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Committee for the Rights of Persons with Disabilities
Human Rights Council and Treaty Mechanisms Division
Office of the United Nations High Commissioner for Human Rights
Palais Wilson, 52 Rue des Pâquis, 1201 Geneve, Switzerland

1. Introduction

The Center for Health and Human Rights at the O'Neill Institute for National and Global Health Law, Georgetown University Law Center, respectfully submits the following comments on the "Draft guidelines on Disability-based violence" as of 6 June 2026. The O'Neill Institute is a non-profit institution located at Georgetown University in Washington, D.C. Its mission is to conduct rigorous research to identify solutions to pressing national and international health concerns. The Center for Health and Human Rights, one of the areas of work within the O'Neill Institute, works to improve health through academic research that focuses on the intersection of health and national and international human rights law. A key facet of our work involves engagement in domestic and international standard-setting processes to advance health, justice, and equity in all its dimensions through the strategic use of human rights legal frameworks.

2. Comments and recommendations

- In general, we suggest organizing the guidelines around thematic axes so that the different recommendations are not fragmented throughout the text. Likewise, this structure helps avoid repetition and allows for the introduction of key concepts that are necessary for their interpretation throughout the text.

- **Paragraph 5:** We support the inclusion of the category of "violence in medical contexts" or the explicit recognition of "psychiatric violence" as an independent form of violence. This would more accurately reflect the experiences documented in the survey and discussed throughout the guidelines. Recognizing these as distinct categories would also help capture the specific forms of abuse, coercion, discrimination, and rights violations that occur within healthcare and psychiatric settings, which may not be adequately addressed under broader categories of violence.

- **II. Framework for freedom from exploitation, violence and abuse, B, paragraph 9:** Considering that the guidelines address potential violations of Articles 10 (Right to Life), 14 (Liberty and Security of the Person), 19 (Living Independently and Being Included in the Community), and 23 (Respect for Home and the Family) of the Convention, we suggest explicitly incorporating these rights into the overarching framework of the guidelines. Doing so would strengthen the human rights foundation of the document and provide a clearer basis for the recommendations that follow.

- **III. Scope of disability-based violence, A. Conceptualization and causes, paragraph 14:** We suggest acknowledging that disability-based violence can also occur in medical settings and may include violations of informed consent, forced or non-consensual medical interventions, involuntary institutionalization, and other forms of violence.

- **III. Scope of disability-based violence, A. Conceptualization and causes, paragraph 18:** As this paragraph addresses gender-based violence and disability-based violence, we suggest explicitly acknowledging

the harmful stereotypes faced by women with disabilities regarding their sexuality, reproductive autonomy, and perceived fitness for motherhood. In addition, women with disabilities are often viewed as unreliable or lacking credibility, which contributes to the dismissal of their complaints by law enforcement and the justice system and can further facilitate violence by reinforcing the perception that "no one will believe them." Addressing these intersecting stereotypes would strengthen the analysis of the structural and discriminatory factors that enable violence against women with disabilities.

- **III. Scope of disability-based violence, A. Conceptualization and causes, paragraph 21:** As this paragraph acknowledges that concepts such as "therapeutic need," "medical necessity," and the "best interests" doctrine may give rise to disability-based coercive measures, we suggest also including the concept of "quality of life" assessments of perceived quality of life can perpetuate ableist biases and stereotypes that fuel violence and discrimination against persons with disabilities. For example, such assumptions may contribute to decisions that deprioritize or deny access to life-saving medical resources in situations of emergency or resource scarcity, based on the discriminatory belief that the lives of persons with disabilities are of lesser value or are less worthy of medical intervention.

- **III. Scope of disability-based violence, A. Conceptualization and causes, paragraph 23:** This paragraph explains that disability-based violence is often exacerbated in situations of heightened risk and acknowledges that the COVID-19 pandemic revealed increased instances of such violence. We suggest adding that, in contexts of medical emergencies or resource scarcity, persons with disabilities may be denied or deprioritized for medical care based on utilitarian approaches to resource allocation. Stereotypes concerning the quality of life of persons with disabilities, together with implicit or explicit biases regarding the value of their lives, can foster "clinical pessimism," leading healthcare professionals to withhold or withdraw treatment faster than they would for others[1].

Similarly, in the section "Discrimination in medical triage practices and end-of-life care," particularly paragraphs 85 and 97, we suggest clarifying that discriminatory practices—such as exclusion from organ transplantation or the deprioritization of persons with disabilities in situations of resource scarcity—are not solely the result of individual prejudice. They are also facilitated by the existence of triage protocols and clinical decision-making frameworks that rely on problematic criteria, including "remaining life expectancy",

[1] See for example: Benjamin Tolchin, Stephen R. Latham, Lori Bruce, Lauren E. Ferrante, Katherine Kraschel, et al, "Developing a Triage Protocol for the COVID-19 Pandemic: Allocating Scarce Medical Resources in a Public Health Emergency," *J Clin Ethics*, 31, no 4:303–17, (2020). Katie Savin y Aura Guidry-Grimes, "Confronting Disability Discrimination During the Pandemic", *The Hasting Center*, (April, 2020), https://www.thehastingscenter.org/confronting-disability-discrimination-during-the-pandemic/. Joseph Stramondo, "Tragic Choices: Disability, Triage, and Equity Amidst a Global Pandemic", *Journal of Philosophy of Disability*, 1:201-210 (2021), https://philpapers.org/rec/STRTCD-6 . *Marina, Tsaplina y Joseph Stramondo* , "#WeAreEssential: Why Disabled People Should Be Appointed to Hospital Triage Committees", *The Hasting Center*, (mayo 15, 2020), https://www.thehastingscenter.org/weareessential-why-disabled-people-should-be-appointed-to-hospital-triage-committees Jackie Leach Scully, "Disability, Disablism, and COVID-19 Pandemic Triage", *J Bioeth Inq*. 2020; 17(4): 601–605, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7445721/ Centro de Representación Pública, "Examining How Crisis Standards of Care May Lead to Intersectional Medical Discrimination against COVID 19 Patients" (February, 11, 2021). https://www.centerforpublicrep.org/wp-content/uploads/FINAL-Intersectional-Guide-Crisis-Care-PDF.pdf.

"social functioning," and assumptions about an individual's "quality of life." Many such protocols draw on bioethical literature and principles that have been incorporated into clinical practice without adequate scrutiny in light of international human rights obligations and without a careful balancing of bioethical principles. As a result, these frameworks may produce discriminatory outcomes and undermine the equal right of persons with disabilities to access life-saving healthcare.

- **III. Scope of disability-based violence, B. Social systems underpinning disability-based violence, paragraph 26:** This paragraph refers to the practice of forced sterilization of women with disabilities by focusing on legal provisions that authorize substituted consent. We suggest broadening the analysis to also address legislation, policies, and practices that fail to ensure the supports and reasonable accommodations women with disabilities require to provide their free and informed consent to sexual and reproductive health services.The analysis should not be limited to substituted decision-making regimes. Even where substituted decision-making has been formally abolished, women with disabilities may still be subjected to undue influence, coercion, or conflicts of interest if appropriate supported decision-making mechanisms are not available in practice. This concern is particularly relevant in jurisdictions such as Colombia and Argentina, which have undertaken significant legal reforms to replace guardianship regimes in accordance with the Convention on the Rights of Persons with Disabilities. Although these reforms represent important progress toward recognizing the legal capacity of persons with disabilities, the absence of effective support systems and accessible decision-making processes may continue to undermine women's autonomy and their ability to make free and informed decisions regarding their sexual and reproductive health.

IV. Gaps in realizing the right of persons with disabilities to be free from all forms of disability-based violence: Throughout this section, the Committee refers to "disability stereotypes and prejudices." We suggest also incorporating the concepts of "conscious and unconscious or implicit or explicit biases" and "intersectional stereotypes", which are introduced later in the guidelines (Section M, *Violence and abuse in health care services and settings*, paragraph 77 and *VI. Aggravated forms of disability-based violence on intersectionality between disability and other social conditions*). These concepts provide a more comprehensive framework for understanding the mechanisms through which discrimination operates, particularly in healthcare, the justice system, and other institutional settings. Their inclusion throughout this section would strengthen the analysis by recognizing that disability-based discrimination is not only driven by explicit stereotypes and prejudice, but also by implicit biases that shape decision-making and interactions with persons with disabilities. Also, it would reinforce the idea that disability-based violence intersects with other forms of discrimination.

- **IV. Gaps in realizing the right of persons with disabilities to be free from all forms of disability-based violence, "Barriers to sexual and reproductive healthcare rights", paragraph 79:** In the list of discriminatory attitudes and practices against women with disabilities by healthcare providers, we suggest recognizing that such violence may also be perpetuated by legal and policy frameworks that restrict access to contraception and abortion, resulting in forced pregnancy and forced motherhood. While women with disabilities are often subjected to forced medical interventions, including forced sterilization, contraception, and abortion, they may also experience violations of their autonomy when they are denied access to reproductive healthcare services. This is particularly the case where access to legal abortion is restricted or where services are not provided in a manner that guarantees free and informed consent through supported decision-making.

- **IV. Gaps in realizing the right of persons with disabilities to be free from all forms of disability-based violence, "Barriers to sexual and reproductive healthcare rights", paragraph 80:** We suggest incorporating "Information regarding the prevention of HPV".

- **IV. Gaps in realizing the right of persons with disabilities to be free from all forms of disability-based violence, "Forced or coerced procedures or medication without informed consent", paragraph 81:** We suggest incorporating eugenics and other discriminatory assumptions as structural factors underlying forced and coerced sterilization. These include the perception that motherhood for women with disabilities is undesirable or unduly burdensome, the belief that society should avoid the birth of children with disabilities, and the management of puberty and menstruation in girls and adolescents with disabilities, which is frequently invoked to justify sterilization procedures. Another structural factor that should be explicitly acknowledged is the disproportionately high prevalence of sexual violence against women and girls with disabilities. Sterilization is often justified through a corrosive normalization of sexual violence, whereby such violence is treated as an unfortunate but inevitable reality, and sterilization is presented as the preferred or pragmatic response. This shifts attention away from the State's obligation to prevent violence, ensure protection and uphold the sexual and reproductive rights of women and girls with disabilities.

In addition, while we recognize that the falsification of medical records may occur to justify sterilizations, we do not consider this to be the most common practice. The guidelines should also address the more frequent situations in which sterilization is justified on purported medical grounds or presented as having been consented to by women with disabilities, despite consent being obtained in contexts of undue influence, coercion, or pressure from healthcare providers or caregivers.

IV. Gaps in realizing the right of persons with disabilities to be free from all forms of disability-based violence, "Denial of free and informed consent and biomedical practices", paragraph 83: This section recognizes that disability-based violence may result from biomedical practices. However, the current wording appears to present practices such as gene-editing technologies, CRISPR, biomedical interventions, and prenatal testing as inherently harmful or contrary to human rights. We suggest clarifying that these interventions are not inherently discriminatory and may, in many cases, provide significant health benefits to persons with disabilities. Rather, it is the context in which they are used, together with ableist biases, stereotypes, and discriminatory decision-making, that can result in violence and human rights violations.

In addition, as the paragraph refers to surgeries on intersex children, we suggest clarifying this issue in line with the approach adopted by other human rights mechanisms. It should also be made clear that intersex children are not necessarily persons with disabilities and that these are distinct legal and human rights frameworks.

- **VIII. Conclusions and recommendations, paragraph 120:** We suggest not limiting the discussion of coercion to mental health services and instead referring more broadly to medical care settings and services. This would better capture other forms of coercion experienced by persons with disabilities, including in sexual and reproductive healthcare and other medical contexts.

- **VIII. Conclusions and recommendations, paragraph 121, (a):** We suggest providing examples of measures that States can adopt to "deconstruct ableism, and harmful stereotypes, prejudices and practices that perpetuate violence against persons with disabilities". For example, in line with CEDAW General Recommendations[2], the guidelines could recommend the adoption of protocols and clinical guidelines to prevent discrimination and violence in healthcare settings, as well as mandatory human rights-based education and training for healthcare professionals on disability, and harmful stereotypes.

Respectfully,

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[2] See for example: CEDAW Committee, General recomnedation No. 24 (1999) Article 12 of the Convention(Women and Health), para. 15 and the draft General Recommendation No. 41 concerning the impact of gender stereotypes on the enjoyment of rights enshrined in the Convention.