to: *‘Enact non-discriminatory legislation that prohibits non-therapeutic sterilization of all children, regardless of disability; and ensure that when sterilisation that is strictly on therapeutic grounds does occur, that this be subject to the free and informed consent of children, including those with disabilities.’* Furthermore, the Committee clearly identified non-therapeutic sterilisation as a form of violence against girls and women, and recommended that the Australian Government *‘develop and enforce strict guidelines to prevent the sterilisation of women and girls who are affected by disabilities and are unable to consent.’*
4. In January 2011, in follow-up to Australia’s *Universal Periodic Review*,[[79]](#footnote-79) the UN Human Rights Council endorsed a recommendation specifically addressing the issue of sterilisation of girls and women with disabilities. It specified that the Australian Government should enact national legislation prohibiting the use of non-therapeutic sterilisation of children, regardless of whether they have a disability, and of adults with disabilities without their informed and free consent.[[80]](#footnote-80) The Australian Government’s formal response to this recommendation illustrates its blatant disregard of the human rights of women and girls with disabilities:

*‘The Australian Government will work with states and territories to clarify and improve laws and practices governing the sterilisation of women and girls with disability.’ [[81]](#footnote-81)*

1. In July 2010, at its 46th session, the UN Committee on the Elimination of Discrimination against Women (CEDAW) expressed concern in its *Concluding Observations on Australia* at the ongoing practice of non-therapeutic sterilisations of women and girls with disabilities and recommended that the Australian Government *‘enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.’* [[82]](#footnote-82)In September 2012, the Australian Government submitted its Interim Report to the CEDAW Committee,[[83]](#footnote-83) to address how it was responding to the recommendations from the 2010 *CEDAW Concluding Observations on Australia*,[[84]](#footnote-84) specifically on violence against women, and Aboriginal and Torres Strait Islander women. Despite the fact that forced sterilisation of women and girls with disabilities constitutes violence against women,[[85]](#footnote-85) the Australian Government’s 42 page response completely ignores the CEDAW recommendation on sterilisation of women and girls with disabilities.
2. In 2005, the Committee on the Rights of the Child in considering Australia’s combined second and third periodic reports[[86]](#footnote-86) under Article 44 of the *Convention on the Rights of the Child* (CRC), recommended that ‘*the State party..…prohibit the sterilization of children, with or without disabilities….’*[[87]](#footnote-87) and in 2007 clearly articulated its position on sterilisation of girls with disabilities, clarifying that States parties to the CRC are expected to prohibit by law the forced sterilisation of children with disabilities.[[88]](#footnote-88)
3. To date, the Australian Government has failed to comply with any of these recommendations.
4. Australia is due to report to the United Nations Human Rights Committee on Australia’s compliance with the *International Covenant on Civil and Political Rights* (ICCPR). It is required to submit its response to the List of Issues Prior to Reporting (LOIPR),[[89]](#footnote-89) (adopted by the Human Rights Committee at its 106th session in late 2012) by 1 April 2013 and is scheduled to appear for review by the Human Rights Committee in 2014. Under the heading of *‘Violence Against Women’*, the LOIPR for Australia contains a question on sterilisation, to which the Australian Government is expected to respond.[[90]](#footnote-90) Specifically, it states:

*Please provide information on whether sterilization of women and girls, including those with disabilities, without their informed and free consent, continues to be practiced, and on steps taken to adopt legislation prohibiting such sterilisations.*

1. Australia is also due to report to the United Nations Committee on the Rights of Persons with Disabilities (CRPD). In April 2013, the CRPD Committee will meet at its 9th session[[91]](#footnote-91) to develop the List of Issues Prior to Reporting (LOIPR) for Australia in relation to its compliance with and implementation of the *Convention on the Rights of Persons with Disabilities*. Australia’s NGO Shadow Report to the CRPD[[92]](#footnote-92) Committee will be considered in the development of the LOIPR for Australia along with information provided by WWDA. It is anticipated that the CRPD LOIPR for Australia will include a specific question on the sterilisation of girls and women with disabilities.
2. International and national *NGO/Civil Society Shadow Reports[[93]](#footnote-93)* submitted to the CRPD Committee for Australia’s upcoming review under the CRPD, explicitly deal with the issue of forced and coerced sterilisation of women and girls with disabilities, and call on the Australian Government to prohibit the practice as well as develop specific legislation prohibiting medical treatment and interventions of people with disabilities without their free and informed consent.
3. In addition to the important analysis and condemnation of forced and coerced sterilisation of disabled women and girls by UN mechanisms, international medical bodies have now developed new protocols and calls for action to put an end to the practice of forced/involuntary sterilisation. In June 2011, the International Federation of Gynecology and Obstetrics (FIGO) released new *Guidelines on Female Contraceptive Sterilization*[[94]](#footnote-94) shoring up informed consent protocols and clearly delineating the ethical obligations of health practitioners to ensure that women, and they alone, are giving their voluntary and informed consent to undergo a surgical sterilisation. The FIGO Guidelines (see Appendix 1) clearly state that: *‘It is ethically inappropriate for healthcare providers to initiate judicial proceedings for sterilization of their patients, or to be witnesses in such proceedings inconsistently with Article 23(1) of the Convention on the Rights of Persons with Disabilities.’* Yet the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), a member of FIGO, has recently asserted that:

*no method of menstrual regulation or sterilisation is perfect, and a small number of disabled girls or women may still have their best interests served by hysterectomy or sterilisation.[[95]](#footnote-95)*

1. In September 2011, the *World Medical Association* (WMA) released a statement condemning the practice of forced and coerced sterilisation as a serious breach of medical ethics. WMA President, Dr. Wonchat Subhachaturas, called involuntary sterilisation *“a misuse of medical expertise, a breach of medical ethics, and a clear violation of human rights.”* On behalf of the WMA, he issued a call to *“all physicians and health workers to urge their governments to prohibit this unacceptable practice.”*[[96]](#footnote-96)
2. In October 2012, the *International NGO Council on Violence against Children*,[[97]](#footnote-97) classified ‘sterilisation of children with disabilities’ as a harmful practice based on tradition, culture, religion or superstition.[[98]](#footnote-98) It has urged States to prohibit the practice by law as a matter of urgency.
3. In 2012, the World Health Organisation (WHO) commenced work on the development of a *WHO Statement on Involuntary Sterilization*,[[99]](#footnote-99) which addresses involuntary sterilisation of people with disabilities. The Statement will highlight the problem of involuntary sterilisation and will reaffirm the commitment of WHO to uphold human rights in the area of sexual and reproductive health. It will enable WHO to support Member States to ensure that law, policy and practice are in line with human rights standards and ethical principles and contribute to implementing best practices among policy-makers, professionals, and civil society. The Statement will be launched in the second quarter of 2013.
4. The *Global Stop Torture in Health Care Campaign*[[100]](#footnote-100) has identified forced sterilisation as one of its three priority issues for international action.[[101]](#footnote-101) In doing so, it states:

*‘Although sterilization may be carried out by individual health providers, it is ultimately the responsibility of governments to prevent such abuses from taking place. Governments must protect individuals from forced sterilization and guarantee all people’s right to the information and services they need to exercise full reproductive choice and autonomy.’*

Rationale used to justify forced sterilisation in Australia

1. Forced sterilisation is performed on young girls and women with disabilities for various purposes, including eugenics-based practices of population control, menstrual management and personal care, and pregnancy prevention (including pregnancy that results from sexual abuse).[[102]](#footnote-102) In Australia, the reasons used to justify forced sterilisations generally fall into four broad categories, all couched as being in the “best interests” of women and girls with disabilities: a) the genetic/eugenic argument; b) for the good of the state, community or family; c) incapacity for parenthood; and d) prevention of sexual abuse.

**The Genetic/Eugenic Argument**

1. This line of argument is based on the fear that disabled women will re/produce children with genetic ‘defects’. For example, in 2004, the Family Court of Australia authorised the sterilisation of a 12 year old intellectually disabled girl with Tuberous sclerosis, a genetic disorder with a 50% inheritance risk factor. Although one out of two people born with tuberous sclerosis will lead ‘normal’ lives with no apparent intellectual dysfunction, the Court accepted evidence from a medical specialist that sterilisation was in the best interests of the young girl because:

*“the result will be complete absence of menstruation and this will undoubtedly be of benefit to H who already appears to have substantial difficulties with cleanliness…….. As a by-product of an absence of her uterus H will never become pregnant. Given the genetic nature of her disorder and the 50% inheritance risk thereof, this would in my view be of great benefit to H.” [[103]](#footnote-103)*

1. This reasoning is clearly grounded in eugenic ideology and in the broad views that society holds of disability as a burden, a personal tragedy or a medical problem, as evidenced by these recent examples of public responses to newspaper articles regarding sterilisation of disabled women and girls in Australia:

*“……Personally I think people with any medium level to high level disability should be completely sterilised to keep the gene pool clean.” [[104]](#footnote-104)*

*“The severity of disability needs to be considered, as well as the genetic likelihood of the disability being passed on.” [[105]](#footnote-105)*

*“The government shouldn't have to support unwanted babies let alone disabled children having disabled children.” [[106]](#footnote-106)*

*“Considering that evolution is merely random mutations of DNA between generations with the result being that some will be stronger and more prone to survival while others will, unfortunately, be weaker and thus suffer a higher mortality rate it would appear irresponsible to allow a 'profoundly disabled' person to have offspring anyway.” [[107]](#footnote-107)*

*Someone I know worked in a mental institution and she told me that the disabled often have very high sexual urges and they often do the deed with each other and then fall pregnant. It apparently results in lots of abortions so sterilisation is certainly a good option. [[108]](#footnote-108)*

*“If you have ever looked after those with a mental disability you would never let them have children - they will end up in care adding to the problem.” [[109]](#footnote-109)*

*“Sterilisation is a common sense approach to anyone not capable of independently looking after a child. Lets forget about the rights of mentally incapacitated adults and lets think about the rights of children. The rights to be born with as close to 100% genetic ability to be "normal". The rights to have a "normal" parent(s). The right to be raised in a "normal" manner and to lead an independent and meaningful life that advantages society. There are way, way too many people on this earth already, to allow those that cannot independently raise children, to breed, is ludicrous.”[[110]](#footnote-110)*

*“The sterilization is a very human solution for all mentally and physically disabled people in their early age. This would be an answer to prevent many disabled person from ongoing problems in their whole life. If I would asking* [sic] *to vote what to do with them, I wouldn't hesitate to recommend the sterilization.” [[111]](#footnote-111)*

1. The residue of this type of thinking continues to have the potential for profound and alarming consequences for girls and women with disabilities.[[112]](#footnote-112) As recently highlighted by Ms Rashida Mijooo, the UN Special Rapporteur on Violence against Women, its Causes and Consequences:

*Although society’s fear that women with disabilities will produce so-called “defective” children is for the most part groundless, such erroneous concerns have resulted in discrimination against women with disabilities from having children.[[113]](#footnote-113)*

1. There is clear evidence to indicate that the causes of impairment are overwhelmingly social and environmental (including for example: war, poverty, environmental degradation, neglect in healthcare, poor workforce conditions, gender-based violence and harmful traditional practices)[[114]](#footnote-114) and only a small number are related to genetic causes.
2. Sterilisation is not 'a treatment of choice' for non-disabled women and girls with genetic disorders.

**For the Good of the State, Community or Family**

1. Arguments here centre on the 'burden' that disabled women and girls and their potentially disabled children place on the resources and services funded by the state and provided through the community. A related and very commonly used argument, is the added ‘burden of care’ that menstrual and contraceptive management places on families and carers.
2. In a recent case, the Family Court of Australia authorised the sterilisation of an 11 year old girl with Rett Syndrome. The application was made by the young girl’s mother to prevent menstruation. No independent children’s lawyer was appointed to advocate for the girl, as the judge determined it would be of ‘no benefit’. In accepting *“without hesitation”* the evidence of Dr T, an Obstetrician and Gynaecologist, the judge said:

*“Undoubtedly and certainly of significant relevance is that there are hygiene issues which must fall to the responsibility of her mother because Angela cannot provide for herself….. the operation would certainly be a social improvement for Angela’s mother which in itself must improve the quality of Angela’s life.”* [[115]](#footnote-115)

1. The ‘burden’ of parents having to deal with menstrual management of their disabled daughters is often used as a valid justification when Australian Courts authorise the sterilisation of disabled females - even before the onset of puberty.[[116]](#footnote-116) For example, in authorising the sterilisation of a 12 year old girl in 2004, the Court accepted medical ‘evidence’ that caring for her was an *“onerous responsibility”* on her parents and that sterilisation would make the task of caring for her *“somewhat less onerous”*, including that it would *“make it easier for her carers if they had one less medication to administer.”* [[117]](#footnote-117)
2. In the case of *Re Katie*,[[118]](#footnote-118) the Court authorised the 15 year olds sterilisation at the onset of her menstruation, on the grounds that there would be ‘appreciable easing of the burden’ on the parents as primary carers:

*“It will lessen the physical burdens for the mother, in particular by decreasing the number of changes necessary in toileting, and quite possibly lessening the physical reactions, such as stiffening in body tone, which make Katie more difficult to handle during menstruation. It would lessen, for the parents, the risks of infection…..Katie's emotional welfare is best served by her continuing to reside in the family and by the demands of her presence being lessened as much as possible, to maximise the ability of the family, in particular the mother, to cope with Katie's needs. Thus the interests of Katie are inextricably linked with the ability of her parents to cope with the burdens of Katie's care.”*

1. In late 2011, the Queensland Civil and Administrative Tribunal (QCAT) authorised the sterilisation of ‘HGL’, a ‘severely intellectually disabled’ 18 year old girl whose menstrual periods had commenced at the age of 17, which according to her parents, caused her ‘distress’. Although it was agreed that *‘the current hormone treatment is managing HGL’S menstruation’*, a hysterectomy was authorised because:

*‘there are risks that the medication will over time fail to achieve this effect and….HGL’s current impairments mean that she will not be a candidate for surgery indefinitely.’* [[119]](#footnote-119)

1. In the case of *Re S*,[[120]](#footnote-120) a 12 year old ‘severely intellectually disabled girl’ who lived in an institution and who had not yet begun to menstruate, the Family Court granted authorisation for her to be sterilised because, according to the specialist paediatric surgeon arranged to carry out the operation:

*‘it would be wiser to avoid problems rather than to wait and see if S copes with menstruation……..surely there is no need for her to suffer the problems that may arise with periodic menstruation’*, which included *‘the possibility that she would develop a phobia of blood’*. The judge agreed this was a *‘realistic and appropriate view’* and that *‘there is no point in the child going through the problems associated with menstruation if she is not ever to bear children’*.

1. In *Re M*,[[121]](#footnote-121) the Family Court authorised the sterilisation of a 15 year old girl prior to the onset of menstruation upon the basis that such treatment was *“necessary to prevent serious damage to the child’s health.”* The rationale for this decision included that: the young girl’s mother and sister experienced ‘painful periods’ and *“there is a very real risk that the same will happen to M”*; that the young girl *“played with her motions and played with herself”* and this ‘behaviour’, coupled with menstruation, *“could cause infections”*. Additional reasons for the decision to sterilise M included that she was: *“aggressive”; “strong-willed”; “stubborn”;* had a *“poor frustration tolerance”*, was *“unco-operative;”* was *“a loner”* andhad *“few friends’’*.
2. In yet another case of a young disabled girl aged 15 years who had yet to commence menstruation, sterilisation was authorised by the Family Court in support of her mother’s submission that menstruation *‘might induce a higher incidence of fits; and the sight of unexplained blood will lead to confusion and fear, which could lead to an increased incidence of fitting’*. The Court also accepted the mother’s concern, which was supported by ‘medical experts’, that:

*‘menstruation will be yet another hazard and perhaps mitigate against (her) chances of being adopted should the mother die.’ [[122]](#footnote-122)*

1. ‘Bad and unruly behaviour’ associated with menstruation is another dimension in applications for, and authorisations of sterilisation of young disabled girls and women:

*“Dr Py. records that "staff" at the ward in which Sarah resides, have told him that she becomes a problem during her menstrual period as she has no concept of personal care, cleanliness or propriety.”* [[123]](#footnote-123)

*“Mrs M [residential care officer] said that S was the most difficult of the six children in the Villa for which she is responsible and that masturbation is a virtual constant activity of the child. It appears that if S is restrained from engaging in masturbation she reacts badly. Mrs M has difficulty in encouraging S to do basic tasks and described the child as being "among the worst" in that regard.”* [[124]](#footnote-124)

*“During the menstrual time, Katie grinds her teeth, throws tantrums, collapses her legs, she seems tired and this has caused her to miss part or whole school days……. She is extremely impatient at meal times……During the menstrual and pre-menstrual period, because of the changes to her temperament, Katie is not taken horse-riding.” [[125]](#footnote-125)*

1. In a 2011 application to the NSW Guardianship Tribunal, a specialist gynaecologist (Dr HJK) lodged an application to perform a sterilisation procedure on a 22 year old woman with Down Syndrome.[[126]](#footnote-126) In the application form Dr HJK recorded the proposed treatment, but he did not provide any details of the treatment, its consequences or provide details of complications likely to be associated with the procedure. He did record that Miss XTV has Down’s Syndrome and that *“Patient becomes distressed and difficult to manage during menstruation”*. The ‘behaviour management problems during menstruation’ identified by Miss XTV’s mother in the application, and supported by the gynaecologist, included that Miss XTV became *‘obsessive with possessions; exhibited anxiety at any change in circumstance and routine; regressed with self-help skills; and developed a phobia about barricades on upper floors of shopping centres’*. Although the application was dismissed in 2012, the Tribunal stated:

*We take this opportunity to note that should the alternate procedure of the insertion of a Mirena IUCD not be carried out, or carried out but not prove effective, and/or other causes of Miss XTV’s behaviours be eliminated, the evidentiary onus required to be satisfied to give consent to endometrial ablation may be met. In those circumstances there is nothing to prevent a further application to the Tribunal for consent.*

1. In terms of the ‘burden’ on families of the care of girls and women with disabilities, lack of resources and appropriate education and support services, respite care, school and post-school options, see many families already struggling to manage the care of their girl or young woman with disabilities. Faced with the prospect of added personal care tasks in dealing with menstruation and in the limited availability or accessibility of specific reproductive health and training services (including those for menstrual management), families may well see sterilisation as the only option open to them.[[127]](#footnote-127) The denial of a young woman’s human rights through the performance of an irreversible medical intervention with long term physical and psychological health risks is wrongly seen as the most appropriate solution to the social problem of lack of services and support.[[128]](#footnote-128)
2. Evidence suggests however that menstrual and contraceptive concerns, even for women and girls with high support needs can be successfully met with approaches usually taken with non-disabled women and girls.[[129]](#footnote-129) Research has found that when parents and carers are given appropriate support and resources the issue of sterilisation loses potency.[[130]](#footnote-130)
3. A diagnosis of intellectual disability does not by itself constitute a clinical reason for sterilisation. The onset of menstruation is the same in girls with and without intellectual disabilities, and girls with intellectual disabilities present with the same types of common menstrual problems as the rest of the young female population.[[131]](#footnote-131) Arguments for elimination of menstruation in girls and young women with disabilities are primarily about social taboos.[[132]](#footnote-132)
4. Sterilisation is not 'a treatment of choice' for non-disabled females who are approaching menstruation, who menstruate, or who experience menstrual problems. Like their non-disabled counterparts, women and girls with disabilities have the right to bodily integrity, the right to procreate, the right to sexual pleasure and expression, the right for their bodies to develop in a natural way, and the right to be parents.[[133]](#footnote-133)

**Incapacity for Parenthood**

1. Australia has a history of removing children from their natural parents based on the personal characteristic of the parents, such as indigenous background or marital status. In Australia today, a parent with a disability is up to ten times more likely than other parents to have a child removed from their care.[[134]](#footnote-134) Courts and child protection authorities are removing children from their parents on the basis of the parent’s disability rather than actual neglect or abuse. A parent’s capacity to parent his or her child, even with full community support is not properly assessed:[[135]](#footnote-135)

*“My son was removed from my care when he was born by the department of child safety. They hadn’t assessed my abilities as a parent nor did they tell me they were going to take away my son before I gave birth. They didn’t trust me and said that they wanted to prevent me from harming my baby, even when I had done nothing wrong. No support has ever been provided to help me be a parent of my son. We got an independent assessment done and it showed that even though I have a mild intellectual impairment, my behavioural functioning is normal. Even now, I only see him every Friday and he stays overnight once a fortnight.” [[136]](#footnote-136)*

1. Widely held societal attitudes that disabled women cannot be effective parents mean there is pressure to prevent pregnancy in disabled women, particularly women with intellectual disabilities. Women with disabilities are typically seen as child-like, asexual or over-sexed, dependent, incompetent, passive, and genderless[[137]](#footnote-137) and therefore considered inadequate for the *‘nurturing, reproductive roles considered appropriate for women’*.[[138]](#footnote-138) For women with intellectual disabilities, the label of intellectual disability per se is mistakenly taken for prima facie evidence of likely parental incapacity or risk of harm to the child.[[139]](#footnote-139) This is also the case for women with psychosocial impairments.[[140]](#footnote-140) Such incapacity is automatically deemed to be an irremediable deficiency in the parent such that it cannot be overcome.
2. Incapacity for parenthood is a common theme in applications for and Court authorisations of sterilisation of disabled females in Australia:

*‘It is clearly established that S is unfit to, and ought not, bear a child.’* [[141]](#footnote-141)

*‘Katie could not possibly care for a child.’* [[142]](#footnote-142)

*‘A pregnancy would be disastrous.’* [[143]](#footnote-143)

*‘It is clear that H has at least moderate intellectual disability……….she would be unable to care for a child if she were to become pregnant.’* [[144]](#footnote-144)

*‘It is understood and accepted that the child would never marry or enter into any relationship in which she would bear children. She is quite unable to understand the processes of conception and birth and would be quite unable to bear a child. Pregnancy would be most likely to have a highly detrimental effect upon her and should she become pregnant, for her own sake, her pregnancy would be terminated.’* [[145]](#footnote-145)

*‘If she were to be the victim of sexual assault, and to become pregnant, this would be a very complicated situation, both ethically and medically. The hysterectomy would remove the chance of an unwanted pregnancy and further medical complications associated with a pregnancy.’ [[146]](#footnote-146)*

1. There is ample evidence that many women with disabilities successfully parent happy children within our communities.[[147]](#footnote-147) There is no clear relationship between competence or intelligence and good parenting – in fact, more than six decades of research has demonstrated that intellectual disability per se is an unreliable predictor of parenting performance.[[148]](#footnote-148)

**Incapacity to Develop and Evolve**

1. The determination of capacity is inextricably linked to the exercise of the right to autonomy and self-determination. To make a finding of incapacity results in the restriction of one of the most fundamental rights enshrined in law, the right to autonomy.[[149]](#footnote-149) Millions of people with disabilities are stripped of their legal capacity worldwide, due to stigma and discrimination, through judicial declaration of incompetency or merely by a doctor’s decision that the person “lacks capacity” to make a decision. Deprived of legal capacity, people are assigned a guardian or other substitute decision maker, whose consent is deemed sufficient to justify forced treatment.[[150]](#footnote-150)
2. Incapacity is often used as a valid justification for Court authorisation of sterilisation of disabled women and girls. Incapacity in this context, is considered to be a fixed state, with no consideration given to the possibility of capacity evolving over time:

*"Those who are severely intellectually disabled remain so for the rest of their lives".[[151]](#footnote-151)*

*“There is no prospect that she will ever show any improvement in her already severely retarded mental state.” [[152]](#footnote-152)*

*Katie would never be able to contribute to self-care during menstruation…… Katie is unable to understand re-production, contraception, pregnancy and birth and that inability is unlikely to change in the foreseeable future. [[153]](#footnote-153)*

*Sarah is unable to understand reproduction, contraception and birth and that inability is permanent……her condition will not improve. [[154]](#footnote-154)*

*‘HGL is unlikely, in the foreseeable future, to have capacity for decisions about sterilisation.’ [[155]](#footnote-155)*

*‘There has been no alteration in H’s capacity for eighteen months and it has been assessed that there will be no improvement in H in the future.’[[156]](#footnote-156)*

1. Views such as these fail to acknowledge the fact that ‘incapacity’ can very often be a function of the environment and more often than not, a lack of support for the individual concerned.
2. In the case of *Re Katie*,[[157]](#footnote-157) her lack of capacity was a key consideration in the Family Court’s decision to approve her sterilisation at the age of 16. Katie was described as *‘being able to finger feed, drink out of a cup and use a spoon with assistance’* yet determined as not having *‘the cognitive capacity to understand what is required, nor does she have the motor skills necessary to take care of her needs, i.e. to change pads’*. However, it was also stated that it was *‘likely that Katie will continue to make some slow progress in her development if able to participate fully in educational therapy programs. Failure to carry out the proposed surgery could significantly reduce her ability to participate in these programs.’* Paradoxically, Katie was sterilised because she had ‘lack of capacity to develop’ but also so that she might ‘develop capacity’.
3. One of the key principles guiding the *Convention on the Rights of Persons with Disabilities* is ‘respect for the evolving capacities of children with disabilities’, a concept which should be seen as a positive and enabling process that supports the maturation, autonomy and self-expression of the child. Through this process, children progressively acquire knowledge, competencies and understanding. Research has shown that information, experience, environment, social and cultural expectations, and levels of support can dramatically impact the development of a child’s capacities to form a view.[[158]](#footnote-158)
4. It is evident however, that sterilisation is easier, quicker, and cheaper than providing the programs, services and supports to enable young disabled women and girls to ‘progressively acquire knowledge, competencies and understanding’ about their bodies, their sexuality, relationships, safety and their human rights:

*“the proposed operation would avoid the necessity of time-consuming and constantly repeated programmes to enable the child to acquire skills to manage her menstruation, thereby freeing her to learn important social skills which could only improve her quality of life and opportunities to lead a "normal" life.” [[159]](#footnote-159)*

1. The UN Special Rapporteur on Torture has recently re-iterated that the law should never distinguish between individuals on the basis of capacity or disability in order to permit sterilisation specifically of people [girls and women] with disabilities.[[160]](#footnote-160) Yet in the 2009 case of *Re BAH*,[[161]](#footnote-161) a 14 year old disabled girl whose mother sought to have her sterilised prior to the onset of menstruation, the NSW Guardianship Tribunal stated:

*Ms BAH’s disability is clearly central to the Tribunal’s deliberations in this matter. But for Ms BAH’s intellectual disability, the Tribunal would not have given consideration to the proposed treatment.*

**Prevention of Sexual Abuse**

1. Sterilisation has been said to protect disabled women and girls from sexual abuse and the consequences of abuse.[[162]](#footnote-162) Indeed, ‘vulnerability to sexual abuse’ is a dominant theme in many of the applications seeking authorisation for sterilisation of disabled women and girls in Australia.[[163]](#footnote-163) In this context, 'inappropriate behaviour’, and ‘good looks’ are considered major determinants of sexual activity or abuse.[[164]](#footnote-164)
2. For example, in the case of *Re Katie*,[[165]](#footnote-165) her ‘attractive looks’ were considered to make her more ‘vulnerable’ to sexual abuse, and formed part of the Court’s rationale for her to be sterilised at the aged of 16:

*“It is highly unlikely that Katie will ever have the capacity to understand and voluntarily enter into a sexual relationship..... It is however well documented that disabled children are particularly vulnerable to sexual abuse and Katie is quite an attractive girl."*

1. Similarly, in a case[[166]](#footnote-166) where the Court authorised the sterilisation of a 14 year old girl prior to the onset of menstruation, the judge stated:

*“it is unlikely she will have any form of relationship involving sexual intercourse. She could, of course, be the victim of a sexual assault and with her normal physical development and attractive looks that cannot be discounted.*

1. In *JLS v JES*,[[167]](#footnote-167) where authorisation for sterilisation was sought for a 14 year old girl who was described as *‘extremely severely handicapped’*, prevention of sexual abuse was a key factor in seeking the application. According to the Judge, the young girl’s mother *‘expressed concern at the possibility of the child becoming pregnant through sexual abuse while out of the plaintiff's direct supervision, as would increasingly occur as she approaches adulthood. The mother expresses a moral opposition to the concept of abortion…..’* A number of ‘experts’ supporting the application identified risk of sexual abuse as ‘evidence’ of why the sterilisation should be authorised:

*“I do agree, especially as she is an attractive girl, that she is at great risk of pregnancy and also of pelvic infection as she develops sexual maturity."* [Consultant Neurologist]

*"It would prevent a pregnancy, to the risk of which the child might become exposed in more social environments such as Respite Care, out of continual supervision by her mother. Having regard to her mental retardation she was incapable of communicating any symptoms relating to pregnancy. An epileptic episode during pregnancy would increase three or four times the risk of foetal abnormality.”* [Consultant Obstetrician and Gynaecologist]

*‘…it was unacceptable to have her exposed to the risk of becoming pregnant having regard to her mental retardation, epilepsy and condition generally.’* [Consultant Obstetrician and Gynaecologist]

1. In other cases, the young girls’ ‘behaviour’ with men was a consideration in authorising their sterilisation prior to the onset of their menstruation:

*“Ever since Elizabeth was a very young child, she was prone to run to men. If her mother takes her out she will go to any man, including strangers. On many occasions in public when the mother has not been holding Elizabeth tightly, she has run over to a man who is a complete stranger and taken his arm. She shows no fear and would happily go off with any man. She has to be physically restrained from chasing after men in public and throwing her arms around them.” [[168]](#footnote-168)*

*“S is likely to wander….[she] has a preference when singling out an adult for attention for men over women and particularly for men with beards..….S is generally solitary by choice……[she] likes soft sticky textures and regularly engages in faecal smearing…….I have included the foregoing statements because they give something of an overall picture of the child. I would add that, if not common ground, it is clearly established that S is unfit to, and ought not, bear a child.” [[169]](#footnote-169)*

*“…since the onset of sexual maturity she displays an affectionate promiscuity which is the characteristic of women with intellectual disability.” [[170]](#footnote-170)*

1. In the case of *Re S*,[[171]](#footnote-171) sterilised at the age of 12 and described as having a *‘mental age of no greater than 1 year old’* with *‘no prospect of any improvement in her already severely retarded mental state’*, the judge stated:

*‘Although I agree that the risk of pregnancy, on its own, is not of sufficient likelihood as to indicate a need to submit her to a sterilisation procedure I would not dismiss the probability of sexual intercourse occurring’.*

1. Sterilisation as a ‘valid’ reason for prevention of sexual abuse also emerges as a strong theme in analysis of public commentary on the issue of sterilisation of disabled women and girls in Australia, as evidenced by these recent examples of public responses to newspaper articles on the issue:

*“My mother worked with profoundly retarded young adults some years ago and saw how easily several were 'taken advantage of' - she knew of three girls who were made pregnant by one repugnant ward assistant and they had to have abortions. I believe that all severely mentally retarded young females should be sterilised if nothing other than to protect them from assault - it does happen.” [[172]](#footnote-172)*

*“This happened to my sister who is profoundly disabled 15 years ago and was not the big deal that this seems to be now. have we gone backwards in 15 years. our decision to do this was less about menstral* [sic] *cycles and more about some sicko taking advantage of her and her having a child she was unable to look after.” [[173]](#footnote-173)*

*“It is also important to consider the possibility that this girl could be sexually assaulted and fall pregnant. If she cannot talk and is not able to communicate to anyone what has happened, her pregnancy may not be discovered until it is too late to consider options such as abortion. Surely this situation would be far more traumatic for Angela, as well as for her parents, than undergoing a hysterectomy.” [[174]](#footnote-174)*

*“Considering the possibility of some sicko taking advantage of this girl who could not give consent, and the possibility of pregnancy from such assault, as well as the easing of this child's other suffering, this was a brave and very wise decision.” [[175]](#footnote-175)*

*“Certainly if it helps discomfort go for it and in any case surely a good idea to prevent an unwanted pregnancy at the hands of some other party. That would be an abomination for all.” [[176]](#footnote-176)*

1. Research has demonstrated that rather than protecting against sexual abuse, forced sterilisation can increase vulnerability to sexual abuse.[[177]](#footnote-177) It is widely acknowledged that sexual abuse of women and girls with disabilities occurs at very high rates in our communities.[[178]](#footnote-178) A young woman who has been sterilised is less likely to be taught about sexuality or sexual abuse because she cannot become pregnant. Sterilisation can also inadvertently serve to cover up the sexual abuse of women with disabilities, since pregnancy is often the only clear evidence that sexual abuse has occurred. Others may know she has been sterilised and she may be seen as a safe target. On the other hand women who have been sterilised may also be assumed to be non-sexual and therefore not considered for sexual and reproductive health screening.[[179]](#footnote-179)
2. In 1993, [then] Family Court Judge, Justice Warnick rejected an application[[180]](#footnote-180) for sterilisation of Sarah, a 17 year old disabled girl whose parents had sought authorisation for her to be sterilised to prevent her being sexually abused (and potentially becoming pregnant) at a new residential facility she was due to move into. He acknowledged that the parents had *“brought their application, at least in part, in reliance upon the views of ‘responsible professionals’”*. In rejecting the application, Justice Warnick stated:

*‘To make a decision in this case, in favour of sterilisation, would be virtually equivalent to establishing a policy that all females, with profound disabilities resembling those afflicting Sarah, should be sterilised. There is nothing substantial about the risk, nor clearly detrimental to Sarah about pregnancy, which justifies the interference with personal inviolability, unless it be that where there is any risk (as there must always be) sterilisation should occur. I cannot think that such an approach is consistent with human dignity, the fundamental nature of the right to personal inviolability, and the responsibility of the capable for the incapable.’*

1. In relation to sterilisation as a justification to avoid the risk of pregnancy as a result of sexual abuse, Justice Brennan, in *In re JWB [“Marion's Case”]*,[[181]](#footnote-181) said, in part:

*“Depending on the circumstances, the use - or, a fortiori, the exploitation - of the sexual attributes of a female child may entail tragic consequences, yet the risk or even the likelihood of tragic consequences affords no justification for her sterilization. What difference does it make that the risk is occasioned by an intellectual disability?............. To accord in full measure the human dignity that is the due of every intellectually disabled girl, her right to retain her capacity to bear a child cannot be made contingent on her imposing no further burdens, causing no more anxiety or creating no further demands. If the law were to adopt a policy of permitting sterilization in order to avoid the imposition of burdens, the causing of anxiety and the creating of demands, the human rights which foster and protect human dignity in the powerless would lie in the gift of those who are empowered and the law would fail in its function of protecting the weak.”*

*"Where it is desirable to avoid the risk of pregnancy, the risk may be avoidable by means which involve no invasion of the girl's personal integrity. Those who are charged with responsibility for the care and control of an intellectually disabled girl (by which I mean a female child who is sexually mature) - whether parents, guardians or the staff of institutions - have a duty to ensure that the girl is not sexually exploited or abused. If her disability inclines her to sexual promiscuity, they have a duty to restrain her from exposing herself to exploitation. It is unacceptable that an authority be given for the girl's sterilisation in order to lighten the burden of that duty, much less to allow for its neglect. In any event, though pregnancy be a possibility, sterilisation, once performed, is a certainty……….Such a situation bespeaks a failure of care, and sterilisation is not the remedy for the failure. Nor should it be forgotten that pregnancy and motherhood may have a significance for some intellectually disabled girls quite different from the significance attributed by other people. Though others may see her pregnancy and motherhood as a tragedy, she, in her world, may find in those events an enrichment of her life."*

1. Sterilisation will never overcome vulnerability to sexual abuse. Sexual assault is a problem for all women, including young women with intellectual disabilities and it demonstrates the need for the development of targeted and gendered educational, protective behaviour, and violence prevention programs for disabled women and girls. Women and girls with disabilities, like all women and girls, have a human right to live free from violence, abuse, exploitation and neglect.

**The ‘best interest’ argument**

1. Successive Australian Governments have continued to use the ‘best interest’ argument to justify the torture of women and girls with disabilities by forced sterilisation, asserting that sterilisation is only ever carried out as a ‘last resort’ and when it is in the girl or woman’s ‘best interests’.[[182]](#footnote-182)
2. The best interest approach has, in effect, been used to perpetuate discriminatory attitudes against women and girls with disabilities, and has only served to facilitate the practice of forced sterilisation.[[183]](#footnote-183) When analysing the applications to Courts and Tribunals for sterilisation of disabled women and girls in Australia to date, it is clear that the best interest approach has in reality, very little to do with the young girl or woman, and more to do with the ‘best interests’ of others, particularly families and caregivers.

*“The interests of Katie are inextricably linked with the ability of her parents to cope with the burdens of Katie's care.” [[184]](#footnote-184)*

*“This Court does not find itself in any doubt that the practical lessening of such burdens on the parents, the emotional and psychological relief coming to them from the expected removal, in a final sense, of problems in their daughter's life, and the betterment of the whole of their family circumstances, can only result in a material and significant improvement in the present and long term welfare of the child.” [[185]](#footnote-185)*

*“The operation would certainly be a social improvement for Angela’s mother which in itself must improve the quality of Angela’s life.”* [[186]](#footnote-186)

*“There is evidence in the case which suggests that* [the child’s older brother] *interests have been seriously affected by the long time and intense concentration by his parents on the need to provide special care for his sister……This is but another example of the requirement of assessing the child's position, not in isolation but in the family context. It is most likely that relieved of the need, to implement, maintain and monitor the sort of programmes envisaged for the child if she does not undergo hysterectomy, his parents can increase and intensify their efforts to increase his quality of life and his psychological development.” [[187]](#footnote-187)*

*“It is probable that H’s parents, who clearly are charged with and undertake the day to day onerous responsibility of caring for H may find that task somewhat less onerous if H undergoes a hysterectomy…..The Court accepts that the sole motivation of the parents is the welfare of H. Even so, it is somewhat simplistic to ignore the reality that the parents undertaking the care of a child such as H ought not be obliged to shoulder difficulties and burdens beyond those which are needlessly onerous. The test is not the best interests of the parents but of H, but, assisting her parents to care for H must be seen as realistically enhancing the care H receives and corresponding enjoyment of life which she may expect.” [[188]](#footnote-188)*

*“Not only would S be unable to care appropriately for herself it would also be difficult for others to care for her as a result of menstruation.” [[189]](#footnote-189)*

*“While we're not concerned so much about the abuse side of things now, if she ever went to a group home or any institution we just we want her safe. I don't think there's any guarantees, even though the hysterectomy wouldn't necessarily stop abuse, it might stop the consequences of it, or possible consequences of it and we just feel as well that we're getting that little bit older, Laura's getting quite big, she's hard to handle. She's got a brother and sister and I don't want to leave them the problems. I don't want them to feel that they've got that problem later on, of having to be worried about that sort of thing, they've got their own lives to live”.[[190]](#footnote-190)*

*“It is clear* *upon the evidence that, because of this strong and determined will in this child, all the more difficult because it is unreasoning and because of the child's increasing strength and the fact that the mother is getting older, M will be harder and harder to deal with.” [[191]](#footnote-191)*

1. The UN *Committee on the Rights of the Child* (CRC) has made it clear that the principle of the ‘best interests of the child’ cannot be used to justify practices which conflict with the child’s human dignity and right to physical integrity:

*“The Committee emphasizes that the interpretation of a child’s best interests must be consistent with the whole Convention, including the obligation to protect children from all forms of violence. It cannot be used to justify practices, including corporal punishment and other forms of cruel or degrading punishment, which conflict with the child’s human dignity and right to physical integrity. An adult’s judgment of a child’s best interests cannot override the obligation to respect all the child’s rights under the Convention.”* [[192]](#footnote-192)

1. The UN Special Rapporteur on Torture has also made it clear that ‘best interest’ and ‘medical necessity’ are no justification for forced/involuntary sterilisation of disabled women and girls:[[193]](#footnote-193)

*The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.*

*The Special Rapporteur recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on the grounds of administrative efficiency, behaviour modification or medical necessity…..*

*The mandate has recognized that medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned. This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity. For example, the mandate has held that….. the administration of non-consensual medication or involuntary sterilization, often claimed as being a necessary treatment for the so-called best interest of the person concerned, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of “good intentions” by medical professionals.*

1. In 1986 the Canadian Supreme Court ruled in *Re Eve[[194]](#footnote-194)* that a sterilisation could not be performed on someone who cannot give consent – that no one (not even the Court) can consent on their behalf. This resulted in a blanket prohibition of non-voluntary sterilisation. The court reasoned that it can never *“safely be determined that a procedure such as sterilisation is for the benefit of the person considering the grave intrusion on their rights and the physical damage that ensues from the non-voluntary sterilisation without consent, when compared to the highly questionable advantages that can result.”*
2. In making judgements about best interests it is crucial then, that we are clear about whose best interests are really at stake.[[195]](#footnote-195) We need to be clear about whether 'best interests' is judged according to human rights principles or whether the judgement is about the 'best compromise between the competing interests' of parents, carers, service providers and policy makers. To really determine 'best interest' for women and girls with disabilities it is crucial to focus on the fact that a person will be subjected to an irreversible medical procedure with life-long consequences without free and informed consent. [[196]](#footnote-196)
3. Medical professionals are often very influential in the decision to sterilise disabled women and girls. The propensity of Courts and parents to value medical opinion above all else – and in many cases elevating opinions and assertions to the status of fact - has the effect of reducing the ‘best interests’ of disabled women and girls to the ‘best [and easiest, quickest and cheapest] ways’ of controlling and managing their unruly bodies and ‘behaviour’.[[197]](#footnote-197) Yet these judgements are made from a particular perspective which must be vigorously challenged – that the woman or girl with a disability is essentially the sum of her biology or her psychology and her human right to bodily integrity is less important than controlling her body and her behaviour.[[198]](#footnote-198) As former Justice Michael Kirby pointed out at a recent International Conference on Adult Guardianship:

*‘the fact is that most of the judges charged with this task [determining authorisations for sterilisation of disabled girls and women] were atypical, privileged and elderly males. The rules therefore tended to reflect their gender, class, education, means and life experience.’ [[199]](#footnote-199)*

The Impact

1. In *Marion’s Case*,[[200]](#footnote-200) Justice Brennan, said:

*Human dignity requires that the whole personality be respected: the right to physical integrity is a condition of human dignity but the gravity of any invasion of physical integrity depends on its effect not only on the body but also upon the mind and on self-perception. In assessing the significance of sterilization of a female child, it is erroneous to have regard only to the physical acts of the anaesthetist and surgeon…..and to the physiological consequences. Regard must also be had to the disturbance of the child's mind and the emotional aftermath of the sterilization and a comparison must be made between her self-perception when sterilized and the perception she would have had of herself if she had been permitted to live with her natural functions intact.*

1. However, the blatant disregard for the long-term negative impact and effects of forced sterilisation on women and girls with disabilities is clearly evident in the cases that have proceeded to legal judgment in Australia, where, the opinion of the medical specialist is 'authoritative' and sterilisation is characterised as a 'simple' and 'common' procedure. In a technical sense it is portrayed as inconsequential and of minimum risk. In a social sense (from a medical perspective) it offers a final solution to a myriad of problems potentially encountered because of disability.[[201]](#footnote-201) The social and psychological effects on the disabled female are deemed irrelevant:

*“There is unlikely to be any psychological impact of the procedure on H as she has no understanding of the nature of the procedure.” [[202]](#footnote-202)*

*“The longer term consequences are less relevant despite the irreversibility of the procedure because as I have earlier mentioned, Angela is never going to have the benefits of a normal teenage and adult life.” [[203]](#footnote-203)*

*“There would be no long-term social or psychological effects of hysterectomy.” [[204]](#footnote-204)*

1. Crucially, the voices of the women and girls with disabilities who have been the subject of these applications, judgements, laws and debates, have not been heard.
2. It is widely recognised that whatever the context, forced sterilisation has long lasting physical and psychological effects, permanently robbing women of their reproductive capabilities and causing severe mental pain and suffering, extreme psychological trauma, including depression and grief.[[205]](#footnote-205) The removal of such a basic bodily function as the ability to reproduce seriously disrupts women’s physical well-being and violates their physical integrity and bodily autonomy. As highlighted by Sifris:[[206]](#footnote-206)

*In the context of sterilising people with intellectual disabilities, studies suggest that many people with an intellectual disability understand the effects of sterilisation, maintain negative feelings towards the procedure, and (as occurs in people without an intellectual disability) exhibit signs of ‘depression, sexual insecurity, symbolic castration and regret over loss of child-bearing ability.’ Further, the view has been expressed that most people with an intellectual disability ‘can understand the implications of sterilization’ and that ‘sterilizing mentally handicapped people [sic] against their will can produce serious and significant psychological damage.’ In addition, sterilisation of women with intellectual disabilities has also been associated with loss of self-esteem, increased anxiety, degraded status and perception of the self as deviant.*

1. Women with disabilities have spoken[[207]](#footnote-207) about forced sterilisation as a life sentence, as loss and betrayal, and of the health effects they can anticipate:

*“I was devastated when my doctor advised me that the previous surgeon had done more than tie my tubes. He had actually removed parts of my reproductive system that could never be replaced……I was shocked and furious.”*

*“Because I have had important parts of my body taken away it is hard to find out what is really going on in my body.”*

*“We have the right to control what happens to our own bodies.”*

*“Because I will not go through obvious menopause, in my culture that means I have no marker for becoming an ‘elder’.”*

*"Surgery of a healthy body is mutilation."*

*“I am…taking a big risk on behalf of myself and my family in speaking up. I would like to know what is being done for us who have had this done twenty or thirty years ago? I don’t have an intellectual disability and it was done before I started having a period. What research is being done to help us who were young children that went through this, and when we go through menopause? It can affect our health in the future. I think of this as my real disability – the physical one that you see isn’t real – the one I had happen to me when I was 12 is the main one and I don’t have anyone to turn to.”*

*“It has resulted in loss of my identity as a woman, as a sexual being.”*

*“I have been denied the same joys and aspirations as other women.”*

*“It stops us from having children if we want to.”*

*“I worry about the future health effects like osteoporosis and other problems.”*

*“The fact that services are not there is no reason for sterilisation.”*

*“Sterilisation takes my choice away.”*

*“I’m angry.”*

*“I want to experience a period.”*

*“Sterilization is a terrible thing to do to a woman. They had no right to do that to me. They never ask you about it. They told me that it was just for my appendix and then they did that to me.”*

*“If they’d told the truth and asked me, I would have shouted ‘No!’ My sterilisation makes me feel I’m less of a woman when I have sex because I’m not normal down there…….When I see other mums holding their babies, I look away and cry because I won’t ever know that happiness.”*

*“Sterilisation takes away your womanhood.”*

*“I do want to have children but I can’t now.”*

*“I got sterilised at 18, my mum said I had to – she said that if I ever had a child, she’d probably have to help look after it. She said: “I went through hell bringing you up and I will not do it again”. It’s more than 30 years now since I was sterilised and the pain is still unspeakable. It is the biggest regret of my life.”*

*“For me it has meant a denial of my womanhood.”*

*“I was sterilised and I wasn’t ever told when I was getting it done. The specialist told mum about it but I didn’t know I’d had it done until I was 18.”*

*“I have always had a fear of speaking out about it – it’s been very isolating.”*

*“I want to help others who don’t have a voice, to stop it happening to them – I feel powerless to do that.”*

*“I have been raped.”*

*“It is a basic disrespect of our beliefs in how we should live our lives.”*

*“I will have no way of knowing about the onset of my menopause.”*

*“I know it has resulted in hormone changes in my body that wouldn’t have happened otherwise.”*

*“It can lead to the break-up of relationships.”*

*“I was what I call, ‘socially sterilised’ – I had the operation when I was a young woman because growing up I had been brainwashed to believe that disabled women like me can’t be mothers. I would have loved to be a mother. There are of course, no proper words to describe the loss, the guilt, the regret and the pain I feel every day.”*

*“Other people don’t understand what it means in your life and it’s very hard to explain that to people.”*

*“Other women don’t understand what its like for us – it sets us apart from them.”*

*“For me it is about living with loss.”*

*“It really affects my self esteem.”*

*“It has stopped me having a normal life.”*

*“Its about loss of control.”*

*“For me it has meant a loss of trust – especially of doctors – those who women with disabilities often have to place their trust.”*

*“I have a blockage of emotions.”*

*“It’s a great emotional upheaval.”*

*“I feel alone and isolated.”*

*“The pain is hard to bear.”*

*“I have a fear of not being seen as a sexual identity – of sexual rejection.”*

*“I have feelings of rejection.”*

*“There is no information available for us.”*

*“There are not enough services or people to listen.”*

1. Women with disabilities have also spoken[[208]](#footnote-208) about what needs to happen to enable healing to take place for those already affected, and for safeguards to be put in place to prevent others from experiencing this form of torture and from being denied their fundamental human rights:

*“There needs to be better explanations for women.”*

*“We need to be given more information about our body.”*

*“We need to have information about the whole process and what it means so that we can make an informed choice.”*

*“We need to build a data base on health issues specifically for women who have been sterilised.”*

*“It time people started to listen! And do what we want.”*

*“It’s absolutely necessary to empower women with disabilities to make decisions.”*

*“Let us be in charge of our own bodies.”*

*“Women with disabilities need to have more involvement in the investigation stage so we can say what we want.”*

*“We need to start support groups for women who this has happened to.”*

*“We have to encourage self-advocacy – help women with intellectual disability to say what they want in their lives.”*

*“We have to provide individuals with proper support to make the right decision for them.”*

*“Educate professionals especially doctors and support workers so that they understand how it can affect our lives.”*

*“We must change doctors’ attitudes.”*

*“It is important that we educate the appropriate people to listen to women with disabilities in the investigation process.”*

*“We need to see a change in attitude.”*

*“We have to publicise the issue through public seminars and debates.”*

*“We must help services listen better to the issues for women with disabilities.”*

*“We need to educate all the services that have a role to play in making this happen.”*

*“We need to educate the community, to get them to see it is about the lives of women with disabilities.”*

*“We need to be changing education at all levels.”*

*“We have to break the silence about what has happened.”*

*“We must make sure the voices of women with disabilities are heard at international and UN conventions.”*

*“We have to change the law so that it stops happening.”*

*“We need to send a message to politicians that sterilisation is about women with disabilities and how they live their lives.”*

1. For women with disabilities, the issue of forced sterilisation encompasses much broader issues of reproductive health, including for example: support for choices and services in menstrual management, contraception, abortion, sexual health management and screening, pregnancy, birth, parenting, menopause, sexuality, violence prevention and more. Research has clearly shown that, particularly for women with intellectual disabilities, attitudes toward sexual expression remain restrictive. Women with disabilities express desires for intimate relationships but report limited opportunities and difficulty negotiating relationships. Sexual knowledge in women with disabilities, particularly those with intellectual disabilities, has been shown to be poor and access to education limited. In addition, laws addressing sexual exploitation may be interpreted as prohibition of relationships.[[209]](#footnote-209) Women with disabilities have spoken[[210]](#footnote-210) about the impact of all these issues on their lives, for example:

*"In (my institution) you were not allowed to be with a man. You got into trouble. It's not right."*

*“Persons who reside in institutions are being denied their basic human rights to freedom, privacy and sexuality.”*

*“I’m not allowed to have a boyfriend.”*

*"We want information about relationships and having babies."*

*“Is menstrual flow any more of a problem than incontinence?”*

*“I have known of cases where girls have been given the wrong information by cruel nursing staff and have spent years thinking they are incapable of having intercourse, much less bearing a child.”*

*“A strange man once tried to kiss me in a lift. I said "please don't do that". I should have hit him, or told him to fuck off, but I have had my disability all my life, and I have been taught well not to be angry when my personal space, my body, my emotional integrity have been violated. So I said "please don't do that" and later I cried…..”*

*“Disabled people are just not seen as sexual beings with sexual needs and feelings.”*

*“Many women with disabilities who are raped are too scared to go to the police in case they will not be believed.”*

*"People don't tell us about sex."*

*“Jean lived in the dormitory next door to mine. She was going with her boyfriend, Simon, who lived in a separate part of the same institution and was sometimes permitted to go across the courtyard to visit him. One day, they were caught petting in a seldom-used back room and they were forbidden to see each other thereafter. They were both over the legal age of consent and were doing nothing wrong by normal social standards.”*

*"It seems that periods are sometimes suppressed for the convenience of care givers, support persons and services."*

*“If you go in a group home that’s run by like, a religious organisation, you’re not allowed to have a boy come over. You’re not allowed to even kiss a boy let alone have sex. If you wanted to have sex you would have to go maybe to the park or somewhere.”*

*"There is a glaring lack of in-home assistance and support for families supporting a woman learning about menstruation."*

*"Having your period gives a context for others to decide why you have to be on contraceptives."*

*“Sexuality is not just sexual intercourse. It is much, much more than just the physical act of having sex. Our sexuality is as much a part of us as our clothes-sense, our favourite foods and our personal style. Our need to love and be loved is as vital to our wellbeing as our need to eat, drink and breathe. To deny our sexuality is to deny that we are whole human beings.”*

*“Sexuality within institutional accommodation should not even be an issue. Privacy and freedom are not privileges to be granted or taken away. They are our basic human rights. Just as people who run the institutions would not appreciate their own sex life to be regulated by a stranger, nor do we. What we do in our own rooms, and who we do it with, is not the business of staff, administration the milkman, or anyone else.”*

Forced Sterilisation as a Violation of Human Rights

1. Since 2005, United Nations treaty monitoring bodies have consistently and formally recommended that the Australian Government enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.[[211]](#footnote-211) Successive Australian Governments have to date, failed to do so, despite the current Government’s assertion that:

*Australia is proud of its historical role in the drafting and development of international human rights instruments. Government initiatives since 2007 demonstrate its commitment to engaging with the UN and affirm Australia’s longstanding commitment to the international protection of human rights…. The Government expects public sector officials to act consistently with international treaties to which Australia is a party….[[212]](#footnote-212)*

1. The Australian Government is in violation of international human rights law by allowing women and girls with disabilities to be sterilised in the absence of their free and informed consent. Among the fundamental rights governments are required to respect, protect, and fulfill are: the right to be free from torture, and cruel, inhuman, or degrading treatment or punishment; the right to the highest attainable standard of physical and mental health; the right to life, liberty, and security of person; the right to equality; the right to non-discrimination; the right to be free from arbitrary interference with one’s privacy and family; and the right to marry and to found a family.[[213]](#footnote-213)
2. Forced sterilisation clearly breaches every international human rights treaty and declaration to which Australia is a party.

**Forced sterilisation of persons with disabilities violates the Convention on the Rights of Persons with Disabilities (CRPD)**

1. The *Convention on the Rights of Persons with Disabilities* (CRPD), ratified by Australia in 2008, offers the most comprehensive and authoritative set of standards on the rights of people with disabilities. Its fundamental purpose is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.[[214]](#footnote-214)
2. The CRPD mandates States Parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others. This means that an individual’s right to decision-making cannot be substituted by decision-making of a third party, but that each individual without exception has the right to make their own choices and to direct their own lives, whether in relation to living arrangements, medical treatment, or family relationships.
3. Among other things, the CRPD also mandates States Parties to: protect persons with disabilities from violence, exploitation and abuse (including the gender-based aspects of such violations); ensure that persons with disabilities are not subjected to arbitrary or unlawful interference with their privacy and family, including in all matters relating to marriage, family, parenthood and relationships; guarantee persons with disabilities, including children, the right to retain their fertility; take measures to ensure women and girls enjoy the full and equal enjoyment of their human rights; prevent people with disabilities from being subject to torture, or cruel, inhuman or degrading treatment or punishment; prohibit involuntary treatment and involuntary confinement; and, ensure the right of people with disabilities to the highest attainable standard of health without discrimination.
4. The *Committee on the Rights of Persons with Disabilities*[[215]](#footnote-215) has clearly identified that forced and coerced sterilisation of women and girls with disabilities (as well as discrimination in other areas of their reproductive rights) is in clear violation of multiple provisions of the CRPD.
5. In its *Concluding Observations on Spain*,[[216]](#footnote-216) the CRPD Committee expressed its concern that *‘persons with disabilities whose legal capacity is not recognized may be subjected to sterilization without their free and informed consent’*. It urged the State party to abolish the administration of medical treatment, in particular sterilization, without the full and informed consent of the patient; and ensure that national law especially respects women’s rights under articles 23 and 25 of the Convention. The Committee also urged the State party to ensure that the informed consent of all persons with disabilities is secured on all matters relating to medical treatment; and made several recommendations regarding the need to address violence against women with disabilities and children.
6. In its 2012 *Concluding Observations on Peru*,[[217]](#footnote-217) the CRPD Committee expressed its deep concern at the forced sterilisation of people with ‘mental disabilities’ and urged the State party to abolish administrative directives on forced sterilization of persons with disabilities. It also made strong recommendations for the State party to take action to replace regimes of substitute decision-making by supported decision-making, ‘which respects the person’s autonomy, will, and preferences’. The need to accelerate efforts to eradicate and prevent discrimination against women and girls with disabilities, was also recommended.
7. In late September 2012, the CRPD Committee released its *Concluding Observations on China*,[[218]](#footnote-218) expressing its deep concern at the practice of forced sterilization and forced abortion on women with disabilities without free and informed consent, and calling on the State party to revise its laws and policies in order to prohibit these practices. The Committee also made strong recommendations around the prevention of violence against disabled women and girls, in particular the incidents of women and girls with intellectual disabilities being subjected to sexual violence. In addition, the Committee urged the state party to adopt measures to repeal the laws, policies and practices which permit guardianship and trusteeship for adults and take legislative action to replace regimes of substituted decision-making by supported decision making.
8. In its *Concluding Observations on Hungary,[[219]](#footnote-219)* in 2012, the CRPD Committee called upon the State party to take appropriate and urgent measures to protect persons with disabilities from forced sterilisation, to take appropriate measures to enable men and women with disabilities who are of marriageable age to marry and found a family, and to adopt measures to ensure that health care services are based on the free and informed consent of the person concerned. It also recommended that the State party take immediate steps to derogate guardianship in order to move from substitute decision-making to supported decision-making, including with respect to the individual's right, on their own, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry, to work, and to choose their place of residence. The need to address and prevent multiple forms of discrimination of women and girls with disabilities, including violence and abuse, were also recommended.
9. In its *Concluding Observations on Tunisia*,[[220]](#footnote-220) the CRPD Committee expressed its concern the lack of clarity concerning the scope of legislation to protect persons with disabilities from being subjected to treatment without their free and informed consent, and specifically recommended the *‘State party incorporate into the law the abolition of surgery and treatment without the full and informed consent of the patient, and ensure that national law especially respects women’s rights under article 23 and 25 of the Convention.’* The Committee also recommended that the State party design and implement awareness-raising campaigns and education programmes throughout society….on women with disabilities in order to foster respect for their rights and dignity; combat stereotypes, prejudices and harmful practices; and promote awareness of their capabilities and contributions.

**Forced sterilisation of persons with disabilities violates the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**

1. Australia ratified the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT) in 1989. CAT emphasises that gender is a key factor in implementation of the Convention.[[221]](#footnote-221) Discrimination plays a prominent role in an analysis of reproductive rights violations as forms of torture or ill-treatment because sex and gender bias commonly underlie such violations. The mandate has stated, with regard to a gender-sensitive definition of torture, that the purpose element is always fulfilled when it comes to gender-specific violence against women, in that such violence is inherently discriminatory and one of the possible purposes enumerated in the Convention is discrimination.[[222]](#footnote-222) The right to be free from torture and cruel, inhuman or degrading treatment or punishment carries with it non-derogable state obligations to prevent, punish, and redress violations of this right.
2. Forced sterilisation constitutes torture.[[223]](#footnote-223) The UN Special Rapporteur on Torture has clarified that forced sterilisation satisfies the definition of torture contained in Article 1 of the CAT,[[224]](#footnote-224) and has emphasised that forced sterilisation constitutes a crime against humanity when committed as part of a widespread or systematic attack directed against any civilian population.[[225]](#footnote-225) In February 2013, (as outlined earlier in this paper), the UN Special Rapporteur on Torture clarified that:

*Forced interventions [including involuntary sterilization], often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.[[226]](#footnote-226)*

1. In reviewing States parties compliance with CAT, the Committee Against Torture is increasingly recognising forced sterilisation and medical interventions on people with disabilities in the absence of their free and informed consent, as violations of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.
2. In its 2013 *Concluding Observations on Peru*,[[227]](#footnote-227) the Committee Against Torture recommended that the State party accelerate all current investigations related to forced sterilization, initiate prompt, impartial and effective investigations of all similar cases and provide adequate redress to all victims of forced sterilization. In addition, it recommended that State party urgently repeal the suspended administrative decree which allows the forced sterilization of persons with mental disabilities.
3. The Committee Against Torture’s *Concluding Observations of the Czech Republic,*[[228]](#footnote-228) in 2012, dealt in detail with the issue of forced sterilisation. It recommended that the State party investigate promptly, impartially and effectively all allegations of involuntary sterilization of women, extend the time limit for filing complaints, prosecute and punish the perpetrators and provide victims with fair and adequate redress, including adequate compensation and rehabilitation.
4. In its 2009 *Concluding Observations on Slovakia*,[[229]](#footnote-229) the Committee Against Torture recommended that the State party take urgent measures to investigate promptly, impartially, thoroughly, and effectively, allegations of involuntary sterilisation of women, prosecute and punish the perpetrators, and provide the victims with fair and adequate compensation.

**Forced sterilisation of persons with disabilities violates the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**

1. Australia made a formal agreement to be legally bound by the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) in 1983, and in so doing, became legally obliged to respect, protect, promote and fulfil the right to non-discrimination for women and to ensure the achievement of equality between men and women. CEDAW requires States parties to take additional, special measures for women subjected to multiple forms of discrimination, including women and girls with disabilities.[[230]](#footnote-230)
2. CEDAW specifically provides for a proper understanding of maternity as a social function, access to family planning information, and the elimination of discrimination against women in marriage and family relations. Furthermore, CEDAW mandates that women be provided the same rights to decide freely on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights.[[231]](#footnote-231)
3. The CEDAW Committee has clearly articulated the link between forced sterilisation and violation of the right to reproductive self-determination noting that *‘compulsory sterilization…adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children’*.[[232]](#footnote-232) In addition, the Committee characterises forced sterilisation as a form of violence against women, and directs States to ensure that forced sterilisations do not occur.[[233]](#footnote-233)
4. In its 2012 *Concluding Observations on Chile*,[[234]](#footnote-234) the CEDAW Committee expressed its concern about reported cases of involuntary sterilization of women, and recommended that the State party ensure that fully informed consent is systematically sought by medical personnel before sterilizations are performed, that practitioners performing sterilizations without such consent are sanctioned and that redress and financial compensation are available for women victims of non-consensual sterilization. The Committee also recommended that the State party provide adequate access to family planning services and contraceptives.
5. The CEDAW Committee’s *Concluding Observations on* *Jordan*,[[235]](#footnote-235) in 2012, clearly detailed the Committee’s ongoing concern at the practice of forced sterilisation of women and girls with ‘mental disabilities’, as well as its concern at the absence of a comprehensive law protecting women with mental disabilities from forced sterilization. The Committee urged the State party to adopt a comprehensive law protecting women, in particular girls with mental disabilities, from forced sterilization, and to ensure that the State party intensify its efforts in providing social and health services support to families with girls and women with disabilities.
6. In its 2012 *Concluding Observations on* *Comoros,[[236]](#footnote-236)* the CEDAW Committee recommended that the State party put in place a comprehensive strategy to eliminate harmful practices and stereotypes that discriminate against women, and that such a strategy should include concerted efforts to educate and raise public awareness about this subject.
7. As highlighted elsewhere in this paper, in 2010, the CEDAW Committee expressed concern in its *Concluding Observations on Australia[[237]](#footnote-237)* at the ongoing practice of non-therapeutic sterilisations of women and girls with disabilities and recommended that the Australian Government enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.
8. In its *Concluding Observations on* *the Czech Republic[[238]](#footnote-238)* in 2010, the CEDAW Committee made detailed recommendations regarding forced sterilisation of women with disabilities. The Committee urged the State party to: adopt legislative changes clearly defining the requirements of free, prior and informed consent with regard to sterilizations, in accordance with relevant international standards, including a period of at least seven days between informing the patient about the nature of the sterilization, its permanent consequences, potential risks and available alternatives and the patient’s expression of her free, prior and informed consent; review the three-year time limit in the statute of limitations for bringing compensation claims in cases of coercive or non-consensual sterilizations in order to extend it and, as a minimum, ensure that such time limit starts from the time of discovery of the real significance and all consequences of the sterilization by the victim rather than the time of injury; consider establishing an ex gratia compensation procedure for victims of coercive or non-consensual sterilizations whose claims have lapsed; provide all victims with assistance to access their medical records; and investigate and punish illegal past practices of coercive or non-consensual sterilizations. The Committee further recommended that the State party adopt a law on women’s reproductive rights; that clarified that all interventions are performed only with the woman’s free, prior and informed consent. Mandatory training for all health professionals on women’s reproductive rights and related ethical standards was also recommended.
9. In 2006, the CEDAW Committee issued a view finding Hungary in violation of the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), for its failure to protect the reproductive rights of Ms. Andrea Szijjarto, a Hungarian Romani woman was subjected to coerced sterilisation by medical staff at the public hospital in Fehérgyarmat.[[239]](#footnote-239) The CEDAW Committee found that the *‘failure of the State party, through the hospital personnel, to provide appropriate information and advice on family planning’* constituted a violation of Articles 10, 12, and 16 of CEDAW. Similarly, the State of Hungary was responsible for the hospital’s failure to obtain informed consent and the deprivation of the woman’s right to decide the number and spacing of her children in violation of CEDAW.[[240]](#footnote-240) Therefore, the CEDAW Committee held the State of Hungary responsible for an involuntary sterilisation procedure performed in one of its public hospitals. The Committee subsequently recommended that Hungary provide Ms. Szijjarto with appropriate compensation. More generally, the Committee recommended that Hungary:

*‘take further measures to ensure that the relevant provisions of the Convention and the pertinent paragraphs of the Committee’s general recommendations Nos. 19, 21 and 24…are known and adhered to by all relevant health professionals; review domestic law on informed consent in sterilization cases and ensure conformity with international standards; and monitor health centres performing sterilizations so as to ensure fully informed consent is being given, with sanctions in place for breaches.*’

The decision marks the first time that an international human rights body in an individual complaint has held a government accountable for failing to provide necessary information to a woman to enable her to give informed consent to a reproductive health procedure.[[241]](#footnote-241)

**Forced sterilisation of persons with disabilities violates the International Covenant on Civil and Political Rights (ICCPR)**

1. The *International Covenant on Civil and Political Rights* (ICCPR) ratified by Australia in 1980, commits its parties to respect the civil and political rights of individuals, including the right to life, freedom of religion, freedom of speech, freedom of assembly, family rights, electoral rights and rights to due process and a fair trial. Article 3 implies that all human beings should enjoy the rights provided for in the Covenant, on an equal basis and in their totality.
2. The *Human Rights Committee*, responsible for the monitoring of the ICCPR, has clarified to State parties that forced sterilisation is in contravention of Articles 7, 14, 17 and 24 of the ICCPR.[[242]](#footnote-242) More than 14 years ago, the Human Rights Committee identified the forced sterilisation of disabled women as being in in contravention of the ICCPR. In its 1999 *Concluding Observations on Japan*,[[243]](#footnote-243) the Committee expressed its regret that the law had not provided for a right of compensation to women with disabilities who were subjected to forced sterilization, and recommended that the necessary legal steps be taken in this regard.
3. In its 2012 *Concluding Observations on* *Lithuania,[[244]](#footnote-244)* the Human Rights Committee expressed its concern at the potential negative consequences of the courts’ authority to authorise procedures such as abortion and sterilisation to be performed on disabled women deprived of their legal capacity.
4. In 2011, in its review of *Slovakia’s[[245]](#footnote-245)* report under the ICCPR, the Human Rights Committee stated its regret at the lack of information on concrete measures to eliminate forced sterilisation, and recommended the State Party ensure that all procedures are followed in obtaining the full and informed consent of women who seek sterilisation services. It further recommended that special training for health personnel aimed at raising awareness about the harmful effects of forced sterilization, be introduced.
5. As outlined earlier in this paper, the Human Rights Council requires the Australian Government to address the issue of forced sterilisation in Australia’s upcoming review under the ICCPR.[[246]](#footnote-246) Specifically, the Human Rights Council has asked the Australian Government to:

*Please provide information on whether sterilization of women and girls, including those with disabilities, without their informed and free consent, continues to be practiced, and on steps taken to adopt legislation prohibiting such sterilisations.*

**Forced sterilisation of persons with disabilities violates the Convention on the Rights of the Child (CRC)**

1. Australia ratified the *Convention on the Rights of the Child* (CRC) in 1990. The CRC generally defines a child as any human being under the age of eighteen years, and requires States parties to ensure that all children within their jurisdiction enjoy all the rights enshrined in the Convention without discrimination of any kind. The CRC recognises that children with disabilities belong to one of the most marginalised groups of children, and that factors such as gender can increase this vulnerability.[[247]](#footnote-247) The CRC specifically recognises that:

*Girls with disabilities are often even more vulnerable to discrimination due to gender discrimination. In this context, States parties are requested to pay particular attention to girls with disabilities by taking the necessary measures, and when needed extra measures, in order to ensure that they are well protected, have access to all services and are fully included in society.*[[248]](#footnote-248)

1. The *Committee on the Rights of the Child* has expressly identified forced sterilisation of girls with disabilities as a form of violence and clearly articulates that all forms of violence against children are unacceptable without exception.[[249]](#footnote-249) It has advised that State parties to the CRC are expected to prohibit by law the forced sterilisation of children with disabilities,[[250]](#footnote-250) and made it very clear that the principle of the “best interests of the child” cannot be used to justify practices which conflict with the child’s human dignity and right to physical integrity.[[251]](#footnote-251)
2. In 2006, the Committee on the Rights of the Child expressed its deep concern about *‘the prevailing practice of forced sterilisation of children with disabilities, particularly girls with disabilities’,* and emphasised that forced sterilisation *‘seriously violates the right of the child to her or his physical integrity and results in adverse life-long physical and mental health effects’.*[[252]](#footnote-252)
3. In June 2012, the Committee on the Rights of the Child, in its *Concluding Observations on Australia*[[253]](#footnote-253) expressed its serious concern that the absence of legislation prohibiting non-therapeutic sterilisation of girls and women with disabilities is discriminatory and in contravention of the CRC. The Committee urged the State party to: *‘Enact non-discriminatory legislation that prohibits non-therapeutic sterilization of all children, regardless of disability; and ensure that when sterilisation that is strictly on therapeutic grounds does occur, that this be subject to the free and informed consent of children, including those with disabilities.’* Furthermore, the Committee clearly identified non-therapeutic sterilisation as a form of violence against girls and women, and recommended that the Australian Government develop and enforce strict guidelines to prevent the sterilisation of women and girls who are affected by disabilities and are unable to consent.
4. In its *Concluding Observations on Australia*[[254]](#footnote-254)in 2005, theCommittee on the Rights of the Child, recommended that Australia: *‘prohibit the sterilisation of children, with or without disabilities…’* [[255]](#footnote-255)
5. In 1999, the Committee on the Rights of the Child expressed its regret that ‘forced sterilization of mentally disabled children is legal with parental consent’ in *Austria*,[[256]](#footnote-256) and recommended that existing legislation be reviewed in accordance with the provisions of the Convention, especially articles 3 and 12.

**Forced sterilisation of persons with disabilities violates the International Covenant on Economic, Social and Cultural Rights (CESCR)**

1. The *International Covenant on Economic, Social and Cultural Rights* (CESCR) was ratified by Australia in 1975. The CESCR commits States Parties to work toward the granting of economic, social, and cultural rights to individuals, including labour rights and rights to health, education, and an adequate standard of living. The CESCR protects human rights that are fundamental to the dignity of every person. In particular, Article 3 of this Covenant provides for the equal right of men and women to the enjoyment of rights it articulates, and this is a mandatory and immediate obligation of States parties.[[257]](#footnote-257)
2. The Committee on Economic, Social and Cultural Rights (CESCR) has made it clear that forced sterilisation of girls and women with disabilities is in breach of Article 10 of the *Convention on Economic, Social, and Cultural Rights*:[[258]](#footnote-258)

*‘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 sterilization of, and the performance of an abortion on, a woman with disabilities without her prior informed consent are serious violations of article 10 (2).’*

1. The Committee on Economic, Social and Cultural Rights (CESCR) has also made it clear that:

*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…… States parties should ensure that laws and social policies and practices do not impede the realization of these rights. Women with disabilities also have the right to protection and support in relation to motherhood and pregnancy.[[259]](#footnote-259)*

1. The right to sexual and reproductive health is an integral component of the right to health. The CESCR emphasises aspects of the right to sexual and reproductive health in Article 12. The UN Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, have made it very clear that States have an obligation to respect, protect and fulfil the right to health of all individuals, including those with disabilities, and have recognised that forced sterilisation of women and girls with disabilities is inherently inconsistent with their sexual and reproductive health rights and freedoms, violates their right to reproductive self-determination, physical integrity and security, and injures their physical and mental health.[[260]](#footnote-260)
2. In 2009, the United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental health, re-iterated that the existence of a disability is not a lawful justification for any deprivation of liberty, including denial of informed consent. The Special Rapporteur made it clear that policies and legislation sanctioning non-consensual treatments lacking therapeutic purpose or aimed at correcting or alleviating a disability, including sterilisations, abortions, electro-convulsive therapy and unnecessarily invasive psychotropic therapy, violate the right to physical and mental integrity and may constitute torture and ill-treatment.[[261]](#footnote-261) He clarified that:

*‘informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being.’ States must provide persons with disabilities equal recognition of legal capacity, care on the basis of informed consent, and protection against non-consensual experimentation; as well as prohibit exploitation and respect physical and mental integrity.’ [[262]](#footnote-262)*

1. In 2011, Mr Anand Grover, UN Special Rapporteur [on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health], in his report on the interaction between criminal laws and other legal restrictions relating to sexual and reproductive health and the right to health, stated:

*‘The use of……coercion by the State or non-State actors, such as in cases of forced sterilization, forced abortion, forced contraception and forced pregnancy has long been recognized as an unjustifiable form of State-sanctioned coercion and a violation of the right to health. Similarly, where the…… law is used as a tool by the State to regulate the conduct and decision-making of individuals in the context of the right to sexual and reproductive health the State coercively substitutes its will for that of the individual………………the use by States of criminal and other legal restrictions to regulate sexual and reproductive health may represent serious violations of the right to health of affected persons and are ineffective as public health interventions. These laws must be immediately reconsidered. Their elimination is not subject to progressive realization since no corresponding resource burden, or a de minimis one, is associated with their elimination.’ [[263]](#footnote-263)*

**Forced sterilisation of persons with disabilities violates the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)**

1. The *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD) was one of the first human rights treaties to be adopted by the United Nations, and was ratified by Australia in 1975.[[264]](#footnote-264) As its title suggests, the ICERD commits its members to the elimination of racial discrimination and the promotion of understanding among all races.
2. The Committee on the Elimination of All Forms of Racial Discrimination (CERD) pays special attention to cases where such multiple forms of discrimination are involved. Regarding the intersectionality of gender, CERD has emphasised that racial discrimination does not always affect women and men equally or in the same way, and certain forms of racial discrimination directly affect women - such as forced and coerced sterilisation of indigenous women,[[265]](#footnote-265) or sexual violation against women of particular racial or ethnic groups. At the same time, racial discrimination may have consequences where women are primarily or exclusively affected (e.g. racial bias-motivated rape). Against this backdrop the Committee has been enhancing its efforts to integrate a gender perspective into its work and also recommending that States parties provide disaggregated data with regard to the gender dimensions of racial discrimination as well as to take necessary actions in this regard.[[266]](#footnote-266)
3. In its *Concluding Observations on Mexico*[[267]](#footnote-267)in 2006, theCommittee on the Elimination of All Forms of Racial Discrimination (CERD), expressed its concern at the alleged practice of forced sterilization indigenous men and women in Chiapas, Guerrero and Oaxaca, and urged the State party to take all necessary steps to put an end to practices of forced sterilization, and to impartially investigate, try and punish the perpetrators of such practices. It also recommended that the State party ensure that fair and effective remedies are available to the victims, including those for obtaining compensation.
4. In its *Concluding Observations on Slovakia*[[268]](#footnote-268)in 2004, the ICERD Committee expressed its concern about reports of cases of sterilisation of Roma women without their full and informed consent. The Committee “strongly recommended” that the State party take all necessary measures to put an end to *“this regrettable practice………..the State party should also ensure that just and effective remedies, including compensation and apology, are granted to the victims.”*

**Other Key International and National Standards and Frameworks**

1. The 1994 *International Conference on Population and Development (ICPD) Programme of Action*,[[269]](#footnote-269) affirmed that woman’s ability to access reproductive health and rights is cornerstone of her empowerment, and protects the right to decide freely and responsibly the number and spacing of one’s children. A total of 179 governments (including Australia) signed up to the ICPD Programme of Action which set out to, amongst other things, provide universal access to family planning and sexual and reproductive health services and reproductive rights. The programme of action and benchmarks added at the ICPD+5 review went on to inform the eight *Millennium Development Goals* (MDG’s),[[270]](#footnote-270) of which gender equality is central.
2. The *Beijing Declaration and Platform for Action (BPA)* identifies forced sterilisation as an act of violence and reaffirms the rights of women, including women with disabilities, to found and maintain a family, to attain the highest standard of sexual and reproductive health, and to make decisions concerning reproduction free from discrimination, coercion, and violence.[[271]](#footnote-271) The commitment to the BPA was further reaffirmed by member states in the outcome document of the *Twenty-third Special Session of the UN General Assembly[[272]](#footnote-272)* in 2000. This meant that the Australian Government committed to *further* actions and initiatives to accelerate the implementation of the BPA, particularly in regard to addressing the needs of women and girls with disabilities.
3. *Biwako Plus Five*,[[273]](#footnote-273) a supplement to the *United Nations Biwako Millennium Framework for Action towards an Inclusive, Barrier-free and Rights based Society in Asia and the Pacific (BMF),[[274]](#footnote-274)* (adopted by the Australian Government in 2002), specifically required Governments to, amongst other things: *‘take appropriate measures to address discrimination against women with disabilities in all matters, including those relating to marriage, family, parenthood and relationships, to ensure their full development, advancement and empowerment.’*
4. At the domestic level, forced sterilisation of women and girls with disabilities runs contrary to a number of national legislative and policy frameworks and strategies in areas (such as disability, child protection, family violence, human rights and women’s health).[[275]](#footnote-275) For example, forced sterilisation meets the definition of family violence as articulated in the *Commonwealth Family Law Legislation*.[[276]](#footnote-276) The *Australian Law Reform Commission* has clarified that forced sterilisation and abortion is a type of family violence experienced by people with disabilities.[[277]](#footnote-277)

**Other Legal Precedents: Forced and Coerced Sterilisation as a Violation of Human Rights**

1. The issue of forced sterilisation of women and girls is increasingly being recognised in the Courts as a violation of women’s fundamental human rights.
2. In November 2012, the European Court of Human Rights ruled against Slovakia in a case of forced sterilization (*I.G. and Others vs. Slovakia*).[[278]](#footnote-278) The case was lodged with the European Court by three applicants, who were forcibly sterilised in Krompachy Hospital under different circumstances in 1999-2002. Two of the applicants were underage minors at the time of the interventions. The European Court confirmed that forced sterilization – sterilization without an informed consent - represents a serious interference into women’s fundamental human rights, guaranteed by the European Convention and other treaties. The European Court ruled in favour of the applicants the ordered the Slovak Government to pay compensation to the applicants and the reimbursement of their legal costs.
3. In November 2011, the European Court of Human Rights delivered its judgement in the case of *V.C. v. Slovakia*.[[279]](#footnote-279) This case concerned a woman from Slovakia who was coercively sterilised in 2000 in the hospital in Prešov (eastern Slovakia). After unsuccessfully claiming her rights on national level, she recoursed to the European Court of Human Rights. The Court held that the sterilisation carried out without her informed consent violated her right not to be subject to torture or to inhuman or degrading treatment (Article 3 of the European Convention) and her right to respect for private and family life (Article 8). The Court noted that: *“sterilization constitutes a major interference with a person’s reproductive health status”* and *“bears on manifold aspects of the individual’s personal integrity, including his or her physical and mental well-being and emotional, spiritual and family life.”* [[280]](#footnote-280) The Court held that Slovakia was to pay the applicant 31,000 euros (EUR) in respect of non-pecuniary damage and EUR 12,000 for costs and expenses.
4. In July 2012, in a landmark judgment, the High Court in Windhoek found that the Namibian government had coercively sterilised three HIV-positive women in violation of their basic rights. The case, *H.N. and Others v Government of the Republic of Namibia[[281]](#footnote-281)* involved three HIV-positive women who sought to access pre-natal services at public hospitals in Namibia. The three women ranged in age from mid-20s to mid-40s when they were sterilised. All three were sterilised without their informed consent while accessing such services. Ruling in the women’s favour, the High Court held that obtaining consent from women when they were in severe pain or in labour did not constitute informed consent. The Court further found that failure to obtain the three women’s informed consent violated the women’s rights under common law. The women will be awarded damages, although the amount is still to be decided.
5. The issue of forced sterilisation is neither small nor new in Africa. Over 40 HIV-positive women who were allegedly sterilized against their will in Kenya are currently preparing to go to court to demand justice and possible compensation. National Gender and Equality Commission Chairperson, Winfred Lichuma who is championing the women's cause, described what happened to the women as *"atrocious an infringement of their human rights and contrary to medical ethics."* There are several similar cases pending before the courts in Zambia, South Africa, Malawi and Nambinia.[[282]](#footnote-282)
6. In late 2011, Peru’s chief prosecutor re-launched a criminal investigation into the forced sterilizations of thousands of poor and indigenous women, allegedly carried out by the government of disgraced former president Alberto Fujimori. The investigation centers on the case of *Mamérita Mestanza*, a 33-year-old mother of seven who died from complications from forced sterilization surgery. The case had been shelved in 2009 after it was decided that the statute of limitations had run out. But in November 2011 the office of Peru’s attorney general, José Peláez, informed the *Inter-American Commission on Human Rights* that it was reopening the case and reclassifying the sterilizations as a crime against humanity, effectively removing the time limit for a prosecution. In one of the cases that has so far come to court, Victoria Vigo, a now 49 year old woman who was forcibly sterilised in Piura in 1996, was eventually awarded $3,500 in compensation. During the trial the doctor argued that he had simply been obeying orders, and that the sterilization was official policy.[[283]](#footnote-283)
7. A current case before the Inter-American Commission on Human Rights (*F.S. v. Chile*) is seeking government accountability for violations of the sexual and reproductive rights of women living with HIV. The case centres on F.S., a young woman from a rural town in Chile, was forcibly sterilised without her knowledge or consent when she was just 20 years old because she is HIV-positive. The Centre for Reproductive Rights (litigating the case with its partner Vivo Positivo) asserts that: *“the Chilean State has a responsibility to address the human rights violation that F.S. suffered, to provide reparations, and to adopt and enforce policies that guarantee women living with HIV the freedom to make reproductive health decisions without coercion.”*[[284]](#footnote-284)
8. On 12 December 2012, the International Federation for Human Rights (FIDH) and REDRESS[[285]](#footnote-285) filed a complaint against Uzbekistan before the UN Human Rights Committee, on behalf of *Mrs Mutabar Tadjibayeva*, who was nominated for the Nobel Peace Prize in 2008 for her work as a human rights defender. Mrs Tadjibayeva was forcibly sterilised after being imprisoned for her human rights activities in Uzbekistan. In bringing the case before the UN Human Rights Committee, the litigants are hoping to *“help her receive the remedies she deserves from Uzbekistan for the grave damage and suffering caused by years of torture and ill-treatment”.[[286]](#footnote-286)*
9. Until recently, Swedish law had required all transgender people to undergo sterilisation if they wanted to legally change their sex. In a decision on December 19 2012, the Stockholm Administrative Court of Appeal overturned the law, declaring it unconstitutional and in violation of the European Convention on Human Rights. Now, many of the estimated 500 people who have undergone forced sterilisation since the law was passed are demanding compensation.[[287]](#footnote-287)

Redress & Transitional Justice

1. Forced sterilisation of women and girls with disabilities, and the inadequacy of Australian Governments’ responses to it, represent extremely grave violations of multiple human rights. The Australian Government is obliged to exercise due diligence to:

* prevent the practice of forced and coerced sterilisation from taking place;
* investigate promptly, impartially and effectively all cases of forced sterilisation of women and girls with disabilities;
* remove any time limits for filing complaints;
* prosecute and punish the perpetrators; and,
* provide adequate redress to all victims of forced or coerced sterilisation.

Meeting these obligations requires the Australian Government to take into account the marginalisation of disabled women and girls, whose rights are compromised due to deeply rooted power imbalances and structural inequalities, and to take all appropriate measures, including focused, gender-specific measures to ensure that disabled women and girls experience full and effective enjoyment of their human rights on an equal basis as others.

1. In regard to ‘victims of forced or coerced sterilisation’, the United Nations has made it clear that in this context:

*victims are persons who individually or collectively suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that constitute gross violations of international human rights law, or serious violations of international humanitarian law.[[288]](#footnote-288)*

1. The International Human Rights treaties to which Australia is a party, all clearly articulate the requirement for available, effective, independent and impartial remedies to be available to those whose rights have been violated under the various treaties. The Human Rights Committee has emphasised that such remedies are particularly urgent in respect of violations of the right to freedom from torture and cruel, inhuman and degrading treatment and punishment.[[289]](#footnote-289)
2. Forced sterilisation constitutes torture.[[290]](#footnote-290) Article 14(1) of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* specifies that States parties have a duty to ensure that victims of torture obtain redress and that they have *‘an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible’*. The Special Rapporteur on Torture [and Other Cruel, Inhuman or Degrading Treatment or Punishment] has recently made it very clear that victims of torture must be provided with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation.[[291]](#footnote-291) The *Convention on the Rights of the Child* at Article 39 also clearly articulates the importance of rehabilitation for victims of torture:

*‘States Parties shall take all appropriate measures to promote physical and psychological recovery and social integration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment………Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.’*

1. Therefore, redressing the harm done to women and girls with disabilities who have been sterilised in the absence of their free and informed consent requires multi-faceted responses. The right to redress and transitional justice[[292]](#footnote-292) is articulated as an integrated right that consists of measures of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery.[[293]](#footnote-293)
2. Critically, in the development and implementation of any measure of redress or transitional justice for women and girls with disabilities who have been forcibly sterilised (including for eg legislation, policies, services, programs, supports, and other measures) women and girls with disabilities (including through representative organisations where they exist), must be at the forefront of all consultative and decision-making processes.

**Satisfaction: An Official Apology**

1. Discriminatory laws, policies and practices that allowed (and continue to allow) disabled women and girls to be forcibly sterilised have left, and will leave, legacies of personal pain and distress that will continue to reverberate long into the future. First and foremost, redress demands that Governments acknowledge the pervasive practice of forced and coerced sterilisation of disabled women and girls (through a full and public disclosure of the truth) - and issue an official apology to those affected (including public acknowledgement of the facts and acceptance of responsibility).[[294]](#footnote-294)
2. In 2000, the Canadian Government issued a national apology to the 703 people who were forcibly sterilised under that province’s Sexual Sterilisation Act.[[295]](#footnote-295) In 2002, the State of North Carolina issued a formal apology to the estimated 7,600 people forcibly sterilised in that State between 1929 and 1974.[[296]](#footnote-296)

**Guarantees of non-repetition – Law Reform**

1. The monitoring committees of the International Human Rights Treaties have made it clear that legislative reform is a critical component of redress for women and girls who have been sterilised in the absence of their free and informed consent. Legislative reform in this context includes, but is not restricted to:

* the enactment of national legislation prohibiting, except where there is a serious threat to life, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent. Such legislation must criminalise the removal of a child or adult with a disability from the Country with the intention of having a forced sterilisation procedure performed;[[297]](#footnote-297)
* the enactment of national legislation that replaces regimes of substitute decision making for people with disabilities with supported decision-making which respects the persons autonomy, will and preferences;[[298]](#footnote-298)
* repealing any laws, policies and practices which permit guardianship and trusteeship for adults (and replacing regimes of substituted decision-making by supported decision making).[[299]](#footnote-299)
* ensuring that the requirement for full and informed consent in all interventions and treatments concerning people with disabilities is enshrined in relevant legal frameworks at national and state/territory levels;[[300]](#footnote-300)
* ensuring that criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent is clarified in the law, and that no distinction between persons with or without disabilities is made; and,[[301]](#footnote-301)
* ensuring that any law or policy which restricts in any way, a disabled woman’s [and girls] right to full enjoyment of her sexual and reproductive health rights and freedoms, is amended as a matter of urgency. This includes laws, policies or programs that deny disabled women the right to found a family (including for eg: policies that deny access to assisted reproduction, adoption, surrogacy) and to maintain a family (eg: policies that enable removal of babies and children from parents with disabilities on the basis of parental disability).[[302]](#footnote-302)

**Compensation**

1. Compensation is an important component of redress and transitional justice for women and girls who have been sterilised in the absence of their free and informed consent. Whilst it is recognised that financial compensation can never make up for the immense harm caused to the women and girls affected, it is a critical element in States accountability for those harms. Financial compensation has been awarded in a number of cases where girls and women with disabilities were sterilised in the absence of their free and informed consent.[[303]](#footnote-303)
2. In October 1989, Leilani Muir filed a lawsuit against the Alberta government for wrongfully classifying her as “feeble-minded,” which lead to her forced sterilisation. In 1995, the provincial Court of Queen’s Bench ruled in Muir’s favour, and awarded her $740,000 in damages, and another $230,000 in legal costs. Leilani Muir’s lawsuit was the first one to ever successfully sue the government for forced sterilisation.[[304]](#footnote-304)
3. In 2000, in a joint action suit that arose from the Leilani Muir case, the Alberta Government financially compensated 703 other defendants who were forcibly sterilised under that province’s Sexual Sterilisation Act.[[305]](#footnote-305)
4. In 1999, the Swedish Government finally compensated approximately 200 citizens - mostly female - who were forcibly sterilised between 1935 and 1975.[[306]](#footnote-306)
5. In North Carolina, Governor Beverly Perdue established the *North Carolina Justice for Sterilization Victims Foundation*[[307]](#footnote-307) in 2010 to provide justice and compensate victims who were forcibly sterilised by the State of North Carolina, under the former North Carolina Eugenics Board program. From 1929 until 1974, an estimated 7,600 North Carolinians, women and men, many of whom were disabled, were forcibly sterilised under the Program. In March 2011, Governor Perdue established a five-member Task Force[[308]](#footnote-308) to recommend possible methods or forms of compensation to those affected. The Task Force’s Final Report,[[309]](#footnote-309) released in 2012, recommended a package of compensation that:

*“provides a lump-sum financial payment* [$50,000] *and mental health services to living victims. The package also provides for the expansion of the N.C. Justice for Sterilization Victims Foundation and public education to serve as a deterrent against any future abuse of power by the government of North Carolina.”*

**Rehabilitation & Recovery**

1. Women and girls with disabilities who have been forcibly sterilised are entitled to a full range of rehabilitation and recovery measures. In this context, ‘rehabilitation and recovery’ must be understood holistically, recognising that measures would need to include for example: psychological, physical, health and medical care; legal and social services; economic empowerment; housing; education and employment; transport; access to justice; as well as the elements of political and moral rehabilitation.[[310]](#footnote-310) Importantly, rehabilitation and recovery measures should be tailored to each individual’s needs and particular situation and ensure active participation of the survivors and their allies. Moreover, as highlighted by Somasundaram:[[311]](#footnote-311)

*“it is necessary to consider the effects of torture and other violations on families, communities and society (collective trauma). Rehabilitation and recovery programmes should promote individual, family and social healing, recovery and reintegration.”*

1. Rehabilitation and recovery measures for women and girls with disabilities who have been forcibly sterilised, must also be understood as not merely a form of reparation, but also as an explicit right under Article 26 of the *Convention on the Rights of Persons With Disabilities* (CRPD).[[312]](#footnote-312)

**Promoting the Sexual and Reproductive Health Rights of Women and Girls with Disabilities**

1. Reproductive rights and freedoms rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. It also includes the right to make decisions regarding reproduction free of discrimination, coercion and violence.[[313]](#footnote-313) For women and girls with disabilities, reproductive rights and freedoms encompass for example: the right to bodily integrity and bodily autonomy, the right to procreate, the right to sexual pleasure and expression, the right for their bodies to develop in a normal way, the right to sex education, to informed consent regarding birth control, to terminate a pregnancy, to choose to be a parent, to access reproductive information, resources, medical care, services, and support; the right to experience and express their sexuality; the right to experience love, intimacy, sexual identity; the right to privacy, and the right to be free from interference.[[314]](#footnote-314)
2. Yet, as highlighted earlier in this Submission, no group has ever been as severely restricted, or negatively treated, in respect of their reproductive rights and freedoms, as women and girls with disabilities.[[315]](#footnote-315) The practice of forced sterilisation is itself part of a broader pattern of denial of human and reproductive rights of Australian disabled women and girls which also includes systematic exclusion from appropriate reproductive health care and sexual health screening, forced contraception and/or limited contraceptive choices, a focus on menstrual suppression, poorly managed pregnancy and birth, selective or coerced abortion and the denial of rights to parenting.[[316]](#footnote-316) These practices are framed within traditional social attitudes that continue to characterise disability as a personal tragedy, a burden and/or a matter for medical management and rehabilitation.[[317]](#footnote-317)
3. Whilst there are exceptions,[[318]](#footnote-318) there appear to be very few specific, targeted initiatives for women and girls with disabilities in Australia regarding a rights based approach to sexual and reproductive health. Where they exist, the majority of initiatives focusing on disability, sexuality and reproductive rights – are not gendered, focus largely on people with intellectual disabilities, tend to overlook the sexual and reproductive health needs of other women and girls with disabilities, and appear to be primarily targeted at service providers and/or parents and carers.[[319]](#footnote-319)
4. It is outside the scope of this Submission to address the wide-ranging and extensive raft of actions required to promoting the sexual and reproductive health rights of women and girls with disabilities. It is however, clearly an area that requires urgent and intensive attention, in consultation with women and girls with disabilities and their allies.

Conclusion

This Submission from WWDA to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia, establishes beyond doubt, that forced and coerced sterilisation of women and girls with disabilities is a form of torture – a heinous, inhuman practice which violates multiple human rights, and clearly breaches every international human rights treaty to which Australia is a party.

For decades, uninterested and apathetic Australian Governments have been complicit in allowing this form of torture to be perpetrated against women and girls with disabilities, indifferent to the devastating and life-long effects it has on some of our countries most marginalised and excluded citizens.

This Submission has provided an extensive amount of evidence which warrants the Australian Government stop procrastinating on this issue, and act immediately and decisively to put an end to the barbaric practice that is forced sterilisation. In so doing, it must acknowledge and take full responsibility for the wrongs that have been done to those affected, including formally apologising for the discriminatory actions, policies, culture and attitudes that result in forced and coerced sterilisation and that acknowledges, on behalf of the nation, the immense harm done to those who have been forcibly sterilised and experienced other violations of their reproductive rights.

In addition, the Australian Government must do everything in its power to not only enable redress and justice for all those affected by forced and coerced sterilisation, but also take all measures necessary, including focused, gender-specific measures, to ensure that disabled women and girls experience full and effective enjoyment of all their human rights on an equal basis as others.

Appendix 1: FIGO Guidelines



**FEMALE CONTRACEPTIVE STERILIZATION**

**Background**

1. Human rights include the right of individuals to control and decide on matters of their own sexuality and reproductive health, free from coercion, discrimination and violence. This includes the right to decide whether and when to have children, and the means to exercise this right.
2. Surgical sterilization is a widely used method of contraception. An ethical requirement is that performance be preceded by the patient’s informed and freely given consent, obtained in compliance with the Guidelines Regarding Informed Consent ( 2007) and on Confidentiality (2005). Information for consent includes, for instance, that sterilization should be considered irreversible, that alternatives exist such as reversible forms of family planning, that life circumstances may change, causing a person later to regret consenting to sterilization, and that procedures have a very low but significant failure rate.
3. Methods of sterilization generally include tubal ligation or other methods of tubal occlusion. Hysterectomy is inappropriate solely for sterilization, because of disproportionate risks and costs.
4. Once an informed choice has been freely made, barriers to surgical sterilization should be minimised. In particular: a) sterilization should be made available to any person of adult age; b) no minimum or maximum number of children may be used as a criterion for access; c) a partner’s consent must not be required, although patients should be encouraged to include their partners in counseling; d) physicians whose beliefs oppose participation in sterilization should comply with the Ethical Guidelines on Conscientious Objection (2005).
5. Evidence exists, including by governmental admission and apology, of a long history of forced and otherwise non-consensual sterilizations of women, including Roma women in Europe and women with disabilities. Reports have documented the coerced sterilization of women living with HIV/AIDS in Africa and Latin America. Fears remain that ethnic and racial minority, HIV-positive, low-income and drug-using women, women with disabilities and other vulnerable women around the world, are still being sterilized without their own freely-given, adequately informed consent.
6. Medical practitioners must recognize that, under human rights provisions and their own professional codes of conduct, it is unethical and in violation of human rights for them to perform procedures for prevention of future pregnancy on women who have not freely requested such procedures, or who have not previously given their free and informed consent. This is so even if such procedures are recommended as being in the women’s own health interests.
7. Only women themselves can give ethically valid consent to their own sterilization. Family members including husbands, parents, legal guardians, medical practitioners and, for instance, government or other public officers, cannot consent on any woman’s or girl’s behalf.
8. Women’s consent to sterilization should not be made a condition of access to medical care, such as HIV/ AIDS treatment, natural or cesarean delivery, or abortion, or of any benefit such as medical insurance, social assistance, employment or release from an institution. In addition, consent to sterilization should not be requested when women may be vulnerable, such as when requesting termination of pregnancy, going into labor or in the aftermath of delivery.
9. Further, it is unethical for medical practitioners to perform sterilization procedures within a government program or strategy that does not include voluntary consent to sterilization.
10. Sterilization for prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman’s life or health, she will not become pregnant immediately, and therefore must be given the time and support she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health.
11. As for all non-emergency medical procedures, women should be adequately informed of the risks and benefits of any proposed procedure and of its alternatives. It must be explained that sterilization must be considered a permanent, irreversible procedure that prevents future pregnancy, and that non-permanent alternative treatments exist. It must also be emphasized that sterilization does not provide protection from sexually transmitted infections. Women must be advised about and offered follow-up examinations and care after any procedure they accept.
12. All information must be provided in language, both spoken and written, that the women understand, and in an accessible format such as sign language, Braille and plain, non-technical language appropriate to the individual woman’s needs. The physician performing sterilization has the responsibility of ensuring that the patient has been properly counseled regarding the risks and benefits of the procedure and its alternatives.
13. The U.N. Convention on the Rights of Persons with Disabilities includes recognition “that women and girls with disabilities are often at greater risk … of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation”. Accordingly, Article 23(1) imposes the duty “to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

a) The right of all persons with disabilities who are of marriageable age to marry and to found a family … is recognized;

b) The rights…to decide freely and responsibly on the number and spacing of their children …are recognized, and the means necessary to enable them to exercise these rights are provided;

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

**Recommendations**

1. No woman may be sterilized without her own, previously-given informed consent, with no coercion, pressure or undue inducement by healthcare providers or institutions.
2. Women considering sterilization must be given information of their options in the language in which they communicate and understand, through translation if necessary, in an accessible format and plain, non-technical language appropriate to the individual woman‘s needs. Women should also be provided with information on non-permanent options for contraception. Misconceptions about prevention of sexually transmitted diseases (STDs) including HIV by sterilization need to be addressed with appropriate counseling about STDs.
3. Sterilization for prevention of future pregnancy is not an emergency procedure. It does not justify departure from the general principles of free and informed consent. Therefore, the needs of each woman must be accommodated, including being given the time and support she needs, while not under pressure, in pain, or dependent on medical care, to consider the explanation she has received of what permanent sterilization entails and to make her choice known.
4. Consent to sterilization must not be made a condition of receipt of any other medical care, such as HIV/AIDS treatment, assistance in natural or cesarean delivery, medical termination of pregnancy, or of any benefit such as employment, release from an institution, public or private medical insurance, or social assistance.
5. Forced sterilization constitutes an act of violence, whether committed by individual practitioners or under institutional or governmental policies. Healthcare providers have an ethical response in accordance with the guideline on Violence Against Women (2007).
6. It is ethically inappropriate for healthcare providers to initiate judicial proceedings for sterilization of their patients, or to be witnesses in such proceedings inconsistently with Article 23(1) of the Convention on the Rights of Persons with Disabilities.
7. At a public policy level, the medical profession has a duty to be a voice of reason and compassion, pointing out when legislative, regulatory or legal measures interfere with personal choice and appropriate medical care.

Goa, March 2011

Appendix 2: Letter to the Australian Government from the United Nations Special Rapporteurs

**NATIONS UNIES UNITED NATIONS**

**HAUT COMMISSARIAT DES NATIONS UNIES OFFICE OF THE UNITED NATIONS**

**AUX DROITS DE L’HOMME HIGH COMMISSIONER FOR HUMAN RIGHTS**

**PROCEDURES SPECIALES DU SPECIAL PROCEDURES OF THE**

**CONSEIL DES DROITS DE L’HOMME HUMAN RIGHTS COUNCIL**

**Mandates of the Special Rapporteur on the right of everyone to the enjoyment of the highest**

**attainable standard of physical and mental health, and the Special Rapporteur on violence against**

**women, its causes and consequences**

REFERENCE: AL Health (2002-7) G/SO 214 (89-15)

AUS 2/2011

18 July 2011

Excellency,

We have the honour to address you in our capacities as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and Special Rapporteur on violence against women, its causes and consequences pursuant to General Assembly resolution 60/251 and to Human Rights Council resolutions 15/22 and 16/7.

In this connection, we would like to bring to the attention of your Excellency’s Government information we have received concerning **the alleged ongoing practice of non-therapeutic, forced sterilization of girls and women with disabilities in Australia.**

According to the information received:

It is alleged that non-therapeutic, forced sterilization is performed on young girls and women with disabilities for various purposes, including pregnancy prevention, population control, menstrual management and personal care. Reportedly, non-therapeutic sterilization is sterilization for a purpose other than to treat some malfunction or disease, and it refers to procedures carried out in circumstances that do not involve a serious threat to the health or life of the individuals. Forced sterilization refers to sterilization that has occurred in the absence of the individual’s consent.

It is also alleged that cases of non-therapeutic, forced sterilization of girls have occurred in greater numbers than those formally authorized by courts and tribunals. It is further alleged that the existing State and Territory legislation and federal court mechanisms have not adequately addressed non-therapeutic, forced sterilizations of young girls with disabilities, in particular with regard to preventing such children from being taken out of Australia for sterilization procedures elsewhere.

While we do not wish to prejudge the accuracy of these allegations, we would appreciate information from your Government on the steps taken by the competent authorities with a view to ensuring the right to the highest attainable standard of health of girls and women with disabilities. This right is enshrined, inter alia, in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ratified on 10 December 1975), which provides for the right of everyone to the enjoyment of the highest attainable standard of mental and physical health. This includes an obligation on the part of all States parties to ensure that health facilities, goods and services are accessible to everyone, especially the most vulnerable or marginalized sections of the population, without discrimination. In that connection, General Comment No. 14 of the Committee on Economic, Social and Cultural Rights elucidates that the right to health contains both freedoms and entitlements and holds that “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” (para. 8). I would also like to refer your Excellency’s Government to General Comment No. 5 of the Committee, which holds that “Women with disabilities also have the right to protection and support in relation to motherhood and pregnancy…Both the sterilization of, and the performance of an abortion on, a woman with disabilities without her prior informed consent are serious violations of article 10 (2) [of the International Covenant on Economic, Social and Cultural Rights]” (para.30).

We would like to draw the attention of your Excellency’s Government to Article 17 of the Convention on the Rights of Persons with Disabilities (ratified on 17 July 2008), which states: “Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others”. We would also like to refer your Excellency’s Government to Article 23 of the Convention, which holds that “States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that: (…) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized.”

Furthermore, we would like to draw the attention of your Excellency’s Government to Article 24 of the Convention on the Rights of the Child (ratified on 17 Dec 1990), which holds that “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. I would also like to refer your Excellency’s Government to General Comment No.9 of the Committee of the Rights of the Child which states: “The Committee is deeply concerned about the prevailing practice of forced sterilisation of children with disabilities, particularly girls with disabilities. This practice, which still exists, seriously violates the right of the child to her or his physical integrity and results in adverse life-long physical and mental health effects. Therefore, the Committee urges States parties to prohibit by law the forced sterilisation of children on grounds of disability.”

We would also like to refer your Excellency’s Government to General Recommendation No. 18 of the Committee on the Elimination of Discrimination against Women, which recommends that “States parties [to the Convention in the Elimination of all Forms of Discrimination against Women (ratified on 28 July 1983)] 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”. In that context, I would like to note paragraph 43 of the Concluding observations of the Committee on the Elimination of Discriminations against Women (CEDAW/C/AUL/CO/7, 30.07.2010) which recommended that Australia “enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilization of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent”.

Finally, we deem it appropriate to make reference to Commission on Human Rights Resolution 2005/41 on the Elimination on Violence against women, which provides that women should be empowered to protect themselves against violence and, in this regard, stresses that women have the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. In this context, we would also like to draw your attention to the Platform for Action of the Beijing World Conference on Women and the Programme of Action of the Cairo International Conference on Population and Development, which reaffirm the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so.

We urge your Excellency’s Government to take all necessary measures to ensure the protection and full enjoyment of the right to the highest attainable standard of health for girls and women with disabilities in accordance with international standards.

It is our responsibility under the mandate provided by the Human Rights Council to seek to clarify all cases brought to my attention regarding the right to health. Since we are expected to report on these cases to the Council, we would be grateful for your cooperation in addressing the following matters:

1. Are the facts alleged in the above summary of the case accurate?
2. Please provide details of any actions to prevent further non-therapeutic, forced sterilization of girls and women with disabilities?
3. Please provide details of any actions to sanction medical staff carrying out illegal non-therapeutic, forced sterilizations of girls and women with disabilities. Please provide details, and where available the results, of any investigation and judicial or other inquiries carried out in relation to such cases. If no inquiries have been made, or if they have been inconclusive, please explain why.
4. Please provide details of any actions to ensure that reparation, including compensation and rehabilitation, is provided to those girls and women with disabilities who may have been forcibly sterilized?
5. Please provide details of any actions to ensure that informed consent requirements are adequately implemented for all medical interventions with regard to children and persons with disabilities?
6. What measures are being taken to ensure the enjoyment of the right to health of girls and women with disabilities?

We undertake to ensure that your Excellency’s Government’s response to each of these questions is accurately reflected in the reports that will be submitted to the Human Rights Council for its consideration.

Please accept, Excellency, the assurances of our highest consideration.

Anand Grover

Special Rapporteur on the right of everyone to the enjoyment of the

highest attainable standard of physical and mental health

Rashida Manjoo

Special Rapporteur on violence against women, its causes and consequences

Appendix 3: Responses from the Australian Government to the United Nations Special Rapporteurs



Note Number: 108/2011

The Australian Permanent Mission to the United Nations in Geneva presents its compliments to the Office of the High Commissioner for Human Rights, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.

The Australian Government has the honour to refer to the Special Rapporteurs’ letter of 18 July 2011 requesting the Australian Government’s observations on the alleged practice of non-therapeutic, forced sterilisation of girls and women with disabilities in Australia.

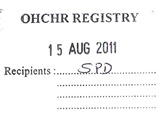
The Australian Government is currently considering the information and questions contained in the letter. The Government is consulting with relevant stakeholders, including state and territory governments, and will provide a full response by 17 October 2011.

The Australian Permanent Mission to the United Nations avails itself of this opportunity to renew to the Office of the High Commissioner for Human Rights and the Special Rapporteurs the assurances of its highest consideration.



Geneva

12 August 2011





Note Number: 127/2011

The Australian Permanent Mission to the United Nations in Geneva presents its compliments to the Office of the High Commissioner for Human Rights, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.

The Australian Government has the honour to refer to the Special Rapporteurs’ letter of 18 July 2011 requesting the Government’s response regarding the alleged practice of non-therapeutic, forced sterilisation of girls and women with disabilities in Australia.

The Australian Government has the further honour to refer to its correspondence of 12 August 2011, in which the Special Rapporteurs were informed that a response would be provided by the Australian Government by 17 October 2011.

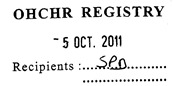
The Australian Government is currently considering the information and questions contained in the letter of 18 July 2011. The Commonwealth Attorney-General’s Department is in the process of compiling a detailed Australian Government response to this request for information.

The Australian Government regrets that in order to ensure the Australian Government’s response to this request is as comprehensive as possible, further consultation with the State and Territory governments is required, and consequently it is unlikely that this consultation will be completed before the earlier indicated date for submission of 17 October 2011.

The Australian Government is committed to upholding its international obligations and would prefer to take more time to ensure an accurate and fully considered response can be prepared on this important topic.

The Australian Government regrets this delay in response and will submit its final response to the Special Rapporteurs by 16 December 2011.

The Australian Permanent Mission to the United Nations avails itself of this opportunity to renew to the Office of the High Commissioner for Human Rights and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.



Australian Permanent Mission to the UN

Chemin des Fins 2 – Case Postale 102 – 1211 Geneve 19 Tel. 022 799 91 00 Fax 022 799 91 75



Note number: 185/2011

The Australian Permanent Mission to the United Nations in Geneva presents its compliments to the Office of the High Commissioner for Human Rights, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.

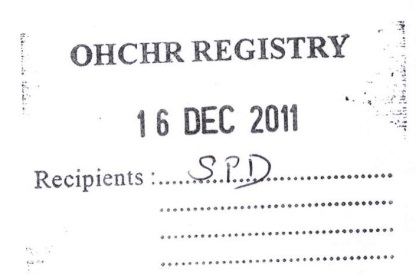
The Australian Government has the honour to refer to the Special Rapporteurs' letter of 18 July 2011 requesting the Government's response regarding the alleged practice of non-therapeutic, forced sterilisation of girls and women with disabilities in Australia.

The Australian Government has the further honour to enclose, for the Special Rapporteurs' consideration, its response to the issues raised in that letter.

The Australian Permanent Mission to the United Nations avails itself of this opportunity to renew to the Office of the High Commissioner for Human Rights and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.







**United Nations Office of the High Commissioner for Human Rights**

**Special Rapporteurs' request for information -**

**Allegations of non-therapeutic forced sterilisation of girls and women with disabilities in Australia**

Australia is party to the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC).

The Australian Government welcomes the Special Rapporteurs' interest in Australian law and practice concerning sterilisation.

Australia has recently submitted its initial report under the CRPD and, as that report notes, persons with disabilities are highly valued members of Australian communities and workplaces and make a positive contribution to Australian society. Moreover, the Australian Government is committed to improving and enriching the lives of all women to enable them to participate equally in all aspects of Australian life.

The Australian Government notes that the issue of Australian practices in relation to sterilisation of people with disabilities was raised in the course of Australia's recent Human Rights Universal Periodic Review (UPR).[[320]](#footnote-320) In response to concerns expressed internationally and domestically, the then Commonwealth Attorney-General undertook to initiate further discussions with State and Territory counterparts on this issue. This consultation is ongoing at this time.

**1. Are the facts alleged in the summary of the case accurate?**

The Australian Government is committed to respecting the human rights of all persons with disabilities, including their right to personal integrity and reproductive rights. Sterilisation is a serious and irreversible procedure. Many people choose sterilisation as a method for controlling their fertility, but sterilisation can have significant physical and psychological consequences for those who undergo it. Sterilisations should never be carried out in the absence of a person's free and informed consent where that person is capable of making the decision, including where a person requires support to make that decision.

The Government takes its international human rights obligations seriously and has noted the concerns raised domestically and internationally regarding Australia's approach to sterilisation of children and adults with disabilities. The former Attorney-General has asked the Attorney­ General's Department to consider options for reform in this area and has undertaken to raise this issue with State and Territory counterparts. This work will form part of the Government's National Human Rights Action Plan, the draft of which was launched to coincide with International Human Rights Day, 10 December 2011.

Under current laws, for children and adults who have an impaired capacity to consent and are unable to make an independent decision about whether to undergo a sterilisation procedure, Australian laws provide for authorisation by a court or guardianship tribunal. These laws are designed to protect the rights of those involved and to ensure procedures are authorised only where they are in the person's best interests.

Detail of the different laws governing sterilisation in Australia is set out below, however, broadly, in all Australian jurisdictions the authorisation of a court or tribunal is required in cases where a sterilisation procedure is not considered to be clearly therapeutic (the requirements vary between jurisdictions but would include, for example, surgery to remove a cancer). This is a greater protection than is applied for most other medical treatments, recognising the serious nature of sterilisation procedures and the possible challenges for carers to objectively determine what is in the person's best interests.

Courts and tribunals hear a range of evidence; often including the views of the person concerned, medical evidence and evidence from carers. In many cases, an independent advocate is appointed to represent the person's interests to the court or tribunal. Appointment of an independent advocate is usually a matter for the Court or Tribunal to decide. Sterilisations are authorised only where they are the last resort, as less invasive options have failed or are inappropriate, and where they are in the person's best interests.

A review conducted at the behest of the Standing Committee of Attorney General's (SCAG), the national ministerial council made up of the Australian Attorney-General and the State and Territory Attorneys-General, indicated in 2006 that sterilisations of children with an intellectual disability had declined significantly since Australia's 1997 country report to the Committee on the Elimination of All Forms of Discrimination Against Women. Evidence also indicated that alternatives to surgical procedures to manage the menstruation and contraceptive needs of girls and women with disabilities are increasingly available and seem to be successful in the most part.

The Australian Government recognises that the issues faced by children and women with disabilities and their parents and carers in these situations are sensitive, and that members of the community have strong concerns about children and women with disabilities being subjected to medical procedures which result in sterilisation.

The Australian Government would be very concerned if concrete evidence were made available that demonstrated that current mechanisms were not adequately protecting girls and women with disabilities, or that cases of sterilisation that are unlawful without court or tribunal authorisation had occurred in greater numbers than those formally authorised. The Australian Government would also be concerned if children with disabilities were being taken out of Australia for sterilisation procedures elsewhere that would be unlawful without court or tribunal authorisation in Australia. However the Australian Government is unaware of any such evidence at this time.

**2. Please provide details of any actions to prevent further non­**

**therapeutic, forced sterilisation of girls and women with disabilities.**

The Australian Government recognises the right of persons with disabilities to retain their fertility on an equal basis with others. Given its serious consequences sterilisation (of a child or of an adult with a disability who is unable to give consent), that is not performed to cure a disease or correct some malfunction, may only be authorised by a court or tribunal as a measure of last resort. In many cases, an independent advocate is appointed to represent the person's interests to the court or tribunal.

***A National Approach?***

Australia is a federation with nine separate jurisdictions, the Commonwealth or federal jurisdiction and eight State and Territory jurisdictions. The 2006 SCAG review considered model legislation on a nationally consistent approach, which would have applied to the authorisation procedures required for the lawful sterilisation of minors across all the jurisdictions.

After deliberation and the review of findings presented by a working group, it was decided that there would be limited benefit in developing such model legislation at that point in time.

SCAG agreed instead to review State and Territory arrangements to ensure that all tribunals, or bodies with the power to make orders concerning the sterilisation of minors with an intellectual disability, are required to be satisfied before such an order is made that all less invasive alternatives to sterilisation are inappropriate or have been tried and found to be unsuccessful.

Subsequently, across the jurisdictions the legal framework currently applied to prevent unnecessary sterilisation of children and of women who are unable to independently consent differs. In 2011 the then Commonwealth Attorney-General undertook to initiate further discussions with State and Territory counterparts on this issue. These discussions are ongoing at this time and may influence future change to the Federal, State and Territory legal frameworks. In the interim, the following information outlines the current requirements in each jurisdiction.

***Commonwealth Jurisdiction***

At the federal level, the Family Court of Australia (Family Court) has jurisdiction under the *Family Law Act 1975* to make orders relating to the welfare of children, such as to authorise special medical procedures for children, including sterilisation that is not to treat a disease or correct some malfunction. The Family Court has a general welfare jurisdiction that enables the court to give consent to special medical procedures in place of the parents where the consent required is outside the bounds of parental authority. When considering a request the court must regard the child's best interests as the paramount consideration in these decisions. The following information outlines the approach taken by the courts in such cases.

Parent or guardian consent to sterilisation will be sufficient only where sterilisation is a by-product of surgery appropriately carried out to treat a malfunction or disease. In addition, a medical practitioner can lawfully carry out a sterilisation procedure in emergency situations, that is, where the procedure is necessary to save a person's life or to prevent serious damage to that person's health.

Where a child cannot consent due to a lack of maturity or a disability, court or tribunal approval is required for serious medical procedures including sterilisation. The Family Court is empowered to make such decisions, and in doing so is required to treat the best interests of the child as the paramount consideration

**Marion's Case**

The High Court of Australia (HCA) established the framework for authorisation of sterilisation of children in Australia in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992),[[321]](#footnote-321) on appeal from the Family Court. This appeal considered the processes required to authorise procedures that would render a 14 year old girl with intellectual disabilities infertile but prevent menstruation, pregnancy and hormonal fluxes and consequently reduce psychological and behavioural problems.

A majority judgement held that children who have a sufficient understanding and intelligence to enable them to understand fully what is proposed are capable of giving (or withholding) informed consent. The majority also held that where a child is insufficiently mature to give consent on his or her own behalf then, as a general rule, his or her parents or guardian have lawful authority to consent to medical treatment of the child, provided that the treatment is in the child's best interests.

The HCA acknowledged the uncertainty in the term 'therapeutic', but defined it to mean sterilisation that is 'a by-product of surgery appropriately carried out to treat some malfunction or disease.' The majority found that the parental power to consent to a sterilisation procedure is limited to circumstances in which sterilisation is therapeutic in this sense, because sterilisation 'requires invasive, irreversible and major surgery.'

Accordingly, only a court or tribunal, that has a relevant welfare jurisdiction, has the power to authorise sterilisation procedures that are not carried out as a by-product of surgery appropriately carried out to treat some malfunction or disease. The majority went on to provide guidance on the issues a court should consider when asked to give authorisation for such sterilisation and held that the court must decide 'whether, in the circumstances of the case, [authorisation of sterilisation] is in the best interests of the child' (the 'best interests test'). The HCA noted that within that context, sterilisation can only be authorised where other procedures or treatments are or have proved to be inadequate, have failed, or will not 'alleviate the situation so that the child can lead a life in keeping with his or her needs and capacities.'

Thus, a best interest test is applied by the Family Court throughout Australia when determining whether to authorise the sterilisation of a minor *(Marion's Case).* The *Family Law Rules 2004* set out evidence that must be considered in applying the best interests test. Additional details on these Rules are provided below. In addition, Family Court may appoint an independent children's lawyer to represent the child's best interests.

**Angela's Case**

An recent example of the application of the *Family Law Rules* and the test in *Marion's Case* can be found in *Re Angela (Special Medical Procedure),* where the Family court authorised the performance of a hysterectomy on an eleven year old girl with a decision making disability.[[322]](#footnote-322)

Angela suffered from heavy menstrual bleeding and was anaemic. She also had epileptic seizures around the time of menstruation and menstruation brought pain, fatigue and hygiene discomfort. The judge found that Angela would 'never be in a position to make a decision about her own welfare'. Overall the judge was satisfied in this case that sterilisation was a last resort treatment that would contribute to an improvement in Angela's quality of life. The Family Court decided not to appoint an independent children's lawyer in this case.

**Medicare Benefits**

In addition to the legal framework set up at the Commonwealth level to assess applications for sterilisation, there are additional protections provided through the regulations of the Medicare Benefits Schedule (MBS).

Through the MBS, the Australian Government facilitates universal access to allied health, general practice and specialist medical services by subsidising fee-for-service care. No Medicare benefits are payable for services which are provided in contravention of Commonwealth or State and Territory laws.

Medicare benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3(1) of the *Health Insurance Act 1973.* Section 3(1) states that a clinically relevant service must be provided by a medical practitioner in accordance with accepted medical practice.

The MBS does not provide any specific information on the sterilisation of the girls or women with disabilities, however, the following information is provided in relation to the sterilisation of minors:

* It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (e.g. malignancies of the reproductive tract) unless legal authorisation has been obtained.
* Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court or another court or tribunal with jurisdiction to give such authorisation.

***State and Territory Jurisdictions***

In addition, the various Australian States and Territories have developed their own procedures for authorising the sterilisation of children and adults who do not have the capacity to consent on their own behalf. All States and Territories have their own procedures for adults, however New South Wales, Queensland, South Australia and Tasmania also have provisions for children. These procedures operate concurrently to the Family Court procedure for authorising sterilisations in the best interests of the child. The following information outlines the current legal requirements in various jurisdictions:

**New South Wales**

In NSW, two different legal regimes are in place to govern the sterilisation of children and adults. For children aged under 16, the provisions contained within section 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) apply. For people aged 16 and over who are incapable of giving consent to medical treatment, the regime under the *Guardianship Act 1987* (NSW) applies.

Under section 175(1) of the *Care and Protection Act 1998,* it is an offence to carry out special medical treatment on a child that is not in accordance with the provisions of this section. Special medical treatment includes non-therapeutic sterilisation, that is, medical treatment that is intended, or is reasonably likely to render a person permanently infertile. Section 175(2) of this Act provides that non-therapeutic sterilisation may only be performed in an emergency to save the child's life or prevent serious damage to health, or with the approval of the Guardianship Tribunal which must apply similar criteria when determining whether to give consent.

A person under 16 is entitled to be legally represented in proceedings before the Guardianship Tribunal. This representation is available free of charge through Legal Aid, with no means or merit tests applied.

Under the provisions of the *Guardianship Act 1987,* only the Guardianship Tribunal can consent to 'special treatment' of a person aged over 16 who is incapable of giving consent. Special treatment is defined to include 'any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out.'

Two exceptions apply under the provisions this Act:

1. The guardian of a patient may also consent to the carrying out of continuing or further special treatment if the Tribunal has previously given consent to the carrying out of the treatment and has authorised the guardian to give consent to the continuation of that treatment or to further treatment of a similar nature.
2. If the medical practitioner carrying out or supervising the treatment considers the treatment is necessary, as a matter of urgency to save the patient's life or to prevent serious damage to the patient's health.

The *Guardianship Act 1987* requires that the Tribunal must not consent to the carrying out of the treatment unless it is satisfied that it is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being. Further, the Tribunal must not give consent to special treatment unless it is satisfied that the treatment is necessary to save the patient's life or to prevent serious damage to the patient's health.

The combined effect ofthe *Children and Young Persons (Care and Protection) Act 1998* and the *Guardianship Act 1987* is that no person under 16, regardless of competence, nor persons over 16 who are incapable of giving consent, can consent to a non-therapeutic sterilisation. Under this legal framework, it is beyond the scope of parents' or guardians' powers to consent on behalf of a child. Significant penalties of imprisonment for up to 7 years apply to persons who carry out unauthorised sterilisations under both Acts.

Decisions of the Tribunal about sterilisation or termination can be appealed to the Supreme Court of NSW which has the power to review such decisions and to set them aside or to make orders in substitution if it thinks fit.

**Victoria**

Victorian legislation provides that involuntary treatments such as sterilisations and abortions can only be carried out by order of the Victorian Civil and Administrative Tribunal (VCAT).

Under the Victorian *Guardianship and Administration Act 1986* a 'special procedure' is defined to include: 'any procedure that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out'; 'termination of pregnancy'; and 'any removal of tissue for the purposes of transplantation to another person'.

The *Guardianship and Administration Act 1986* sets out the manner in which the VCAT may consent to the performance of a 'special procedure' where the person in question is unable to give consent and the procedure would be in the patient's best interests. This Act only applies to a person who is aged 18 years of over.

The Victorian Office of the Public Advocate (OPA) must be given notice of any application and is entitled to participate in the case. The OPA's role in these applications is to assist VCAT to make a decision that is in a person's best interests by gathering information about the person's disability and their ability to make decisions about the proposed special procedure. The OPA is also occasionally involved as an amicus curiae, and sometimes even as a party, in Family Court cases where medical treatment decisions concerning children are being considered.

A decision of the Tribunal is reviewable by the superior courts. The *Guardianship and Administration Act 1986* provides quite severe penalties for any medical practitioner who carries out a special procedure without having obtained the proper consent.

While the *Guardianship and Administration Act 1986* is currently being reviewed by the Victorian Law Reform Commission, there is no indication at present that the Commission will make any recommendations to reform the provisions relating to obtaining consent for forced sterilisations and abortion.[[323]](#footnote-323)

**Queensland**

In Queensland where a health service or treatment is provided without a person's consent, the provider of the service may be liable to a criminal or civil prosecution. Where an adult has impaired capacity, a comprehensive substitute decision-making regime is established to provide the consent. For special health matters, such as a termination of pregnancy, sterilisation, removal of tissue while the adult is still alive, and participation in special medical research or experimental health care, only a Tribunal may provide consent for such a health matter and only in specified circumstances. These circumstances ensure that the adult's rights and interests are protected.

Queensland, like NSW, has an independent expert tribunal and separate legal representation of the child is provided by legal aid at no cost to the child. In Queensland, the Tribunal may consent to sterilisation of a child where:

* it is medically necessary;
* the child is likely to be sexually active and there is no reasonable method of contraception;
* the female child has menstruation problems and sterilisation is the only practicable way of overcoming the problems.

Further, the sterilisation cannot be reasonably postponed and must otherwise be in the child's best interests.

The Queensland medico-legal fraternity is well aware of the precedent set in *Marion's Case.* The requirement for permanent surgical sterilisation to deal with issues of fertility and menstrual problems in women with disabilities has been virtually eliminated by the availability of long acting, reversible implants referred to in the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Guidelines, see page 20.

**Western Australia**

In Western Australia, there is no specific legislation concerning the sterilisation of children.

At common law, a child is capable of giving informed consent to medical treatment, including therapeutic and non-therapeutic sterilisation, when he or she is sufficiently mature and intelligent to understand fully the implications of the treatment proposed. Where a particular child, whether because of intellectual disability, or simply youth or immaturity, is incapable of giving a valid consent, then his or her parents (or other guardians) are authorised to consent to medical treatment, including therapeutic sterilisation. However, court authorisation is necessary for non-therapeutic sterilisation *(Marion's Case).* The criterion to be applied by a court with the necessary jurisdiction, is whether carrying out the procedure is in the best interests of the child.

The Western Australian *Guardianship and Administration Act 1990* requires that the consent of the State Administrative Tribunal is obtained for an adult with a decision-making disability who lacks capacity to give or refuse consent to sterilisation. A person has a right of appeal to the Supreme Court or Court of Appeal, and sterilisation is not able to proceed until all rights have been exhausted. Following the conclusion of any appeals, the treating doctor must have written consent from both the State Administrative Tribunal and the guardian.

In Western Australian, a therapeutic sterilisation (in very general terms) is a sterilisation which is the incidental result of surgery or treatment appropriately carried out to cure a disease or treat an injury whereas non-therapeutic sterilisation involves surgery or treatment carried out for the purpose of rendering the person infertile.

In relation to adults, the *Guardianship and Administration Act 1990* places limitations on the sterilisation of persons who are under guardianship and lack the capacity to consent to treatment. Under the *Guardianship and Administration Act 1990,* a person is prohibited from carrying out or taking part in any procedure for the sterilisation of a represented person, unless both the guardian and the State Administrative Tribunal have provided written consent to the sterilisation and all rights of appeal have lapsed or have been exhausted. The Tribunal may only consent to the sterilisation of a represented person if it is satisfied that it is in the best interests of that person. In addition to the guardianship provisions, the *Guardianship and Administration Act 1990* also provides that a person responsible (i.e. partner, closest adult relative or friend, or unpaid primary care provider) for a patient who is unable to make reasonable judgments in respect of any treatment proposed, cannot consent to the sterilisation of the patient.

A civil action in trespass and a criminal prosecution for assault may be brought against a health professional if medical treatment is given without consent. However, section 259 of the Western Australian *Criminal Code Act 1913* removes criminal responsibility for the administration in good faith of medical treatment for a person's benefit if the treatment is reasonable, having regard to the person's state at the time and to all the circumstances of the case.

King Edward Memorial Hospital (KEMH) is Western Australia's public tertiary maternity, neonatal and gynaecological hospital. KEMH medical staff follow RANZCOG guidelines and refer cases where appropriate to the State Guardianship Board via the hospital's social work department. These generally include those patients requiring therapeutic sterilisation such as hysterectomy for menorrhagia

The Western Australian Health Hospital Morbidity Data System does not record any cases that are coded as non-therapeutic sterilisation in combination with a disability code. This includes both private and public hospital data.

**South Australia**

The South Australian *Guardianship and Administration Act 1993* has provision to approve sterilisations where by reason of their mental incapacity (defined as: inability to look after his or her own health, safety or welfare...as a result of damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration of the brain or mind, or any physical illness or condition that renders the person unable to communicate his or her intentions or wishes) the person is deemed to be unable to make the decision for themselves.

Section 5 of the *Guardianship and Administration Act 1993* allows certain relatives to provide consent for medical or dental treatment , unless the treatment is defined as a 'prescribed treatment,' which is treatment that must not be carried out without the written consent of the South Australian Guardianship Board.

Under the *Guardianship and Administration Act 1993* 'prescribed treatment' includes medical treatments such as sterilisation and termination of pregnancy. In order for the South Australian Guardianship Board to approve 'prescribed treatment' it must satisfy the criteria in section 61.

The criteria include non-therapeutic treatment such as:

* No method of contraception that could ... reasonably be expected to be successfully applied; (Section 61(2)).
* Cessation of her menstrual cycle would be in her best interests (Section 61(2)).

**Tasmania**

The *Guardianship and Administration Act 1995* provides a comprehensive and flexible statutory scheme for the authorisation and approval of medical and dental treatment for persons with a disability who are incapable of giving or refusing consent to treatment. The *Guardianship and Administration Act 1995* gives authority for the 'person responsible', who may be a spouse, carer or close friend of the person unable to give consent, to provide a substitute consent. However, the Guardianship and Administration Board (the Board) must consent to some types of very serious treatments, such as sterilisation.

The *Guardianship and Administration Act 1995* defines sterilisation as 'any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out' and makes it a special treatment under section 3. The Board's jurisdiction to deal with applications to consent to special treatment is provided by sections 44, 45 and 46 of the *Guardianship and Administration Act 1995.* The Board's jurisdiction usually extends only to adults with disability, however in the area of sterilisation, the Board is the only body who may consent to this treatment for any person with a disability, including minors.

In giving consent, the Board must observe the principles set out in Section 6 of the *Guardianship and Administration Act 1995* which states:

'...a function or power conferred, or duty imposed, by this Act is to be performed so that -

1. the means which is the least restrictive of a person's freedom of decision and action asis possible in the circumstances is adopted; and
2. the best interests of a person with a disability or in respect of whom an application is made under this Act are promoted; and
3. the wishes of a person with a disability or in respect of whom an application is made under this Act are, if possible, carried into effect.

Section 45 of the *Guardianship and Administration Act 1995* sets out the following conditions upon which the Board may grant consent:

1. On hearing an application for its consent to the carrying out of medical or dental treatment the Board may consent to the carrying out of the medical or dental treatment if it is satisfied that-

(a) the medical or dental treatment is otherwise lawful; and

(b) that person is incapable of giving consent; and

(c) the medical or dental treatment would be in the best interests of that person.

1. For the purposes of determining whether any medical or dental treatment would be in the best interests of a person to whom this Part applies, matters to be taken into account by the Board include-

(a) the wishes of that person, so far as they can be ascertained; and

(b) the consequences to that person if the proposed treatment is not carried out; and

(c) any alternative treatment available to that person; and

(d) whether the proposed treatment can be postponed on the ground that better treatment may become available and whether that person is likely to become capable of consenting to the treatment; and

(e) in the case of transplantation of tissue, the relationship between the 2 persons concerned; and

(f) any other matters prescribed by the regulations.

**Australian Capital Territory**

The ACT Government does not support non-therapeutic, forced sterilisation on young girls and women with disabilities. The Canberra Hospital does, however, recognise the need where these young girls and women become extremely distressed with the management of their menstrual cycle, to implement appropriate medication management that may inhibit or decrease their symptoms related to menstruation, with their consent or their carers' consent.

The ACT *Power of Attorney Act 2006* can appoint power of attorney to make medical decisions in the event that an individual loses capacity. Under this Act, an adult can grant another adult an enduring power of attorney to make decisions for a person with impaired decision-making capacity, as defined by this Act. Individuals to whom a power of attorney has been granted may not exercise power in relation to 'special health care matters'. Special health care matters are defined by Section 37 of this Act to be:

(a) removal of non-regenerative tissue from the principal while alive for donation to someone else;

(b) sterilisation of the principal if the principal is, or is reasonably likely to be, fertile;

(c) termination of the principal's pregnancy;

(d) participation in medical research or experimental health care;

(e) treatment for mental illness;

(f) electroconvulsive therapy or psychiatric surgery;

(g) health care prescribed by regulation.

If a person cannot give their own consent (i.e. if they have an 'impaired decision making ability') for a prescribed treatment, an ACT Civil and Administrative Tribunal (ACAT) order is required. The law applicable to ACT adult residents unable to provide informed medical consent is the *Guardianship and Management of Property Act 1991.* Under this Act, sterilisations and other matters are referred to as prescribed medical procedures and such medical determinations may only be made by the ACAT. ACAT is required to give consideration to the following:

(a) the procedure is otherwise lawful; and

(b) the person is not competent to give consent and is not likely to become competent in the foreseeable future; and

(c) The procedure would be in the person's best interests; and

(d) The person, the guardian and any other person whom the ACAT considers should have notice of the proposed procedure are aware of the application for consent.

In addition, for prescribed medical procedures including sterilisation, legislation requires that:

1. The ACAT must appoint the person's guardian, or the public advocate or some other independent person, to represent the person in relation to the hearing relating to the consent.
2. In deciding whether a particular procedure would be in the person's best interests, the matters that the ACAT must take into account include:

(a) The wishes of the person, so far as they can be ascertained; and

(b) What would happen if it were not carried out; and

(c) What alternative treatments are available; and

(d) Whether it can be postponed because better treatments may become available; and

(e) For a transplantation of tissue-the relationship between the 2 people and other matters.

Compulsory treatment and intervention can only be used when the legislation is satisfied either under the *Crimes Act* or the *Mental Health (Treatment and Care) Act.* Safeguards include criteria-based treatment and intervention, the capacity to review decisions, transparency in decision making, and the statutory requirement for periodic review, procedural fairness mechanisms, and the person to whom the compulsory measures are taken being afforded representation.

Oversight agencies, such as the Public Advocate, also play a role in educating the community about special medical procedures and the legal requirements that must be followed, and about the rights of all girls and women, particularly girls and women who are unable to provide informed medical consent.

**Northern Territory**

In the NT sterilisation procedures are governed by two separate systems; one for adults and one for children.

**Adults**

NT legislation does allow for sterilisation to be carried out however only in a situation where the consent of the court is obtained.

Section 21(2) of the *Adult Guardianship Act* (NT) provides that a medical practitioner or dentist must not carry out a 'major medical procedure' on a 'represented person' unless the consent of the court has been obtained.

A 'represented person' is an adult in respect of whom an adult guardianship order is in effect. An adult guardianship order is only made under section 15 of the *Adult Guardianship Act* if the court is satisfied the person is under an intellectual disability and in need of an adult guardian.

Medical procedures relating to contraception or the termination of a pregnancy, are defined as 'major medical procedures' under section 21(4)(b) of the *Adult Guardianship Act.*

Section 21(8) of the *Adult Guardianship Act* provides that the court must be satisfied that the sterilisation procedure would be in 'the best interests' of the represented person before making the order. The currently used 'best interest' test is the common law test formulated by the Family Court in *Marion 's Case.* Under section 21(8) if the court is satisfied on hearing an application under this section that it would be in the best interest of the represented person, it may, by order, consent to the major medical procedure.

The Court, in considering whether to make an order for a major medical procedure to be undertaken, will take into account the best interests of the adult. The court must also ascertain the wishes of the represented person as far as is reasonably possible (section 21(6)). Section 21(7) of the *Adult Guardianship Act* provides that, subject to section 21(8)- the 'best interest' test, if the court is satisfied that the represented person understands the nature of the proposed major medical procedure and is capable of giving or refusing consent to that procedure, the court shall give effect to the represented person's wishes.

**Children**

Where a child is incapable of giving consent (due to an intellectual disability or immaturity), the NT follows the common law as laid down by the HCA in *Marion's Case.* Only the Family Court may give consent for a child to undergo sterilisation for non-therapeutic purposes (i.e. otherwise than as a by-product of surgery appropriately carried out to treat a malfunction or disease).

**Emergencies**

Under the *Emergency Medical Operations Act* (NT) there is no need for authorisation if a medical practitioner believes that waiting for authorisation, to carry out the procedure from the courts, would be harmful to the patient or result in the death of the patient. Similarly the *Adult Guardianship Act* provides that section 21 does not apply in respect of any medical or dental procedure carried out on any person in an emergency where the medical or dental procedure appears necessary to save the life of that person.

It is noted that:

* Section 60 of the *Mental Health and Related Services Act* (NT) prohibits sterilisation as a treatment for those suffering from a mental illness or mental disturbance.
* Section 64 of the *Mental Health and Related Services Act* provides that a major medical procedure cannot be performed on a person who is an involuntary patient or subject to a community management order unless the Mental Health Review Tribunal has given its approval. Separate legal representation is also provided at no cost to a person who appears before the Tribunal.

**3. Please provide details of any actions to sanction medical staff carrying out illegal non-therapeutic, forced sterilisations of girls and women with disabilities, and where available, the results of any investigation and judicial or other inquiries carried out in relation to such cases. If no inquiries have been made, or if they have been inconclusive, please explain why.**

The Australian Government is not aware of any recent evidence concerning sterilisations of girls or women with disabilities that have been carried out in contravention of Australian law. Also, the 2006 SCAG review concluded that sterilisations of children with an intellectual disability had declined significantly in Australia since 1997. If such evidence were presented the Australian Government would be very concerned.

***Current Avenues for Sanction***

Under Australian law generally, there are a range of regulations and protections to ensure that medical practitioners are appropriately sanctioned in the event of a medical procedure being carried out in a manner that contravenes the law or disregards the rights of patients

**Sanctions of Medical Practitioners**

Medical practitioners in Australia are required to be registered by the Medical Board of Australia (MBA), in accordance with the *Health Practitioner Regulation National Law Act 2009* (National Law) as adopted in each State or Territory. The MBA is responsible for regulating the practice of the medical profession by registering practitioners, developing professional practice standards, overseeing the assessment of the skills of overseas trained practitioners and managing notifications and complaints against practitioners. The MBA is supported in its role by the Australian Health Practitioner Regulation Agency (AHPRA), an independent statutory agency.

The MBA has issued a code of conduct for doctors in Australia, entitled *Good Medical Practice: A Code of Conduct for Doctors in Australia.* This code articulates the ethical and professional conduct expected of all practitioners and has been developed to be consistent with the *Declaration of Geneva and the International code of Medical Ethics,* issued by the World Medical Association.

Where a medical practitioner's behaviour departs from the code of conduct, the MBA may take action against the practitioner. This action may take the form of cancelling the practitioner's registration, cautioning the practitioner, requiring an undertaking, placing conditions on the practitioner's registration or referring the matter to the health complaints entity in the relevant State or Territory. Where the MBA considers that a practitioner's conduct constitutes professional misconduct, the matter must be referred to a responsible tribunal in the relevant State or Territory. A tribunal may impose a range of sanctions, including suspension or cancellation of the practitioner's registration.

All tribunal outcomes are made available to the public online at:

<[http://www.ahpra.gov.au/Notifications-and-Outcomes/Hearing-Decisions.aspx>](http://www.ahpra.gov.au/Notifications-and-Outcomes/Hearing-Decisions.aspx)

Members of the public may report concerns about a medical practitioner's professional conduct to AHPRA. In addition, other health professionals regulated by the National Law, and employers of medical practitioners, are required to report a reasonable belief that a medical practitioner has placed the public at risk by practising in a way that significantly departs from accepted professional standards. The exception to this is that health professionals in WA are not bound by mandatory notification if the health professional in question is a client or patient, however they may still volunteer the information.

The notification process can be found in full detail online at:

[<http://www.ahpra.gov.au/Notifications-and-Outcomes/Notification-Process.aspx>.](http://www.ahpra.gov.au/Notifications-and-Outcomes/Notification-Process.aspx)

**Medicare Australia and inappropriate practice**

The Australian Government's Department of Human Services' (DHS) objective is to make sure payment of Medicare benefits is correctly made for services properly rendered. DHS operates a Health Provider Compliance function. The Health Provider Compliance function is responsible for preventing, detecting and investigating fraud and inappropriate practice.

Health Provider Compliance works with the health industry to:

* ensure the correct benefits are claimed for properly rendered services, and
* prevent and detect fraud and inappropriate practice with respect to claiming of benefits.

Health Provider Compliance applies a balance of education and compliance strategies to meet the requirements for the *Health Insurance Act 1973, National Health Act 1953,* and the *Medicare Australia Act 1973.*

IfDHS became aware of a claim made for a service that was ineligible for payment of benefits due to an unlawful act, then DHS may take the following actions:

* recover incorrectly paid benefits
* request the Director of Professional Services Review to review the provision of services under Medicare by the practitioner
* refer the matter to Australian Health Practitioner Regulation Agency (AHPRA), and
* refer the matter to the State or Australian Federal police in the relevant jurisdiction.

**State and Territory Sanctions**

In addition, in each of the States and Territories there are a number of schemes and systems which protect the rights of individuals by imposing sanctions where medical practitioners act inappropriately.

For example, the national Health Practitioner Registration and Accreditation Scheme (which is enacted in Victoria through the *Health Practitioner National Law (Victoria) Act 2009* provides the means for sanctions against registered health practitioners who act illegally or unprofessionally. The Victorian Government does not know if any procedures involving the sterilisation of girls and women with disabilities have been the subject of investigations or actions by the scheme.

**4. Please provide details of any actions to ensure that reparation, including compensation and rehabilitation, is provided to those girls and women with disabilities who may have been forcibly sterilised.**

As noted above, Australian Government is not aware of any recent evidence concerning sterilisations of girls or women with disabilities that have been carried out in contravention of Australian law. However, were such allegations to be proven, generally there are a number of avenues for redress under Australian law.

***Current Avenues for Redress***

Compensation can generally be sought in Australia through four different avenues. Victims can:

* receive a court-ordered payment from an offender as part of a criminal penalty after conviction, or
* issue proceedings for civil damages.

In the current context, under Commonwealth, State and Territory laws there are a range of statutory and common-law criminal and civil offences which deal with unauthorised medical procedures and medical negligence.[[324]](#footnote-324)

In Victoria, for example, the *Guardianship and Administration Act 1986* (VIC) provides quite severe penalties, including up to two years imprisonment and 240 penalty units (one penalty unit is $122.14), for any medical practitioner who carries out a special procedure without having obtained the proper consent.

At the request of the previous Attorney-General, the Attorney-General's Department is considering options for reform of the Australian legal framework around sterilisation procedures. The creation of sanctions for unauthorised or inappropriate sterilisations, and options for redress girls and women with disabilities who may have been sterilised without their informed consent, or the consent of a court or tribunal, is an issue under consideration. These issues will be raised these issues during discussions with States and Territories.

**5. Please provide details of any actions to ensure that informed consent requirements are adequately implemented for all medical interventions with regard to children and persons with disabilities.**

***Informed Consent***

There are a number of resources available in Australia to ensure that informed consent requirements are adequately implemented for medical interventions.

The discussions of the HCA in *Marion's Case* regarding the limits of parental authority, consent and medical interventions for children with disabilities have been considered and referenced by judicial officers in both sterilisation and other (non-sterilisation) cases to assist in their assessment of the consent requirements for medical interventions more broadly.[[325]](#footnote-325) In many cases the appointment, at the Court's discretion, of an independent advocate also helps to ensure that the interests of children or adults who cannot provide informed consent are directly represented alongside the wishes of their families or carers.

The States and Territories have also developed statutory frameworks to ensure that an individual's wishes are a primary consideration in decisions made about their health.

In the State of Victoria, for example, the *Guardianship and Administration Act 1986* expressly provides that it is the intent of the Victorian Parliament that any decision or action taken under that Act is the least restrictive of a person's freedom of decision and action; that the best interests of the person are promoted; and the wishes of the person are given effect to wherever possible.

To give effect to these principles Victorian Office ofthe Public Advocate (OPA) publishes a Practice Guideline to assist OPA staff in dealing with applications for special procedures. The Guideline sets out the legal framework surrounding special procedures and the evidentiary requirements to establish the capacity of the person, the medical need for the procedure, what less restrictive alternatives are available and have been tried, the wishes of the person and what is in their best interests.

In addition, both the Victorian Civil and Administrative Tribunal (VCAT) and OPA as public authorities are required to give proper consideration to and act compatibly with the relevant human rights set out in the *Charter of Human Rights and Responsibilities Act 2006* (VIC). This means when considering applications for special procedures OPA and VCAT must have regard to:

* Recognition and equality before the law as this right deals with discrimination.
* Protection from torture, and cruel, inhuman or degrading treatment as this deals with consent to medical treatment.
* Protection of families may be relevant to a person being able to have a family.
* Right to a fair hearing - ensuring that the person with the disability is properly heard at any hearing about the special procedure.

A number of Australian governments also produce guidance materials for non-legal practitioners. The Queensland Government for example, publishes *Health Policy Statements* advising medical professionals and the public of their rights and obligations - this includes the operation of informed consent requirements in relation to children and persons with disabilities.[[326]](#footnote-326)

In addition, there is also a wide variety of relevant guidance materials prepared by advisory groups, professional associations and non-government organisations, all of which assist in educating relevant professionals about the informed consent requirements so that they are adequately implemented.

**The Australian Medical Association (AMA)**

As the peak organisation representing the medical profession, the AMA develops policy solutions and provides responses to a broad range of health and medical issues of ongoing importance to Australia. The AMA has produced guidelines on a number of topics that stress the importance of informed consent, including but not limited to the *AMA Code of Ethics* - *2004 (Editorially Revised 2006),* and Guidelines on topics including Informed Financial Consent and Human Genetic Issues.[[327]](#footnote-327)

***Guidance on Sterilisation***

In addition to resources which assist with upholding informed consent requirements generally, there are also a number of resources to assist persons involved in applications for sterilisation.

**The Family Law Rules**

Guidance for judges in the Family Court can be found in the *Family Law Rules 2004* which make special provision in relation to applications for authorisation of a medical procedure. In particular, Rule 4.09(1) provides that 'if a Medical Procedure Application is filed, evidence must be given to satisfy the court that the proposed medical procedure is in the best interests of the child.'

Further, Rule 4.09(2) requires, under the heading 'Evidence supporting application,' that the evidence a court should consider in such cases:

'...must include evidence from a medical, psychological or other relevant expert witness that establishes the following:

(a) the exact nature and purpose of the proposed medical procedure;

(b) the particular condition of the child for which the procedure is required;

(c) the likely long-term physical, social and psychological effects on the child:

i. if the procedure is carried out; and

ii. if the procedure is not carried out;

(d) the nature and degree of any risk to the child from the procedure;

(e) if alternative and less invasive treatment is available -the reason the procedure is recommended instead of the alternative treatments;

(f) that the procedure is necessary for the welfare of the child;

(g) if the child is capable of making an informed decision about the procedure -whether the child agrees to the procedure;

(h) if the child is incapable of making an informed decision about the procedure-that the child:

i. is currently incapable of making an informed decision; and

ii. is unlikely to develop sufficiently to be able to make an informed decision within the time in which the procedure should be carried out, or within the foreseeable future;

(i) whether the child's parents or carer agree to the procedure.'

Together with the HCA's decision in *Marion's Case,* these Rules provide guidance as to the factors the Family Court should consider when determining whether it is in the best interests of a child to authorise the performance of a sterilisation procedure on that child.

**The Australian Guardianship and Administration Council (AGAC)**

The AGAC provides a national forum for State and Territory agencies that protect adults with a decision-making disability through adult guardianship and administration.

In May 2009, the AGAC issued the *Protocol for Special Medical Procedures (Sterilisation),* which assists the various guardianship tribunals to exercise their decision-making power to promote consistency across jurisdictions when dealing with an application for the sterilisation of a person.

The Protocol, which is periodically reviewed, explains that:

1.1 'In all States and Territories of Australia, sterilisation is considered to be such an invasive and irreversible procedure, that where a person cannot give a valid consent to the procedure, an entity such as the Family Court, a state supreme court or guardianship tribunal is the only authority that can provide consent. Further, because of the invasive and irreversible nature of the procedure, the law in all States and Territories provides that, unlike many other medical procedures, a person's normal substitute decision­ maker for medical and dental treatment cannot make the decision about sterilisation.

1.2 For adults with impaired decision-making abilities, consent to the procedure was, and is, given or refused by the State or Territory tribunals that deal with capacity, guardianship and administration issues.

1.3 For children, the question of sterilisation is a matter for the Family Court of Australia, however the tribunals of four States also have this jurisdiction.

The Protocol specifically notes that it is intended to assist all persons including 'applicants, potential applicants, relevant professionals and members of the public in understanding the decision-making process and what is required of them in bringing, or objecting to an application to sterilise a person.'[[328]](#footnote-328)

**RANZCOG Guidelines**

The Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG), whose primary role is to train and accredit doctors in the specialities of obstetrics and gynaecology, have produced guidelines on *'Sterilisation procedures for women with an intellectual disability'* (C-Gyn 10).

The RANZCOG guidelines state the following:

* In addressing the issues of fertility control for women with an intellectual disability, the least restrictive option and approaches which are similar to those one would consider for women of the same age but without intellectual disability, are the most appropriate.
* Reversible methods such as long acting reversible contraceptive implants (e.g. Implanon or Mirena) should be considered in preference to irreversible surgical options.
* The administration of treatment to a woman with intellectual disabilities must be in accordance with the current law and guardianship provisions of the relevant jurisdictions.[[329]](#footnote-329)

***Guidance on the Rights of Patients***

The Australian jurisdictions also have a detailed system that sets out the rights of health care patients regardless of the medical issue they are experiencing.

**The Australian Charter of Healthcare Rights**

The Australian Commission on Safety and Quality in Health Care (the Health Care Commission) identified a need for a national Charter of patient rights in 2007, in order to build trust in the healthcare system and assist the development of mature and balanced relationships between patients and providers based on a shared understanding of their rights and responsibilities. Following extensive consultation, the Health Care Commission developed the *Australian Charter of Healthcare Rights* (the Charter). The Charter was endorsed by Australian Health Ministers in July 2008.[[330]](#footnote-330)

The purpose of the Charter is to provide information about the rights of patients and consumers to underpin the provision of safe and high quality care, and to support a shared understanding of the rights of people receiving care. The Charter applies in all health care settings including public hospitals, general practice and other ambulatory care environments.

Although each State and Territory has existing patient charters, the national Charter addresses jurisdictional variations and is uniformly applicable in all settings in which healthcare is delivered.

The Charter specifies the key rights of patients and consumers when seeking or receiving health care services. These are: safety, respect, communication, participation, privacy, comment and access. Briefly, the key rights of respect, communication and participation explicitly state that patients have the right to be:

* shown respect, dignity and consideration. The care provided shows respect to the patient, their culture, beliefs, values and personal characteristics
* informed about services, treatment, options and costs in a clear and open way. The patient receives open, timely and appropriate communication about their health care in a way that they can understand, and
* included in decisions and choices about their care.

Under the *National Health Reform Agreement,* signed on 2 August 2011, all States and Territories have agreed the following requirements in relation to patients' rights:

* to prepare and distribute a Public Patients' Hospital Charter (the Charter), in appropriate community languages to users of public hospital services
* to maintain complaints bodies independent of the public hospital system to resolve complaints made by eligible persons about the provision of public hospital services received by them
* to develop the Charter in appropriate community languages and forms to ensure it is accessible to people with disabilities and from non-English speaking backgrounds
* to develop and implement strategies for distributing the Charter to public hospital service users and carers
* to adhere to the Charter
* the Charter will be promoted and made publicly available whenever public hospital services are provided, and
* the Charter will set out a statement of the rights and responsibilities of consumers and public hospitals in the provision of public hospital services in States and the mechanisms available for user participation in public hospital services.[[331]](#footnote-331)

**6. What measures are being taken to ensure the enjoyment of the right to health of girls and women with disabilities?**

The Australian Government has a strong commitment to initiatives that improve the health and wellbeing of people with disabilities, including girls and women, both domestically and internationally. The following initiatives, whilst more broadly targeted at improving the enjoyment of all rights of persons with disabilities, contribute significantly to the enjoyment of the right to health of girls and women with disabilities.

***The National Disability Strategy***

Australia has developed a comprehensive national action framework that aims to improve the lives of people with disability, promote participation, and create a more inclusive society.

The National Disability Strategy 2010-2020 (the NDS) was launched by the Australian Government on 18 March 2011. This represents the first time in Australia's history that all levels of governments have committed to a unified, national approach to improving the lives of people with disability, their families and carers.

The NDS's ten-year framework will guide public policy across governments and aims to bring about changes to all mainstream services and programs, as well as community infrastructure, to ensure they are accessible and responsive to the needs of people with disability. This change is important to ensure that people with disability have the same opportunities as other Australians -a quality education, good health, economic security, a job where possible, access to buildings and transport, and strong social networks and supports. The NDS will also be an important mechanism to ensure that the principles underpinning the CRPD are incorporated into policies, services and programs affecting people with disability, their families and carers.

The NDS acknowledges that people with a long-term disability are among the most disadvantaged and invisible groups in our community, with comparatively poor health status and a health system that often fails to meet their needs. This includes people with an intellectual disability, as well as people with other long-term physical and mental conditions, whether present at birth or acquired later in life. These poorer health outcomes include aspects of health that are unrelated to the specific health conditions associated with their disability.

Consequently, one of the central outcomes of the NDS is to ensure that people with disability attain the highest possible health and wellbeing outcomes throughout their lives. The NDS commits to a range of Areas for Future Action designed to achieve this outcome. These action areas focus on:

* improving the interface between disability services and key health services in local communities
* strengthening the continuity and coordination of care
* addressing issues specific to people with disability as part of key national health strategies, such as dental, nutrition, mental health, and sexual and reproductive health programs, and
* ensuring informal and supported decision makers are part of the preventive, diagnostic and treatment programs where appropriate, always ensuring the rights of the individual are respected and protected.

While the NDS aims to improve the lives of all Australians with disability, it recognises that people with disability have specific needs based on their personal circumstances, including the type and level of support required, gender, age, education, sexuality, and ethnic or cultural background. In particular, it recognises that gender can significantly impact on the experience of disability and women and girls with disability often face different challenges by reason of their gender.[[332]](#footnote-332)

***National Women's Health Policy 2010***

The National Women's Health Policy 2010 (the Policy), released in December 2010, aims to provide a framework to improve the health and wellbeing of all women in Australia, especially those at the greatest risk of poor health, through addressing particular health issues, focusing on the social determinants of health inequities and encouraging the health system to be more responsive to women.

The Policy was developed through an extensive consultation process with a wide range of key women organisations, including Women With Disabilities Australia (WWDA), the peak organisation for women with all types of disabilities in Australia.

The Policy identifies women with disabilities as being one of the groups which are at greater risk of poor health as health is determined by a broad range of social, cultural, environmental, economic factors, as well as the genetic and biological factors.

The Policy seeks to understand health within its social context and is based on a gendered approach that is inclusive of a social view of health, and accounts for the diversity in women's experiences. The social model of health acknowledges the complex ways that the context of a woman's life- including her gender, age, socio-economic status, ethnicity, sexuality, disability and geography- might shape her health outcomes; access to health care; experiences of health, wellbeing and illness; and even her death. Addressing these social determinants is a fundamental step towards reducing health inequalities.

***National Health Reform***

To ensure that the health system is more responsive to the needs of individuals and local communities, the Australian Government is establishing a coordinating network of primary health care organisations called Medicare Locals. Medicare Locals comprise a major component of the Government's National Health Reform agenda, and are critical to supporting and driving improvements in primary health care for both patients and health care providers.

Medicare Locals will provide all patients with increased access to information regarding services available in their local area and make it easier for patients to navigate their local health care system.

Medicare Locals will support primary health care professionals and organisations to identify and address local health care needs, and improve the delivery of integrated primary health care services.

As they develop, each Medicare Local will develop plans for its particular population and its health needs, including preventive health activities. Primary health care providers will work with Medicare Locals to incorporate women's health into the implementation of initiatives to improve the prevention and management of disease in general practice and primary health care.

The Australian Government also supports women's acute care health services by contributing to the funding of Australia's public hospitals which are administered by the State and Territory Governments. These public hospitals include eleven large hospitals dedicated to the provision of services to women and/or children.

The reforms, agreed to by the Council of Australian Governments (COAG) in February, were finalised on 2 August 2011. This Agreement will invest an extra $19.8 billion in public hospitals through to 2019-20, rising to a total extra $175 billion to 2029-30 matched by tough national standards. In this way, the Agreement will benefit women by funding the provision of better public hospital services, including those delivered by the eleven dedicated women and children's hospitals.

Further opportunities for implementing the *National Women's Health Policy 2010* will be considered in the context of National Health Reform.

***The National Disability Insurance Scheme (NDIS)***

On 10 August 2011 the Prime Minister released the Productivity Commission's[[333]](#footnote-333) final report into care and support for people with disability. The Government asked the Productivity Commission to examine reform of disability support services because the Australian Government believes that the system we have today is not delivering the kind of care and support Australians expect for people with disability.

The Productivity Commission has recommended a NDIS that would entitle all Australians to support in the event of significant disability. The Productivity Commission has also recommended a separate National Injury Insurance Scheme (NIIS) to provide no-fault insurance for anyone who suffers a catastrophic injury. The Productivity Commission made clear in its report that there is a lot of work ahead to prepare for a trial of a scheme in 2014.

The Australian Government shares the vision of the Productivity Commission for a system that provides people with disability with the care and support they need over the course of their lifetime. The Commonwealth Government has started work- with States and Territories that are principally responsible for funding and delivering disability support services -to fundamentally reform disability care and support. Work is underway to lay the foundations which are essential for the launch of a National Disability Insurance Scheme. This includes working with the States and Territories to:

* Develop common assessment tools, so people's eligibility for support can be assessed fairly and consistently, based on their level of need.
* Put in place service and quality standards, so that people with disability can expect high quality support irrespective of what disability they have or how they acquired it.
* Build workforce capacity so we have more trained staff to support people with disabilities.[[334]](#footnote-334)

***The National Strategy for Young Australians***

The *National Strategy for Young Australians* sets out the Australian Government's vision for young people 'to grow up safe, healthy, happy and resilient and to have the opportunities and skills they need to learn, work, engage in community life and influence decisions that affect them.' The *National Strategy for Young Australians* will help guide future Australian Government policies and initiatives for young people, including consideration of groups at risk such as young people with a disability, those with mental health issues and young people exiting care.

***Specialised Services***

The Commonwealth, State and Territory governments work together to deliver a wide range of specialist disability services for Australians, including girls and women, through the *National Disability Agreement* (NDA).

Under the NDA, the Commonwealth Government has responsibility for employment and income support payments such as Disability Support Pension. Other specialist services are the responsibility of State and Territory governments. Specialist disability services are accessed by Australian women and men on an equal basis, and are based on functional needs rather than diagnosis.

From 1 January 2009 to 30 June 2015, the Commonwealth Government will be providing around $7.6 billion in funding to the State and Territory governments for increased and improved specialist disability services such as supported accommodation, targeted support and respite. The Agreement means that in 2014-2015, the Commonwealth Government's contribution will be around $1.4 billion, compared to $620 million in 2006-07.

***Recognition and Support for Carers***

The Australian Government recognises the very important role played by Australians who are the carers of girls and women with disabilities. Following public consultation, in August 2011 the Australian Government launched, the National Carer Strategy (NCS). The NCS represents the Australian Government's long term commitment to carers. It will guide future reforms, and it builds on reforms the Government is already delivering to better support carers.

There is wide appreciation in the community that the majority of carers who support girls and women with disabilities are women. The Australian Government has adopted several recent initiatives to ensure improved support to carers; and hence to ensure improved enjoyment of the right to health of girls and women with disabilities.

The Australian Government has also recently put in place legislation that formally recognises the role of carers, *Carer Recognition Act 2010.*

***Support for Non-Government Organisations for People with Disability***

The Australian Government is committed to encouraging participation in and working with non-governmental organisations, peak bodies and associations including those that have a focus on people with disability. These peak bodies represent many types of disabilities, as well as the interests of particular demographic groups of people with disability, for example children and women.

These bodies consult with people with disability and draw on the resources of their member organisations to provide the Australian Government with the perspective of the people with disability they represent. Engagement with these bodies is essential to ensuring that people with disability are consulted and involved in decision-making processes concerning issues relating to people with disability. This includes health issues.

Government support for non-government organisations, whilst more broadly targeted, contributes significantly to the enjoyment of the right to health of girls and women with disabilities.

**The Annual Non-Government Organisation (NGO) Forum**

Recognising the important role played by non-governmental organisations and as part of Australia's Human Rights Framework, an Australian Government NGO Forum on Human Rights is hosted annually by the Commonwealth Attorney-General and the Minister for Foreign Affairs and Trade. The NGO Forum is a key opportunity for comprehensive dialogue on a range of domestic and international human rights issues, including health issues, between the Australian Government and civil society.

**Consultation with women with disabilities on issues that affect them**

The Australian Government provides funds WWDA, the peak body representing women with disabilities in Australia. WWDA is funded to contribute to government policies about disability issues affecting Australian families and communities, to carry information between the Government and the community on social policy issues and to represent the views of its constituents.

WWDA's work is grounded in a human rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. This rights based approach recognises that equal treatment, equal opportunity, and non­discrimination provide for inclusive opportunities for women and girls with disabilities in society.

WWDA also seeks to create greater awareness among governments and other relevant institutions of their obligations to fulfil, respect, protect and promote human rights and to support and empower women with disabilities, both individually and collectively, to claim their rights.

The Australian Government also funds six National Women's Alliances, which work collaboratively to provide informed and representative advice to government on policy development and implementation relevant to the diverse views and circumstances of women. WWDA is an active member organisation of both the Equality Rights Alliance and the Economic Security for Women Alliance

***State and Territory Examples of Measures to Ensure the Right to Health***

Provided below is an example of some of the wide range of projects and programs being implemented by State and Territory Governments that also aim to improve the health and wellbeing of people with disabilities, including girls and women. This information is intended to supplement the information about the federal initiatives listed above, and provide a 'case study' of the important work being done by State and Territory Governments to advance and protect the human rights of people with disabilities.

**Victoria**

The Disability Services Division (DSD), of the Victorian Department of Human Services is working to increase the capacity of both the disability service and the family violence sectors to respond to family violence for women with a disability. This includes the *Disability and Family Violence Crisis Response* initiative which will assist women with a disability experiencing family violence who may require immediate disability support to access specialist family violence services while exploring longer term housing and support options. Short term funding will be available to meet immediate needs where required.

In addition, DSD has been working with the Department of Health to improve the outcomes for people with a disability. In particular there has been a focus on strengthening the communication and working relationship between regional Disability Services and Health Services. The aim is to ensure that people with a disability are assisted via pathways to the most suitable forms of health and disability support.

The first Victorian population health survey in relation to people with an intellectual disability report was released in October 2011. This report represents a significant step forward in understanding the health and well being of Victorians with an intellectual disability. Its findings will better inform decisions about the priorities and health interventions aimed at this vulnerable group.

A key finding from the report was that Victorian women with an intellectual disability were less likely to have mammograms and Pap Tests, compared with women in the general population. To address this issue, a grant has been made available to the Cancer Council of Victoria to increase cancer screening participation of women with an intellectual disability.

In addition to these specific programs, there are external organisations that have a role in monitoring disability service providers to protect and promote the rights of people with a disability. They include:

* Victorian Public Advocate, Including the Community Visitors Program.
* Disability Services Commissioner (independent complaints body).
* Office of the Senior Practitioner (monitoring restrictive interventions).
* National abuse and neglect hotline.

Appendix 4: Terms of Reference

On 20 September 2012 the Senate referred the matter of involuntary or coerced sterilisation of people with disabilities in Australia to the Senate Community Affairs Committee for inquiry and report by 24 April 2013.

The **Terms of Reference** for the Inquiry are:

1. **The involuntary or coerced sterilisation of people with disabilities in Australia, including:**

(a) the types of sterilisation practices that are used, including treatments that prevent menstruation or reproduction, and exclusion or limitation of access to sexual health, contraceptive or family planning services;

(b) the prevalence of these sterilisation practices and how they are recorded across different state and territory jurisdictions;

(c) the different legal, regulatory and policy frameworks and practices across the Commonwealth, states and territories, and action to date on the harmonisation of regimes;

(d) whether current legal, regulatory and policy frameworks provide adequate:

1. steps to determine the wishes of a person with a disability,
2. steps to determine an individual’s capacity to provide free and informed consent,
3. steps to ensure independent representation in applications for sterilisation procedures where the subject of the application is deemed unable to provide free and informed consent, and
4. application of a ‘best interest test’ as it relates to sterilisation and reproductive rights;

(e) the impacts of sterilisation of people with disabilities;

(f) Australia’s compliance with its international obligations as they apply to sterilisation of people with disabilities;

(g) the factors that lead to sterilisation procedures being sought by others for people with disabilities, including:

1. the availability and effectiveness of services and programs to support people with disabilities in managing their reproductive and sexual health needs, and whether there are measures in place to ensure that these are available on a non-discriminatory basis,
2. the availability and effectiveness of educational resources for medical practitioners, guardians, carers and people with a disability around the consequences of sterilisation, and
3. medical practitioners, guardians and carers’ knowledge of and access to services and programs to support people with disabilities in managing their reproductive and sexual health needs; and

(h) any other related matters.

1. **Current practices and policies relating to the involuntary or coerced sterilisation of intersex people, including:**

(a) sexual health and reproductive issues; and

(b) the impacts on intersex people.

1. For more detailed information on Women With Disabilities Australia (WWDA), go to: <http://www.wwda.org.au> [↑](#footnote-ref-1)
2. See WWDA’s *Strategic Plan 2010 – 2015* at: <http://wwda.org.au/stratplan.htm> [↑](#footnote-ref-2)
3. See: *On The Record - A Report on the 1990 STAR Conference on Sterilisation: 'My Body, My Mind, My Choice'*. Edited by Fiona Strahan, Co-Editor Lois Brudenell. Available at: <http://www.wwda.org.au/record.htm> NB: The graphic used above is taken from the *On The Record* Report. [↑](#footnote-ref-3)
4. Commonwealth of Australia (2009) *A Stronger, Fairer Australia: National Statement on Social Inclusion.* Department of the Prime Minister and Cabinet, Canberra; McClelland, R. in Commonwealth of Australia (2010) *Australia’s Human Rights Framework,* Attorney-General’s Department, Canberra; Australian Government *Australian Values Statement*, Department of Immigration & Citizenship, available online at: <http://www.immi.gov.au/living-in-australia/values/statement/long/> Commonwealth of Australia (2007) *Life in Australia*; Department of Immigration & Citizenship, available online at: <http://www.immi.gov.au/living-in-australia/values/book/english/lia_english_full.pdf> [↑](#footnote-ref-4)
5. Roos, P. (1975) Psychological Impact of Sterilization on the Individual; *Law and Psychology Review*, Issue 45, pp.45-54. [↑](#footnote-ref-5)
6. ‘Forced/involuntary sterilisation’ refers to the performance of a procedure which results in sterilisation in the absence of the free and informed consent of the individual who undergoes the procedure - including instances in which sterilisation has been authorised by a third party, without that individual’s consent. Coerced sterilisation occurs when financial or other incentives, misinformation, misrepresentation, undue influences, pressure, and/or intimidation tactics are used to compel an individual to undergo the procedure. Coercion includes conditions of duress such as fatigue or stress. Undue influences include situations in which the person concerned perceives there may be an unpleasant consequence associated with refusal of consent. ‘Non-therapeutic sterilisation’ has been defined as sterilisation for a purpose other than to ‘treat some malfunction or disease’: *Secretary, Department of Health and Community Services v JWB and SMB*, 1992, 175 CLR 218; 106 ALR 385. For further discussion, see for example: Méndez, Juan. E, (2013) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN General Assembly; UN.Doc A/HRC/22/53; Dowse, L. & Frohmader, C. (2001) *Moving Forward: Sterilisation and Reproductive Health of Women and Girls with Disabilities*, A Report on the National Project conducted by Women with Disabilities Australia (WWDA), Canberra. See also: Brady, S., Briton, J., & Grover, S. (2001) *The Sterilisation of Girls and Young Women in Australia: Issues and Progress.* A report commissioned by the Federal Sex Discrimination Commissioner and the Disability Discrimination Commissioner; Human Rights and Equal Opportunity Commission, Sydney, Australia. Available at: [www.wwda.org.au/brady2.htm](http://www.wwda.org.au/brady2.htm); See also: WWDA, Human Rights Watch (HRW), Open Society Foundations, and the International Disability Alliance (IDA) (2011) *Sterilization of Women and Girls with Disabilities: A Briefing Paper.* Available at: <http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.pdf> [↑](#footnote-ref-6)
7. Centre for Reproductive Rights, European Disability Forum, InterRights, International Disability Alliance and the Mental Disability Advocacy Centre (2011) *Written Comments Submitted in the European Court of Human Rights: Joelle Gauer and Others [Applicant] Against France [Respondent]*, 16 August 2011. See also: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-7)
8. The United Nations Special Rapporteurs on Violence Against Women have asserted that forced sterilisation is a method of medical control of a woman’s fertility. It violates a woman’s physical integrity and security and constitutes violence against women. See: Manjoo, Rashida (2012) *Report of the Special Rapporteur on violence against women, its causes and consequences*; UN General Assembly; UN Doc. A/67/227; and also Radhika Coomaraswamy (1999), *Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences: Policies and practices that impact women’s reproductive rights and contribute to, cause or constitute violence against women*, (55th Sess.), E/CN.4/1999/68/Add.4 (1999), [para. 51]. [↑](#footnote-ref-8)
9. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*; UN General Assembly, UN Doc. A/HRC/7/3; Committee on the Rights of the Child (2011) *General Comment No. 13: Article 19: The right of the child to freedom from all forms of violence*; UN Doc. CRC/C/GC/13. [↑](#footnote-ref-9)
10. International NGO Council on Violence against Children (October 2012) *Violating Children’s Rights: Harmful practices based on tradition, culture, religion or superstition.* Accessed online October 2012 at: <http://www.crin.org/docs/InCo_Report_15Oct.pdf> [↑](#footnote-ref-10)
11. A State’s obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres. As underlined by the Committee against Torture, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors. See: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-11)
12. See: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit., [↑](#footnote-ref-12)
13. “*Jus cogens*, the literal meaning of which is "compelling law," is the technical term given to those norms of general international law that are argued as hierarchically superior. These are a set of rules, which are peremptory in nature and from which no derogation is allowed under any circumstances. The doctrine of international jus cogens was developed under a strong influence of natural law concepts, which maintain that states cannot be absolutely free in establishing their contractual relations. States were obliged to respect certain fundamental principles deeply rooted in the international community. The power of a state to make treaties is subdued when it confronts a super-customary norm of jus cogens. In other words, jus cogens are rules, which correspond to the fundamental norm of international public policy and in which cannot be altered unless a subsequent norm of the same standard is established. This means that the position of the rules of jus cogens is hierarchically superior compared to other ordinary rules of international law.” Taken from: Hossain, K. (2005) The Concept of Jus Cogens and the Obligation Under the U.N. Charter. *Santa Clara Journal of International Law*, Vol. 3, pp.72-98. As detailed in *Prosecutor v. Furundzija* “The jus cogens nature of the prohibition against torture articulates the notion that the prohibition has now become one of the most fundamental standards of the international community. States are obliged not only to prohibit and punish torture, but also prevent its occurrence and consequently, are bound to put in place all those measures that may pre-empt the perpetration of torture. See: International human rights law not only prohibits torture (as well as any inhuman and degrading treatment) but also prohibits (a) the failure to adopt the national measures necessary for implementing the prohibition and (b) the maintenance in force or passage of laws which are contrary to the prohibition. See International Criminal Tribunal for the Former Yugoslavia, *Prosecutor v. Furundzija,* Case IT-95-17/1-T; Judgement, 10 December 1998. [↑](#footnote-ref-13)
14. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., See also: Sifris, R. (2010) Conceptualising involuntary Sterilisation as ‘Severe Pain or Suffering for the Purposes of Torture Discourse. *Netherlands Quarterly of Human Rights*, Vol.28/4, pp.523-547. [↑](#footnote-ref-14)
15. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., [↑](#footnote-ref-15)
16. Sifris, R. (2010) Op Cit. [↑](#footnote-ref-16)
17. Ibid. [↑](#footnote-ref-17)
18. Centre for Reproductive Rights et al, Op Cit., Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit., [↑](#footnote-ref-18)
19. Ibid. [↑](#footnote-ref-19)
20. Committee on the Rights of the Child; Consideration of reports submitted by States parties under article 44 of the Convention*; Concluding observations: Australia*; Sixtieth session, 29 May–15 June 2012; CRC/C/AUS/CO/4; UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10; Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7; Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, *Concluding Observations: Australia*, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e). [↑](#footnote-ref-20)
21. Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit. [↑](#footnote-ref-21)
22. Dowse, L. and Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-22)
23. Dowse, L. (2004) *'Moving Forward or Losing Ground? The Sterilisation of Women and Girls with Disabilities in Australia'*. Paper presented to Disabled Peoples' International (DPI) World Summit, Winnipeg, September 8-10, 2004. Available online at: <http://www.wwda.org.au/steril3.htm> ; Steele, L. (2008) Making sense of the Family Court’s decisions on the non-therapeutic sterilisation of girls with intellectual disability; *Australian Journal of Family Law*, Vol.22, No.1.; Prilleltensky, O. (2003) A Ramp to Motherhood: The Experiences of Mothers with Physical Disabilities. *Sexuality and Disability,* Vol. 21, No. 1, pp. 21-47. [↑](#footnote-ref-23)
24. An extensive amount of this work is available on WWDA’s website. See: <http://www.wwda.org.au/sterilise.htm> [↑](#footnote-ref-24)
25. *Universal Declaration of Human Rights*; proclaimed by the United Nations General Assembly on 10 December 1948 General Assembly resolution 217 A (III). [↑](#footnote-ref-25)
26. Such a Task Force must include women with disabilities in its membership, and be chaired by a woman with a disability. [↑](#footnote-ref-26)
27. See for eg: The Nairobi Declaration on Women’s and Girls’ Right to a Remedy and Reparation. Available at: <http://www.redress.org/downloads/publications/Nairobi%20Principles%20on%20Women%20and%20Girls.pdf> [↑](#footnote-ref-27)
28. This includes laws, policies or programs that deny disabled women the right to found a family (including for eg: policies that deny access to assisted reproduction, adoption, surrogacy) and to maintain a family (eg: policies that enable removal of babies and children from parents with disabilities on the basis of parental disability). [↑](#footnote-ref-28)
29. This happens in two main ways: a) the child is removed by child protection authorities and placed in foster or kinship care; and b) a Court, under the *Family Law Act*, may order that a child be raised by the other parent who does not have a disability or by members of the child’s extended family. See: Victorian Office of the Public Advocate (OPA) (2012) *OPA Position Statement: The removal of children from their parent with a disability*. <http://www.publicadvocate.vic.gov.au/research/302/> [↑](#footnote-ref-29)
30. Through the Looking Glass (TLG) is a national disability community based non-profit organization providing research, training, and services for families in which a child, parent or grandparent has a disability or medical issue. TLG includes the *National Center for Parents with Disabilities and their Families* which provides an extensive range of services and support for parents with disabilities. TLG is nationally recognised for designing and fabricating baby care equipment for parents and other caregivers with disabilities, as well as studying the impact of this equipment on parenting. An adaptive equipment hire service is just one of the many services available. See: <http://www.lookingglass.org/> [↑](#footnote-ref-30)
31. For more information see: <http://www.ahpra.gov.au> [↑](#footnote-ref-31)
32. Grover, A., (2009) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* UN General Assembly, UN Doc. A/64/272. [↑](#footnote-ref-32)
33. Sterilisation which is performed in an emergency situation for life-saving purposes, like any life-saving procedure, is not considered to be forced sterilisation. See: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-33)
34. Centre for Reproductive Rights et al (2011) Op Cit. See also: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-34)
35. Dowse, L. and Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-35)
36. Women With Disabilities Australia (WWDA), Human Rights Watch (HRW), Open Society Foundations, & International Disability Alliance (IDA)(2011) *Sterilization of Women and Girls with Disabilities: A Briefing Paper* (November). Available online at: <http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.pdf> See also: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-36)
37. Brady, S. (2001) *The sterilisation of girls and young women with intellectual disabilities in Australia: An audit of Family Court and Guardianship Tribunal cases between 1992-1998*. Available online at: [www.wwda.org.au/brady2001.htm](http://www.wwda.org.au/brady2001.htm) [↑](#footnote-ref-37)
38. See: Commonwealth of Australia (1994) *Sterilisation and Other Medical Procedures on Children.* A report to the Attorney-General prepared by the Family Law Council. Available at: <http://www.ag.gov.au/Documents/sterilisation-and-other-medical-procedures.htm> See also: See also: Brady, S., Briton, J., & Grover, S. (2001) Op Cit. [↑](#footnote-ref-38)
39. Grover, A. (2011) *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. United Nations General Assembly; UN Doc. A/66/254. [↑](#footnote-ref-39)
40. Frohmader, C. & Meekosha, H. (2012) Recognition, respect and rights: Women with disabilities in a globalised world. In *Disability and Social Theory*, Edited by Dan Goodley, Bill Hughes and Lennard Davis, London: Palgrave Macmillan. [↑](#footnote-ref-40)
41. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Sterilise Please at 10:10 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-41)
42. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Kika at 9:47 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-42)
43. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by soap box dude at 11:13 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-43)
44. Morse, F. (2013) Colin Brewer Cornwall Councillor Says 'Disabled Children Should Be Put Down'. *The Huffington Post*, 27/02/2013. Accessed online February 2013 at: <http://www.huffingtonpost.co.uk/2013/02/27/cornwall-councillor-colin-brewer-disabled-children-put-down_n_2771826.html?utm_hp_ref=uk> [↑](#footnote-ref-44)
45. Cooke, E., et al, cited in Dowse, L. & Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-45)
46. Goldhar, J. cited in Dowse, L. & Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-46)
47. Department of Health and Community Services v JWB and SMB (Marion's Case) [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992). At: <http://www.austlii.edu.au/au/cases/cth/high_ct/175clr218.html> [↑](#footnote-ref-47)
48. ‘Non-therapeutic sterilisation’ is sterilisation for a purpose other than to ‘treat some malfunction or disease’: Secretary, Department of Health and Community Services v JWB and SMB, 1992, 175 CLR 218; 106 ALR 385. [↑](#footnote-ref-48)
49. Dowse, L. (2004) Op Cit. [↑](#footnote-ref-49)
50. Jones, M. and Basser Marks, L. (2000) Valuing People through Law: Whatever Happened to Marion? In M. Jones and L. A. Basser Marks (eds) *Explorations on Law and Disability in Australia.* Sydney, Federation Press. [↑](#footnote-ref-50)
51. Dowse, L. and Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-51)
52. Standing Committee of Attorneys-General (SCAG) (2004) *Issues Paper on the Non-Therapeutic Sterilisation of Minors with a Decision-Making Disability*. Available online at: [www.wwda.org.au/scagpap1.htm](http://www.wwda.org.au/scagpap1.htm) [↑](#footnote-ref-52)
53. Dowse, L. and Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-53)
54. Transcript from 2003 Four Corners (ABC TV) Documentary *‘Walk in Our Shoes’*. Available online at: <http://www.wwda.org.au/4corners.htm> [↑](#footnote-ref-54)
55. The Standing Committee of Attorneys-General (SCAG) was the national ministerial council made up of the Australian Attorney-General and the State and Territory Attorneys-General. SCAG provides a forum for Attorneys-General to discuss and progress matters of mutual interest. It seeks to achieve uniform or harmonised action within the portfolio responsibilities of its members. In 2011 the SCAG was re-named the Standing Council on Law and Justice (SCLJ). [↑](#footnote-ref-55)
56. Standing Committee of Attorneys-General (SCAG) Working Group (2006) *Draft 17: Children with Intellectual Disabilities (Regulation of Sterilisation) Bill 2006*. Available at: [www.wwda.org.au/sterbill06.pdf](http://www.wwda.org.au/sterbill06.pdf) [↑](#footnote-ref-56)
57. Standing Committee of Attorneys-General (SCAG) Working Group (2006) *Issues Paper on the Sterilisation of Intellectually Disabled Minors*. Available at: [www.wwda.org.au/scagpap2.htm](http://www.wwda.org.au/scagpap2.htm) [↑](#footnote-ref-57)
58. Standing Committee of Attorneys-General (SCAG) Working Group (2006) *Draft 17: Children with Intellectual Disabilities (Regulation of Sterilisation) Bill 2006*. Available at: [www.wwda.org.au/sterbill06.pdf](http://www.wwda.org.au/sterbill06.pdf) A number of Submissions provided to the SCAG Working Party in response to the Draft *Children with Intellectual Disabilities (Regulation of Sterilisation*) Bill 2006, are available on WWDA’s website at: <http://www.wwda.org.au/steriladv07.htm> [↑](#footnote-ref-58)
59. Standing Committee of Attorneys-General (SCAG) C*ommunique* 28 March 2008. [↑](#footnote-ref-59)
60. Ibid. [↑](#footnote-ref-60)
61. Correspondence to WWDA from WA Attorney-General Christian Porter MLA, 18 June 2009. [↑](#footnote-ref-61)
62. Australian Government (2009) *Response to the United Nations (UNESCAP) Questionnaire for Governments on Implementation of the Beijing Declaration and Platform for Action (BPFA) and the outcomes of the twenty-third special session of the General Assembly (2000)*. Accessed online February 2010 at:

    [www.unescap.org/ESID/GAD/Issues/Beijing+15/Responds\_to\_Questionnaire/Australia.pdf](http://www.unescap.org/ESID/GAD/Issues/Beijing+15/Responds_to_Questionnaire/Australia.pdf) [See page 14]. [↑](#footnote-ref-62)
63. Australian Government (2006) *Sterilisation of Women and Young Girls with an Intellectual Disability - Report to the Senate*. Tabled by the Minister for Family and Community Services and the Minister Assisting the Prime Minister on the Status of Women, December 6, 2000. Available online at: [www.wwda.org.au/senate.htm](http://www.wwda.org.au/senate.htm) [↑](#footnote-ref-63)
64. Hon Robert McClelland (Attorney-General) Correspondence to Women With Disabilities Australia (WWDA), 27 August, 2009. [↑](#footnote-ref-64)
65. Brady, S. and Grover, S. (1997) The Sterilisation of Girls and Young Women in Australia - A legal, medical and social context. Report commissioned by the Federal Disability Discrimination Commissioner for the Human Rights and Equal Opportunity Commission, December 1997. Available online at: <http://www.wwda.org.au/brady.htm> [↑](#footnote-ref-65)
66. Australian Government (2009) *Response to the United Nations (UNESCAP)* Op Cit. [↑](#footnote-ref-66)
67. Ibid. [↑](#footnote-ref-67)
68. Correspondence from WWDA to Hon Robert McClelland, Attorney General, February 24, 2010. [↑](#footnote-ref-68)
69. See for example: Re: Angela [2010] FamCA 98 (16 February 2010); HGL (No 2) [2011] QCATA 259 (19 September 2011);Gardner, J. (2003) cited in Transcript from 2003 Four Corners (ABC TV) Op Cit; Nicholson, Justice Alastair (2003) cited in Transcript from 2003 Four Corners (ABC TV) Op Cit; Australian Human Rights Commission (2012) *The Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, Australian Human Rights Commission Submission to the Senate Community Affairs References Committee; , also: Shepherd, T. (2013) South Australian disability advocates term forced hysterectomies as torture. *The Advertiser*, February 28, 2013. Accessed online February 2013 at: <http://www.adelaidenow.com.au/news/south-australia/south-australian-disability-advocates-term-forced-hysterectomies-as-torture/story-e6frea83-1226587191569> [↑](#footnote-ref-69)
70. Transcript from 2003 Four Corners (ABC TV) Op Cit. [↑](#footnote-ref-70)
71. Transcript from 2003 Four Corners (ABC TV) Op Cit. [↑](#footnote-ref-71)
72. Ibid. [↑](#footnote-ref-72)
73. Australian Government (2008) *Fourth Report under the Convention on the Rights of the Child: Australia*, October 2008, 159, p31. Accessed online August 2009 at: <http://www.ag.gov.au/www/agd/agd.nsf/Page/Humanrightsandantidiscrimination_ReportsundertheConventionontheRightsoftheChild> [↑](#footnote-ref-73)
74. WWDA’s formal complaint is available online at: <http://wwda.org.au/WWDA_Submission_SR2011.pdf> [↑](#footnote-ref-74)
75. Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; and Rashida Manjoo, Special Rapporteur on violence against women, its causes and consequences. See Appendix 2. [↑](#footnote-ref-75)
76. Committee on the Rights of the Child; Consideration of reports submitted by States parties under article 44 of the Convention*; Concluding observations: Australia*; Sixtieth session, 29 May–15 June 2012; CRC/C/AUS/CO/4; UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10; Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7; Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, *Concluding Observations: Australia*, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e). [↑](#footnote-ref-76)
77. Committee on the Rights of the Child; UN Doc. CRC/C/AUS/CO/4. [↑](#footnote-ref-77)
78. Committee on the Rights of the Child; UN Doc*.* CRC/C/AUS/4. [↑](#footnote-ref-78)
79. The Universal Periodic Review (UPR) is a process undertaken by the United Nations and involves the review of the human rights records of the 192 Member States once every four years. The UPR provides the opportunity for each State to declare what actions they have taken to improve the human rights situations in their countries and to fulfil their human rights obligations. The ultimate aim of the Review is to improve the human rights situation in all countries and address human rights violations wherever they occur. For more information see: <http://www.ohchr.org/en/hrbodies/upr/pages/uprmain.aspx> [↑](#footnote-ref-79)
80. UN General Assembly Human Rights Council (2011) UN Doc A/HRC/17/10, Op Cit. [↑](#footnote-ref-80)
81. On 10 December 2012, International Human Rights Day, the Australian Government released its National Human Rights Action Plan. In releasing the Plan, the then Federal Attorney General, Hon Nicola Roxon MP, stated that: *‘This action plan explains in detail how Australia will implement the recommendations accepted during its Universal Periodic Review at the United Nations in 2011.’* See for eg: Commonwealth of Australia (2012) *Australia’s National Human Rights Action Plan 2012*. Accessed online 10 December 2012 at: <http://www.ag.gov.au/Humanrightsandantidiscrimination/Australiashumanrightsframework/Pages/NationalHumanRightsActionPlan.aspx> See also: The Hon Nicola Roxon MP, Attorney-General & Minister for Emergency Management, Media Release *‘National Human Rights Action Plan Released’,* 10 December 2012. [↑](#footnote-ref-81)
82. Committee on the Elimination of Discrimination against Women (2010) UN Doc. CEDAW/C/AUS/CO/7, Op Cit. [↑](#footnote-ref-82)
83. Australian Government (2012) *‘Responses by Australia to the recommendations contained in the concluding observations of the Committee following the examination of the combined sixth and seventh periodic report of Australia on 20 July 2010.’* Accessed February 2013 at: <http://www2.ohchr.org/english/bodies/cedaw/docs/CEDAW.C.AUL.CO.7.Add.1.pdf> [↑](#footnote-ref-83)
84. The CEDAW Committee made two specific recommendations for actions on violence against women and Aboriginal and Torres Strait Islander women, in its Concluding Observations on Australia and requested an update on progress at the 2-year mark, prior to a full review in 2014. The Australian Government was required to report back to the CEDAW committee on its progress on these two areas by July 2012. [↑](#footnote-ref-84)
85. Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit. [↑](#footnote-ref-85)
86. UN Convention on the Rights of the Child (CRC)(2004) *Consideration of Reports Submitted By States Parties Under Article 44 of the Convention; Second and third periodic reports of States parties due in 1998 and 2003:Australia*; 29 December 2004; CRC/C/129/Add.4. [↑](#footnote-ref-86)
87. UN Committee on the Rights of the Child, UN Doc. CRC/C/15/Add.268, Op Cit. [↑](#footnote-ref-87)
88. CRC General Comment No.9 [at para.60] states: *‘The Committee is deeply concerned about the prevailing practice of forced sterilisation of children with disabilities, particularly girls with disabilities. This practice, which still exists, seriously violates the right of the child to her or his physical integrity and results in adverse life-long physical and mental health effects. Therefore, the Committee urges States parties to prohibit by law the forced sterilisation of children on grounds of disability.’ See:* Committee on the Rights of the Child (CRC), *General Comment No. 9 (2006): The rights of children with disabilities*, 27 February 2007, UN Doc.CRC/C/GC/9. [↑](#footnote-ref-88)
89. Since Australia was last reviewed in 2009, the Human Rights Committee has developed a new optional process for the review of states, known as the List of Issues Prior to Reporting (LOIPR). The Human Rights Committee develops a LOIPR on the basis of previous Concluding Observations and information provided by the Office of the High Commissioner on Human Rights (OHCHR), the Universal Periodic Review (UPR), the UN Special Procedures, NGOs and National Human Rights Institutions. The LOIPR on Australia was adopted by the Human Rights Committee at its 106th session in late 2012. [↑](#footnote-ref-89)
90. Human Rights Committee, International Covenant on Civil and Political Rights; *List of issues prior to the submission of the sixth periodic report of Australia* (CCPR/C/AUS/6), adopted by the Committee at its 106th session (15 October–2 November 2012); UN Doc No. CCPR/C/AUS/Q/6; 9 November 2012. [↑](#footnote-ref-90)
91. See: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session9.aspx> [↑](#footnote-ref-91)
92. The Australian Civil Society CRPD Shadow Report is available at: <http://www.disabilityrightsnow.org.au/node/15> [↑](#footnote-ref-92)
93. See Disability Council International’s 2013 Independent Review of Australia’s initial state party report (CRPD/C/AUS/1) available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session9.aspx>; See also Australian Civil Society CRPD Shadow Report, also available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session9.aspx> [↑](#footnote-ref-93)
94. FIGO (International Federation of Gynecology and Obstetrics), *Female Contraceptive Sterilization*. Available at: <http://www.wwda.org.au/FIGOGuidelines2011.pdf> See also Appendix 1. [↑](#footnote-ref-94)
95. Shepherd, T. (2013) South Australian disability advocates term forced hysterectomies as torture. The Advertiser, February 28, 2013. Accessed online February 2013 at: <http://www.adelaidenow.com.au/news/south-australia/south-australian-disability-advocates-term-forced-hysterectomies-as-torture/story-e6frea83-1226587191569> [↑](#footnote-ref-95)
96. World Medical Association (WMA) in conjunction with the International Federation of Health and Human Rights Organizations (IFHHRO) (2011) *Global Bodies call for end to Forced Sterilisation*: Press Release, 5 September 2011. Available at: <http://www.wwda.org.au/sterilWMA2011.htm> [↑](#footnote-ref-96)
97. The International NGO Council on Violence Against Children was formed in 2007 to support strong and effective follow-up to the UN Study on Violence against Children. See: <http://www.crin.org/violence/NGOs/> [↑](#footnote-ref-97)
98. International NGO Council on Violence against Children (October 2012) *Violating Children’s Rights: Harmful practices based on tradition, culture, religion or superstition*. Available online at: <http://www.crin.org/docs/InCo_Report_15Oct.pdf> [↑](#footnote-ref-98)
99. In recent months, WHO led a broad and inclusive consultation process which included: 12 September 2012: a meeting with governments and civil society during the Conference of States Parties in New York. After the consultation, participants were requested to comment on the Statement and twenty responses were received; 27 October 2012: a consultation with people with intellectual disabilities at the Global Forum of Inclusion International in Washington DC; Further consultation with people with intellectual disabilities on a plain language version of the Statement; 15-16 October 2012: an expert consultation held in Geneva to discuss the Statement in detail. As a result of these inputs, the proposed Statement has been strengthened. Other UN agencies are now reviewing the Statement and assessing how they may be able to support its implementation. See: <http://www.who.int/disabilities/media/news/2012/14_11/en/index.html> [↑](#footnote-ref-99)
100. The *Global Stop Torture in Health Care Campaign* is an alliance of international health and human rights organisations working together to put an end to the abuse of individuals in health settings. It is co-ordinated by the Open Society Foundations. See: <http://www.facebook.com/StopTortureInHealthCare> [↑](#footnote-ref-100)
101. See: <http://www.facebook.com/StopTortureInHealthCare> [↑](#footnote-ref-101)
102. Women With Disabilities Australia (WWDA), Human Rights Watch (HRW), Open Society Foundations, & International Disability Alliance (IDA)(2011) Op Cit. See also: Brady, S., Briton, J., & Grover, S. (2001), Op Cit. [↑](#footnote-ref-102)
103. Re H [2004] FamCA 496 (20 May 2004) [↑](#footnote-ref-103)
104. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Comment 70 of 162 posted at 10:14 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-104)
105. Online response to The Advertiser article *‘The International Day of Disability sheds light on the murky world of disability’*; Dec 2, 2012. Response posted by Sarah at 9:53 AM December 03, 2012. Accessed December 2012 at: <http://www.adelaidenow.com.au/news/opinion/the-international-day-of-disability-sheds-light-on-the-murky-world-of-disability-writes-ali-carle/story-e6freai3-1226528397995> [↑](#footnote-ref-105)
106. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Nicki of Brisbane at 8:43 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-106)
107. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by James at 3:52 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-107)
108. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Ben of Sydney at 12:13 PM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-108)
109. Online response to News article *‘Mother tells senate inquiry that sterilising her disabled daughter was a blessing’*. Response posted by Jo at 7:11 PM December 03, 2012. Accessed online December 2012 at: <http://www.news.com.au/lifestyle/parenting/sterilisation-was-a-blessing-mother/story-fnet085v-1226529050764> [↑](#footnote-ref-109)
110. Online response to The Advertiser News article ‘*The International Day of Disability sheds light on the murky world of disability’*.Response posted by Earl Grey at 10:20 PM December 02, 2012. Accessed online December 2012 at: <http://www.adelaidenow.com.au/news/opinion/the-international-day-of-disability-sheds-light-on-the-murky-world-of-disability-writes-ali-carle/story-e6freai3-1226528397995> [↑](#footnote-ref-110)
111. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by ‘mother of one in WA’ at 4:01 PM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-111)
112. Brady, S. and Grover, S. (1997) Op Cit. [↑](#footnote-ref-112)
113. Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit. [↑](#footnote-ref-113)
114. Frohmader, C. and Meekosha, H. (2012) Op Cit. [↑](#footnote-ref-114)
115. Re: Angela [2010] FamCA 98 (16 February 2010) [↑](#footnote-ref-115)
116. Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989) [↑](#footnote-ref-116)
117. Re H [2004] FamCA 496 (20 May 2004) [↑](#footnote-ref-117)
118. Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-118)
119. HGL (No 2) [2011] QCATA 259 (19 September 2011) [↑](#footnote-ref-119)
120. Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989) [↑](#footnote-ref-120)
121. Re M (An Infant) [1992] FamCA 19 (3 April 1992) [↑](#footnote-ref-121)
122. Re Elizabeth Suit [1989] FamCA 20 (3 May 1989) [↑](#footnote-ref-122)
123. Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993) [↑](#footnote-ref-123)
124. Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989) [↑](#footnote-ref-124)
125. Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-125)
126. XTV [2012] NSWGT 5 (6 February 2012) [↑](#footnote-ref-126)
127. Dowse, L. and Frohmader, C. (2001) Op Cit. See also: Dowse, L. (2004) Op Cit. [↑](#footnote-ref-127)
128. Dowse, L. and Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-128)
129. Dowse, L. (2004) Op Cit. See also: Brady, S. & Grover, S. (1997) Op Cit.; Jones M. & Basser Marks L. (1997) Female and Disabled: A Human Rights Perspective on Law and Medicine in K. Petersen (ed) *Intersections: Women on Law, Medicine and Technology* Aldershot, Dartmouth: 49-71. [↑](#footnote-ref-129)
130. Dowse, L. and Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-130)
131. Brady, S. and Grover, S. (1997) Op Cit. [↑](#footnote-ref-131)
132. Ibid. See also: Steele, L. (2008) Op Cit.; Brady, S., Briton, J. and Grover, S. (2001) Op Cit. [↑](#footnote-ref-132)
133. Women With Disabilities Australia (WWDA) (2007) *Policy & Position Paper: The Development of Legislation to Authorise Procedures for the Sterilisation of Children with Intellectual Disabilities*. Available at: <http://www.wwda.org.au/polpapster07.htm> See also: New South Wales Council for Intellectual Disability (2006) *Submission on the Draft Model Bill to regulate the sterilisation of children with an intellectual disability.* Available online at: <http://www.wwda.org.au/sternswcid06.htm>; Intellectual Disability Rights Service (IDRS) (2006) *Submission on the Draft Model Bill to regulate the sterilisation of children with an intellectual disability.* Available online at: <http://www.wwda.org.au/sterirds06.htm> [↑](#footnote-ref-133)
134. This happens in two main ways: a) the child is removed by child protection authorities and placed in foster or kinship care; and b) a Court, under the *Family Law Act*, may order that a child be raised by the other parent who does not have a disability or by members of the child’s extended family. See: Victorian Office of the Public Advocate (OPA) (2012) *OPA Position Statement: The removal of children from their parent with a disability*. <http://www.publicadvocate.vic.gov.au/research/302/> [↑](#footnote-ref-134)
135. Victorian Office of the Public Advocate (OPA) (2012) *OPA Position Statement: The removal of children from their parent with a disability*. <http://www.publicadvocate.vic.gov.au/research/302/> [↑](#footnote-ref-135)
136. Cited in: Cocks, K. (2012) *Human Rights of Parents with Intellectual Disability*. Speech by Queensland Anti-Discrimination Commissioner, to the Bold Network and QUT Symposium *Realising the Dreams and Hopes of Parents with Intellectual Disability* held at QUT Gardens Point, Brisbane City on Monday, 19 November 2012. Accessed online February 2013 at: <http://www.adcq.qld.gov.au/Speeches/Parents_with-Intellectual_Disability.html> [↑](#footnote-ref-136)
137. In Women With Disabilities Australia (WWDA) (2009) *Parenting Issues for Women with Disabilities in Australia: A Policy Paper.* WWDA, Rosny Park, Tasmania. Available online at: <http://www.wwda.org.au/subs2006.htm> [↑](#footnote-ref-137)
138. Ibid. [↑](#footnote-ref-138)
139. Ibid. [↑](#footnote-ref-139)
140. For example, in 2007, the Victorian Law Reform Commission (VLRC) released its final report on Assisted Reproductive Technology (ART) and adoption. The VLRC had been commissioned by the Victorian Government to enquire into and report on the desirability and feasibility of changes to the *Infertility Treatment Act 1995* [Vic] and the *Adoption Act 1984* [Vic] to expand eligibility criteria in respect of all or any forms of assisted reproduction and adoption (VLRC 2007). In relation to access to assisted reproductive technology, the VLRC decided *“not to include impairment or disability as one of the grounds on which discrimination in relation to access to ART should be prohibited. This is because in some cases there is a nexus between disability and risk of harm to a child (for example, some forms of severe mental illness). Such a nexus does not exist in relation to marital status or sexual orientation. This does not mean that people with a disability or impairment should be refused treatment, but that in some cases a different approach is justified. Such an approach should involve making enquiries about any potential risk to the health and wellbeing of a prospective child”* See: Victorian Law Reform Commission (VLRC) (2007) *Assisted Reproductive Technology & Adoption: Final Report.* Victorian Law Reform Commission, Melbourne, Victoria. [↑](#footnote-ref-140)
141. Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989) [↑](#footnote-ref-141)
142. Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-142)
143. Re: Angela [2010] FamCA 98 (16 February 2010) [↑](#footnote-ref-143)
144. Re H [2004] FamCA 496 (20 May 2004) [↑](#footnote-ref-144)
145. Re A Teenager [1988] FamCA 17 (15 November 1988) [↑](#footnote-ref-145)
146. Re H [2004] FamCA 496 (20 May 2004) [↑](#footnote-ref-146)
147. See for example: Sheerin, F. (1998) Parents with learning disabilities: a review of the literature. *Journal of Advanced Nursing*; Vol.28, No.1, pp.126-133; Osfield, S. (2012) ‘This girl has special needs and one day dreams of being a mum. Does anyone have the right to stop her having a baby?’ In *marie claire Magazine*, June 2012; Llewellyn, G. (1993) Parents with Intellectual Disability: Facts, Fallacies and Professional Responsibilities *Community Bulletin* 17 (1), 10 - 19. [↑](#footnote-ref-147)
148. WWDA (2009) *Parenting Issues for Women with Disabilities in Australia: A Policy Paper,* Op Cit. [↑](#footnote-ref-148)
149. Law Reform Commission (Ireland) (2011) *Sexual Offences and Capacity to Consent. A Consultation Paper*. Law Reform Commission, Dublin. [↑](#footnote-ref-149)
150. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-150)
151. Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989) [↑](#footnote-ref-151)
152. Ibid. [↑](#footnote-ref-152)
153. Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-153)
154. Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993) [↑](#footnote-ref-154)
155. HGL (No 2) [2011] QCATA 259 (19 September 2011) [↑](#footnote-ref-155)
156. Re H [2004] FamCA 496 (20 May 2004) [↑](#footnote-ref-156)
157. Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-157)
158. Office of the High Commissioner for Human Rights (undated*) WORKING GROUP 4 - Evolving capacities as an enabling principle in practice*. Accessed online February 2013 at: www2.ohchr.org/english/bodies/crc/docs/20th/BackDocWG4.doc [↑](#footnote-ref-158)
159. Re A Teenager [1988] FamCA 17 (15 November 1988) [↑](#footnote-ref-159)
160. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-160)
161. BAH [2009] NSWGT 8 (28 July 2009) [↑](#footnote-ref-161)
162. Jones M. & Basser Marks L. (1997) Op Cit. [↑](#footnote-ref-162)
163. Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993) [↑](#footnote-ref-163)
164. Brady, S. (2001) Op Cit. [↑](#footnote-ref-164)
165. Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-165)
166. Re A Teenager [1988] FamCA 17 (15 November 1988) [↑](#footnote-ref-166)
167. JLS v JES [1996] NSWSC 217 (21 June 1996) [↑](#footnote-ref-167)
168. Re Elizabeth Suit [1989] FamCA 20 (3 May 1989) [↑](#footnote-ref-168)
169. Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)

     Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-169)
170. Cited in Brady, S. (2001) Op Cit. [↑](#footnote-ref-170)
171. Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)

     Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-171)
172. Online response to News article *‘Parents win permission to sterilise their profoundly disabled 11-year-old daughter’*. Response posted by MissCulture 11/3/2010. Accessed online March 2010 at: <http://www.dailymail.co.uk/news/article-1256806/Australian-court-allows-parents-sterilise-11-year-old-daughter.html> [↑](#footnote-ref-172)
173. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by AD of Syd at 11:30 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-173)
174. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Millie at 10:06 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-174)
175. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by OddMaude at 5:08 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-175)
176. Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by james of metford nsw at 10:38 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430> [↑](#footnote-ref-176)
177. Sobsey, D. & Doe, T. (1991) cited in Dowse, L. and Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-177)
178. Women With Disabilities Australia (2011*) Submission to the Preparation Phase of the UN Analytical Study on Violence against Women and Girls with Disabilities (A/HRC/RES/17/11)*. Available online at: <http://www.wwda.org.au/viol2011.htm> [↑](#footnote-ref-178)
179. Dowse, L. and Frohmader, C. (2001) Op Cit. See also: Dowse, L. (2004) Op Cit. [↑](#footnote-ref-179)
180. Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993) [↑](#footnote-ref-180)
181. Department of Health & Community Services v JWB & SMB ("Marion's Case") [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992) [↑](#footnote-ref-181)
182. See the Australian Government’s response to the UN Special Rapporteurs (at Appendix 3). [↑](#footnote-ref-182)
183. Centre for Reproductive Rights et al (2011) Op Cit. [↑](#footnote-ref-183)
184. Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-184)
185. Re A Teenager [1988] FamCA 17 (15 November 1988) [↑](#footnote-ref-185)
186. Re: Angela [2010] FamCA 98 (16 February 2010) [↑](#footnote-ref-186)
187. Re A Teenager [1988] FamCA 17 (15 November 1988) [↑](#footnote-ref-187)
188. Re H [2004] FamCA 496 (20 May 2004) [↑](#footnote-ref-188)
189. Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989) [↑](#footnote-ref-189)
190. Cited in Transcript from 2003 Four Corners (ABC TV) Op Cit. [↑](#footnote-ref-190)
191. Re M (An Infant) [1992] FamCA 19 (3 April 1992). [↑](#footnote-ref-191)
192. CRC Committee General Comment No. 13 [at para.61] states: *“The Committee emphasizes that the interpretation of a child’s best interests must be consistent with the whole Convention, including the obligation to protect children from all forms of violence. It cannot be used to justify practices, including corporal punishment and other forms of cruel or degrading punishment, which conflict with the child’s human dignity and right to physical integrity. An adult’s judgment of a child’s best interests cannot override the obligation to respect all the child’s rights under the Convention.”* See: UN Committee on the Rights of the Child (CRC), General comment No. 13 (2011): *Article 19: The right of the child to freedom from all forms of violence*, 17 February 2011, CRC/C/GC/13 [↑](#footnote-ref-192)
193. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-193)
194. E. (Mrs.) v. Eve, [1986] 2 SCR 388; See at: <http://www.canlii.org/en/ca/scc/doc/1986/1986canlii36/1986canlii36.html> [↑](#footnote-ref-194)
195. Dowse, L. and Frohmader, C. (2001) Op Cit. See also: Dowse, L. (2004) Op Cit. [↑](#footnote-ref-195)
196. Ibid. [↑](#footnote-ref-196)
197. Ibid. See also: Brady, S. (2001) Op Cit. [↑](#footnote-ref-197)
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199. Honourable Michael Kirby (2012) *Adult Guardianship: Law, Autonomy and Sexuality*. Paper presented at the Second World Congress on Adult Guardianship, Melbourne, Australia, 15 October 2012. [↑](#footnote-ref-199)
200. Department of Health & Community Services v JWB & SMB ("Marion's Case") [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992) [↑](#footnote-ref-200)
201. Brady, S. (2001) Op Cit. [↑](#footnote-ref-201)
202. Re H [2004] FamCA 496 (20 May 2004) [↑](#footnote-ref-202)
203. Re: Angela [2010] FamCA 98 (16 February 2010) [↑](#footnote-ref-203)
204. Re Katie FamCA 130 (30 November 1995) [↑](#footnote-ref-204)
205. Cited in: Center for Reproductive Rights (2010) *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis*; Center for Reproductive Rights, New York. See also: Steele, L. (2008) Op Cit., Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit.; Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit.; Radhika Coomaraswamy (1999), UN Doc. E/CN.4/1999/68/Add.4, Op Cit.; Brown, W. (2012) *The Word on Women - Forced sterilization and the Millennium Development Goals*. Accessed online January 2013 at: <http://www.trust.org/trustlaw/blogs/the-word-on-women/forced-sterilization-and-the-millennium-development-goals>; African Gender and Media Initiative (2012) *Robbed of Choice: Forced and Coerced Sterilization experiences of Women Living with HIV in Kenya*; Accessed online January 2013 at: <http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-Robbed-Of-Choice-Forced-and-Coerced-Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf>; Nair, P. (2011) Litigating Against Forced Sterilization if HIV-Positive Women: Recent Developments in Chile and Namibia. *Harvard Human Rights Journal*, Vol.23, pp.223-231. [↑](#footnote-ref-205)
206. Sifris, R. (2010) Op Cit. [↑](#footnote-ref-206)
207. Dowse, L. & Frohmader, C. (2001) Op Cit.; Transcript from 2003 Four Corners (ABC TV), Op Cit., WWDA (2009) *Submission to the Australian NGO Beijing+15 Review* (September 2009), available on line at: <http://www.wwda.org.au/WWDABeijingSub0909.pdf>; Osfield, S. (2012) Op Cit., Sifris, R. (2010) Op Cit., Strahan, F. (1990) *On The Record - A Report on the 1990 STAR Conference on Sterilisation: 'My Body, My Mind, My Choice'*. Edited by Fiona Strahan, Co-Editor Lois Brudenell. Available at: <http://www.wwda.org.au/record.htm>; Personal stories communicated to WWDA by members. [↑](#footnote-ref-207)
208. Dowse, L. & Frohmader, C. (2001) Op Cit.; Strahan, F. (1990) Op Cit; Personal stories communicated to WWDA by members; Women with Disabilities Feminist Collective (undated) *Women and Disability - An Issue. A Collection of writings by women with disabilities*. [↑](#footnote-ref-208)
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211. Committee on the Rights of the Child; Consideration of reports submitted by States parties under article 44 of the Convention*; Concluding observations: Australia*; Sixtieth session, 29 May–15 June 2012; CRC/C/AUS/CO/4; UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10; Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7; Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, *Concluding Observations: Australia*, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e). [↑](#footnote-ref-211)
212. Australian Government (2012) *Draft 5th Report by Australia on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment For the period 1 January 2008 to 30 June 2012*; Attorney-General’s Department, Canberra. [↑](#footnote-ref-212)
213. Open Society Foundations and the Stop Torture In Health Care Campaign (2011) *Against Her Will: Forced and Coerced Sterilisation of Women Worldwide*. [↑](#footnote-ref-213)
214. The CRPD is underpinned by a ‘human rights’ model of disability (which upholds persons with disabilities as equal and active subjects of their rights) and guiding principles and values, which include respect for inherent dignity, autonomy, including the freedom to make one’s own choices, independence, non-discrimination, full and effective participation in society, respect for difference, and equality of opportunity. [↑](#footnote-ref-214)
215. The Committee on the Rights of Persons with Disabilities (CRPD) is the body of independent experts which monitors implementation of the Convention by the States Parties. All States parties are obliged to submit regular reports to the Committee on how the rights are being implemented. States must report initially within two years of accepting the Convention and thereafter every four years. The Committee examines each report and shall make such suggestions and general recommendations on the report as it may consider appropriate and shall forward these to the State Party concerned. The Optional Protocol to the Convention gives the Committee competence to examine individual complaints with regard to alleged violations of the Convention by States parties to the Protocol. The Committee meets in Geneva and normally holds two sessions per year. See: <http://www.ohchr.org/en/hrbodies/crpd/pages/crpdindex.aspx> [↑](#footnote-ref-215)
216. Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Spain*. UN Doc. No: CRPD/C/ESP/CO/1; 19 October 2011. [↑](#footnote-ref-216)
217. Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Peru*. UN Doc. No: CRPD/C/PER/CO/1; 9 May 2012. [↑](#footnote-ref-217)
218. Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: China*. UN Doc. No: CRPD/C/CHN/CO/1; 27 September 2012. [↑](#footnote-ref-218)
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220. Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Tunisia*. UN Doc. No: CRPD/C/TUN/CO/1; 13 May 2011. [↑](#footnote-ref-220)
221. Committee Against Torture (CAT), *General Comment No. 2: Implementation of Article 2 by States Parties*, 24 January 2008, UN Doc. CAT/C/GC/2. [↑](#footnote-ref-221)
222. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-222)
223. See: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit. [↑](#footnote-ref-223)
224. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-224)
225. Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit. [↑](#footnote-ref-225)
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227. Committee against Torture; *Concluding observations on the combined fifth and sixth periodic reports of Peru*, adopted by the Committee at its forty-ninth session (29 October - 23 November 2012). UN Doc. No: CAT/C/PER/CO/5-6; 21 January 2013. [↑](#footnote-ref-227)
228. Committee against Torture; *Concluding observations of the Committee against Torture: Czech Republic*. UN Doc. No: CAT/C/CZE/CO/4-5; 13 July 2012. [↑](#footnote-ref-228)
229. Committee Against Torture; *Concluding Observations: Slovakia*, UN Doc. No: CAT/C/SVK/CO/2; 17 December 2009. [↑](#footnote-ref-229)
230. In relation to women with disabilities, CEDAW requires governments to specifically report on measures taken to ensure that disabled women can enjoy all economic, social, cultural, civil and political rights. See: UN High Commissioner for Refugees (2009) *Displacement, Statelessness and Questions of Gender Equality under the Convention on the Elimination of All Forms of Discrimination against Women*, August 2009, PPLAS/2009/02, available at: <http://www.unhcr.org/refworld/docid/4a8aa8bd2.html> [accessed 18 June 2010]. [↑](#footnote-ref-230)
231. Grover, A. (2011) *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* United Nations General Assembly; UN Doc. A/66/254. [↑](#footnote-ref-231)
232. Committee on the Elimination of Discrimination against Women. *General Recommendation 19. Violence against women Article 16.* Eleventh Session, 1992, contained in UN Doc A/47/38. [↑](#footnote-ref-232)
233. Ibid. [↑](#footnote-ref-233)
234. Committee on the Elimination of Discrimination against Women; *Concluding observations on the fifth and sixth periodic reports of Chile*, adopted by the Committee at its fifty-third session (1–19 October 2012); UN Doc. CEDAW/C/CHL/CO/5-6; 12 November 2012. [↑](#footnote-ref-234)
235. Committee on the Elimination of Discrimination against Women; *Concluding observations: Jordan.* UN Doc. CEDAW/C/JOR/CO/5; 23 March 2012. [↑](#footnote-ref-235)
236. Committee on the Elimination of Discrimination against Women; *Concluding observations: Comoros.* UN Doc. CEDAW/C/COM/CO/1-4; 24 October 2012. [↑](#footnote-ref-236)
237. Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7. [↑](#footnote-ref-237)
238. Committee on the Elimination of Discrimination against Women; *Concluding observations: Czech Republic.* UN Doc. CEDAW/C/CZE/CO/5; 10 November 2010. [↑](#footnote-ref-238)
239. Committee on the Elimination of Discrimination against Women; Views: Communication No. 4/2004; *Ms. Andrea Szijjarto v Hungary*; UN Doc. CEDAW/C/36/D/4/2004 (29 August 2006) [↑](#footnote-ref-239)
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242. See: Human Rights Committee (2000) International Covenant on Civil and Political Rights (CCPR), *General Comment No. 28: Equality of rights between men and women*, 29 March 2000, CCPR/C/21/Rev.1/Add.10, [paras.11 & 20]. [↑](#footnote-ref-242)
243. General Assembly; Report of the Human Rights Committee, *Volume 1; Official Records*, Fifty-Fourth Session; Supplement No.40, A/54/40; para. 173. [↑](#footnote-ref-243)
244. Human Rights Committee; *Concluding observations: Lithuania*; adopted by the Human Rights Committee at its 105th session, 9-27 July 2012; CCPR/C/SR.2916. [↑](#footnote-ref-244)
245. Human Rights Committee; *Concluding observations: Slovakia*; Adopted by the Human Rights Committee at its 101st session 14 March-1 April 2011; CCPR/C/SVK/CO/3; 20 April 2011. [↑](#footnote-ref-245)
246. Human Rights Committee, International Covenant on Civil and Political Rights; *List of issues prior to the submission of the sixth periodic report of Australia* (CCPR/C/AUS/6), adopted by the Committee at its 106th session (15 October–2 November 2012); UN Doc No. CCPR/C/AUS/Q/6; 9 November 2012. [↑](#footnote-ref-246)
247. Committee on the Rights of the Child (CRC), *General Comment No. 9* *(2006): The rights of children with disabilities,* 27 February 2007, CRC/C/GC/9, available at: <http://www.unhcr.org/refworld/docid/461b93f72.html> [accessed 3 March 2010] [↑](#footnote-ref-247)
248. Ibid. [↑](#footnote-ref-248)
249. Committee on the Rights of the Child (CRC), *General comment No. 13 (2011): Article 19: The right of the child to freedom from all forms of violence*, 17 February 2011, CRC/C/GC/13 [paras.16, 21]. [↑](#footnote-ref-249)
250. *CRC Committee General Comment No.9* [at para.60] [↑](#footnote-ref-250)
251. *CRC Committee General Comment No. 13* [at para.61] states: “The Committee emphasizes that the interpretation of a child’s best interests must be consistent with the whole Convention, including the obligation to protect children from all forms of violence. It cannot be used to justify practices, including corporal punishment and other forms of cruel or degrading punishment, which conflict with the child’s human dignity and right to physical integrity. An adult’s judgment of a child’s best interests cannot override the obligation to respect all the child’s rights under the Convention.” [↑](#footnote-ref-251)
252. Committee on the Rights of the Child, *General Comment No 9 (2006): The Rights of Children with Disabilities,* UN Doc CRC/C/GC/9 (2007). See: <http://www.ohchr.org/english/bodies/crc/comments.htm> [↑](#footnote-ref-252)
253. Committee on the Rights of the Child; UN Doc*.* CRC/C/AUS/CO/4, Op Cit. [↑](#footnote-ref-253)
254. Ibid. [↑](#footnote-ref-254)
255. Committee on the Rights of the Child, UN Doc. CRC/C/15/Add.268, Op Cit. [↑](#footnote-ref-255)
256. Committee on the Rights of the Child, *Concluding observations: Austria*; UN Doc. CRC/C/15/Add.98; 29-01-1999. [↑](#footnote-ref-256)
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259. CESCR General Comment No.5, Op Cit. [↑](#footnote-ref-259)
260. See: Hunt, P. (2005) *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, paras. 48-50, UN Doc. E/CN.4/2005/51 (Feb. 11, 2005); See also: Grover, A. (2011) UN Doc. A/66/254, Op Cit.; Grover, A. (2009) UN Doc. A/64/272, Op Cit. [↑](#footnote-ref-260)
261. Special Rapporteur Anand Grover also clarified that: *‘Informed consent invokes several elements of human rights that are indivisible, interdependent and interrelated. In addition to the right to health, these include the right to self-determination, freedom from discrimination, freedom from non-consensual experimentation, security and dignity of the human person, recognition before the law, freedom of thought and expression and reproductive self-determination. All States parties to the International Covenant on Economic, Social and Cultural Rights have a legal obligation not to interfere with the rights conferred under the Covenant, including the right to health. Safeguarding an individual’s ability to exercise informed consent in health, and protecting individuals against abuses (including those associated with traditional practices) is fundamental to protecting these rights.’* Grover, A. (2009) UN Doc. A/64/272, Op Cit. [↑](#footnote-ref-261)
262. Grover, A. (2009) UN Doc. A/64/272, Op Cit. [↑](#footnote-ref-262)
263. Grover, A. (2011). UN Doc. No: A/66/254, Op Cit. [↑](#footnote-ref-263)
264. From 2007 until December 2010, the Northern Territory Intervention (NTI) legislation suspended the operation of Australia’s legal protection from racial discrimination, the Racial Discrimination Act 1975 (Cth) (RDA), to acts done under, or for the purposes of, the NTI. See: <http://www.hrlrc.org.au/files/Fact-Sheet-2-NT-Intervention.pdf> [↑](#footnote-ref-264)
265. As far back as 1999, the CERD Committee was identifying forced sterilisation of women belonging to indigenous communities as a matter of great concern. See for eg: Committee on the Elimination of Racial Discrimination; *Concluding observations of the Committee on the Elimination of Racial Discrimination: Peru*; UN Doc. CERD/C/304/Add.69 [↑](#footnote-ref-265)
266. Shirane, D. (2011) *ICERD and CERD: A Guide for Civil Society Actors*. International Movement Against All Forms of Discrimination and Racism (IMADR); IMADR Geneva Office, Switzerland. [↑](#footnote-ref-266)
267. Committee on the Elimination of Racial Discrimination; *Concluding observations of the Committee on the Elimination of Racial Discrimination: Mexico*; UN Doc. CERD/C/MEX/CO/15; 4 April 2006. [↑](#footnote-ref-267)
268. Committee on the Elimination of Racial Discrimination; *Concluding observations of the Committee on the Elimination of Racial Discrimination: Slovakia*; UN Doc. CERD/C/65/CO/7; 10 December 2004. [↑](#footnote-ref-268)
269. International Conference on Population and Development (ICPD) Programme of Action, *Summary of the Programme of Action*. See: <http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm> [↑](#footnote-ref-269)
270. The MDGs serve as a time-bound, achievable blueprint for reducing poverty and improving lives agreed to by all countries and all leading development institutions. They guide and focus development priorities for governments, donors and practitioner agencies worldwide. For more information go to: <http://www.un.org/millenniumgoals/> [↑](#footnote-ref-270)
271. The need for special protections guaranteeing a woman’s right to informed consent is reinforced by the Beijing Declaration. Any requirement for preliminary authorisation by a third party is a violation of a woman’s autonomy. See: United Nations, *The Beijing Declaration and the Platform for Action:* Fourth World Conference on Women, Beijing, China, 4-15 September 1995; A/CONF.177/20/Add.1.; See also: Grover, A. (2009) UN Doc. A/64/272, Op Cit. [↑](#footnote-ref-271)
272. United Nations General Assembly (2000) Resolution adopted by the General Assembly: Further actions and initiatives to implement the Beijing Declaration and Platform for Action. Twenty-third special session, UN Doc. A/RES/S-23/3 [↑](#footnote-ref-272)
273. United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2007) *Biwako Plus Five: Further Efforts Towards an Inclusive, Barrier-Free and Rights-Based Society for Persons with Disabilities in Asia and the Pacific.* As adopted by the High-level Intergovernmental Meeting on the Midpoint Review of the Asian and Pacific Decade of Disabled Persons, 2003-2012, on 21 September 2007. UN Doc. E/ESCAP/APDDP(2)/2. [↑](#footnote-ref-273)
274. United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2002) *Biwako Millennium Framework for Action towards an Inclusive, Barrier-free and Rights based Society in Asia and the Pacific*. UN Doc. E/ESCAP/APDDP/4/Rev.1. [↑](#footnote-ref-274)
275. See for eg: The National Disability Strategy (NDS); National Disability Insurance Scheme (NDIS); National Plan to Reduce Violence against Women and their Children 2010-2022; Australia’s Human Rights Framework; National Women’s Health Policy (NWHP); National Framework for Protecting Australia’s Children 2009–2020 [↑](#footnote-ref-275)
276. See: Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011; [↑](#footnote-ref-276)
277. Australian Law Reform Commission (2012) *Family Violence and Commonwealth Laws—People with Disability*. Access online December 2012 at: <http://www.alrc.gov.au/CFV-disability> [↑](#footnote-ref-277)
278. European Court of Human Rights; *I.G. and Others v. Slovakia*; (Application no. 15966/04); Judgement, Strasbourg; 13 November 2012. [↑](#footnote-ref-278)
279. European Court of Human Rights, case of *V. C. v Slovakia*, Application No 18968/07 (judgement delivered on 8 November 2011). [↑](#footnote-ref-279)
280. Centre for Reproductive Rights (17 September 2012) *Correspondence to the United Nations Committee on the Elimination of Discrimination against Women; Re: Supplementary Information on Chile*, scheduled for review by the U.N. Committee on the Elimination of Discrimination against Women during its 53rd session (October 2012). Accessed online January 2013 at: <http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CentroDeDerechosReproductivos_ForTheSession_Chile_CEDAW53.pdf> [↑](#footnote-ref-280)
281. See: Southern Africa Litigation Centre (30 July 2012) *Namibia: High Court Finds Govt Coercively Sterilised HIV Positive Women*. Accessed on line August 2012 at: <http://allafrica.com/stories/201207301026.html> [↑](#footnote-ref-281)
282. Kibira, H. (23 August 2012) *Kenya: Women Seek Justice Over Sterilisation*. The Star. Accessed online January 2013 at: <http://allafrica.com/stories/201208240201.html> [↑](#footnote-ref-282)
283. Tegel, S. (November 8, 2011) *Peru: forced sterilization cases reopened*. The Global Post; Accessed online January 2013 at: <http://www.globalpost.com/dispatch/news/regions/americas/111107/peru-abuse-cases-reopened> [↑](#footnote-ref-283)
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285. REDRESS is an organisation founded by a British torture survivor in 1992. Since then, it has consistently fought for the rights of torture survivors and their families in the UK and abroad. See: [www.redress.org](http://www.redress.org) [↑](#footnote-ref-285)
286. International Federation for Human Rights (FIDH) and REDRESS (27 February 2013) *Nobel Prize nominee and human rights defender Mutabar Tadjibayeva files key complaint against Uzbek government for forcible sterilisation and torture*. Accessed online February 2013 at: <http://www.redress.org/downloads/PressreleaseMutabar-270213.pdf> [↑](#footnote-ref-286)
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288. United Nations General Assembly (2006) *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*. UN Doc. A/RES/60/147. See also: Office of the United Nations High Commissioner for Human Rights and the International Bar Association (2003) *Human Rights In The Administration Of Justice: A Manual on Human Rights for Judges, Prosecutors and Lawyers*. Professional Training Series No. 9; OHCHR, Geneva. [↑](#footnote-ref-288)
289. See UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, 2200A (XXI) United Nations, Treaty Series, vol. 999, p. 171; also Office of the United Nations High Commissioner for Human Rights and the International Bar Association (2003) Op Cit. [↑](#footnote-ref-289)
290. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit. [↑](#footnote-ref-290)
291. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit. [↑](#footnote-ref-291)
292. ‘Transitional justice’ refers to the set of judicial and non-judicial measures that have been implemented by different countries in order to redress the legacies of massive human rights abuses. The different elements of a comprehensive transitional justice policy are not parts of a random list, but rather, are related to one another practically and conceptually. The core elements are: *Criminal prosecutions*, particularly those that address perpetrators considered to be the most responsible; *Reparations*, through which governments recognise and take steps to address the harms suffered. Such initiatives often have material elements (such as cash payments or health services) as well as symbolic aspects (such as public apologies or day of remembrance); *Institutional reform* of abusive state institutions such as armed forces, police and courts, to dismantle—by appropriate means—the structural machinery of abuses and prevent recurrence of serious human rights abuses and impunity; *Truth commissions* or other means to investigate and report on systematic patterns of abuse, recommend changes and help understand the underlying causes of serious human rights violations. For more information see: <http://ictj.org/about/transitional-justice> [↑](#footnote-ref-292)
293. REDRESS (February 2013) *What is reparation? Challenges and avenues to reparation for survivors of sexual violence*, accessed online February 2013 at: <http://www.unhcr.org/refworld/docid/5134a9df2.html> [↑](#footnote-ref-293)
294. See Potts, H. (undated) *Accountability and the Right to the Highest Attainable Standard of Health*. Human Rights Centre, University of Essex, UK. [↑](#footnote-ref-294)
295. Dowse, L. & Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-295)
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298. Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Peru*. UN Doc. CRPD/C/PER/CO/1; 9 May 2012. [↑](#footnote-ref-298)
299. Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: China*. UN Doc. CRPD/C/CHN/CO/1; 27 September 2012. [↑](#footnote-ref-299)
300. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., [↑](#footnote-ref-300)
301. Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., [↑](#footnote-ref-301)
302. Grover, A. (2009) UN Doc. A/64/272, Op Cit. [↑](#footnote-ref-302)
303. European Court of Human Rights; *I.G. and Others v. Slovakia*; (Application no. 15966/04); Judgement, Strasbourg; 13 November 2012.

     European Court of Human Rights, case of *V. C. v Slovakia*, Application No 18968/07 (judgement delivered on 8 November 2011).

     Centre for Reproductive Rights (17 September 2012) *Correspondence to the United Nations Committee on the Elimination of Discrimination against Women; Re: Supplementary Information on Chile*, scheduled for review by the U.N. Committee on the Elimination of Discrimination against Women during its 53rd session (October 2012). Accessed online January 2013 at: <http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CentroDeDerechosReproductivos_ForTheSession_Chile_CEDAW53.pdf>

     See: Southern Africa Litigation Centre (30 July 2012) *Namibia: High Court Finds Govt Coercively Sterilised HIV Positive Women*. Accessed on line August 2012 at: <http://allafrica.com/stories/201207301026.html>; Tegel, S. (November 8, 2011) *Peru: forced sterilization cases reopened*. The Global Post; Accessed online January 2013 at: <http://www.globalpost.com/dispatch/news/regions/americas/111107/peru-abuse-cases-reopened> [↑](#footnote-ref-303)
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310. REDRESS (September 2010) *Rehabilitation as a Form of Reparation: Opportunites and Challenges Workshop Report*, Accessed online February 2013 at: <http://www.redress.org/downloads/publications/Report_of_the_Expert_Seminar_on_Rehabilitation_October_2010.pdf> [↑](#footnote-ref-310)
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312. CRPD Article 26 (Habilitation and rehabilitation) states:

     1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

     (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

     (b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

     2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

     3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation. [↑](#footnote-ref-312)
313. UN General Assembly (2000) *Further actions and initiatives to implement the Beijing Declaration and Platform for Action.* Resolution adopted by the General Assembly: S-23/3.A/RES/S-23/3 [para.27]. [↑](#footnote-ref-313)
314. Women With Disabilities Australia (WWDA) (2009) *Parenting Issues for Women with Disabilities in Australia: A Policy Paper*. OpCit. [↑](#footnote-ref-314)
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316. Dowse, L. and Frohmader, C. (2001) Op Cit. [↑](#footnote-ref-316)
317. Dowse, L. (2004) *'Moving Forward or Losing Ground? The Sterilisation of Women and Girls with Disabilities in Australia'*. Paper presented to Disabled Peoples' International (DPI) World Summit, Winnipeg, September 8-10, 2004. Available online at: <http://www.wwda.org.au/steril3.htm> ; Steele, L. (2008) Making sense of the Family Court’s decisions on the non-therapeutic sterilisation of girls with intellectual disability; *Australian Journal of Family Law*, Vol.22, No.1.; Prilleltensky, O. (2003) A Ramp to Motherhood: The Experiences of Mothers with Physical Disabilities. *Sexuality and Disability,* Vol. 21, No. 1, pp. 21-47. [↑](#footnote-ref-317)
318. See for example: the Sexuality Education Counselling and Consultancy Agency (SECCA) in Western Australia, provides education and training workshops which are able to be customised. One example is the ‘Menstrual Management, Personal Hygiene & Sexual Health’ Training Workshop which aims to ‘provide participants with strategies to teach women with a disability, their carers and other health professionals a positive approach to menstruation’. SECCA also provides a one-on-one specialist counselling and education service in the area of human relationships and sexuality to people who have a disability, their family and significant carers. [↑](#footnote-ref-318)
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320. The Text of UPR recommendation P- 86.39 is available online at: <http://www.upr-info.org/IMG/pdf/recommendations_to_australia_2011.pdf> [↑](#footnote-ref-320)
321. 175 CLR 218 [↑](#footnote-ref-321)
322. [2010] FamCA 98 [↑](#footnote-ref-322)
323. More information on the Victorian Law Reform Commission review of Guardianship is available online at:

     [http://www.lawreform.vic.gov.au/wps/wcm/connect/justlib/Law+Reform/Home/Current+Projects/Guardianship](http://www.lawreform.vic.gov.au/wps/wcm/connect/justlib/Law+Reform/Home/Current+Projects/Guardianship/) [↑](#footnote-ref-323)
324. See for example legislation including but not limited to: the *Criminal Code Act 1995* (Cth), the *Civil Liability Act 2002* (NSW), and the *Wrongs Act 1958* (VIC). See also common-law authorities including but not limited to *Rogers v Whitaker (1992)* 175 CLR 479, and *Chappel v Hart* [1998] HCA 55. [↑](#footnote-ref-324)
325. See for example *Re: Baby D (No. 2)* [2011] FamCA 176 [↑](#footnote-ref-325)
326. For a copy see the Queensland Health website at [<http://www.health.qld.gov.au/consent/documents/14025.pdf.>.](http://www.health.qld.gov.au/consent/documents/14025.pdf) [↑](#footnote-ref-326)
327. For more information see the AMA website- [<http://ama.com.au/>.](file:///L:\WWDA%20Main\Sterilisation%20Senate%20Inquiry%202012\WWDA%20Submission\%3chttp:\ama.com.au\%3e) [↑](#footnote-ref-327)
328. A copy of the Protocol is available on the AGAC website at:

     <<http://www.agac.org.au/images/stories/agac_sterilisation_protocal_30_mar_09.pdf>> [↑](#footnote-ref-328)
329. A copy of these guidelines is available online at [<http://www.ranzcog.edu.au/publications/statements>.](http://www.ranzcog.edu.au/publications/statements) [↑](#footnote-ref-329)
330. A copy of a supporting document developed by the Health Care Commission outlining the roles and responsibilities under the Charter is at *Attachment 1.* [↑](#footnote-ref-330)
331. *Attachment 2* gives details of Australian and state and territory specific charters of health care rights with specific information in relation to informed consent for care/treatment. [↑](#footnote-ref-331)
332. More information about the NDS is available at: [<http://www.fahcsia.gov.au/saJdisability/progserv/govtint/Pages/nds.aspx>.](http://www.fahcsia.gov.au/saJdisability/progserv/govtint/Pages/nds.aspx) [↑](#footnote-ref-332)
333. The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed simply, is to help governments make better policies in the long term interest of the Australian community. More information about the Productivity Commission is available at: [<http://www.pc.gov.au/>.](http://www.pc.gov.au/) [↑](#footnote-ref-333)
334. More information about the NDIS and NHS is available at:

     [<http://www.fahcsia.gov.au/sa/disability/progserv/govtint/Pages/ndis.aspx>.](file:///L:\WWDA%20Main\Sterilisation%20Senate%20Inquiry%202012\WWDA%20Submission\%3chttp:\www.fahcsia.gov.au\sa\disability\progserv\govtint\Pages\ndis.aspx%3e) [↑](#footnote-ref-334)