Washington, D.C., May 2026

Committee on the Elimination of Discrimination Against Women (CEDAW)
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 General Recommendation No. 41 concerning the impact of gender stereotypes on the enjoyment of rights enshrined in the Convention, for consideration by the United Nations Committee on the Elimination of Discrimination Against Women (CEDAW). These comments align with our previous submissions to the Committee focusing on framing gender stereotypes as a determinant of health, naming the most recurring stereotypes and highlighting their impacts in the different dimensions of the right to health, including from an intersectional perspective.

2. Comments and recommendations

• **Paragraph 18**: We suggest incorporating the impact of stereotypes surrounding older women, especially older women with disabilities or chronic health conditions, who are often perceived as less capable of making informed decisions and as having "limited value". Specifically, this could include how such stereotypes contribute to the perception that the medical treatments and interventions they may need should be decided by third parties and/or that they are futile or unnecessary, based on the assumption that "nothing can be done" for their health or that their life is not worth of living.

• **Paragraph 19**: We recommend including "employment and health care" as areas in which women with disabilities also face social exclusion. When referring to a "lack of infrastructural accommodations," we suggest using the term "supports and accommodations," as limiting the concept to infrastructure could be read as excluding the experiences of women with certain disabilities.

We further suggest naming additional effects of the denial of legal capacity on women with disabilities, specifically "the substitution of their informed consent in medical interventions, forced sterilization and contraception, and pressure to terminate or continue their pregnancies."

Moreover, we recommend naming other predominant biases against women with disabilities, including the perception that they "cannot have a good quality of life," as well as stereotypes of "hypersexuality," given that the text currently refers only to their perceived lack of sexuality and its effects. The stereotype of hypersexuality often affects women with psychosocial and intellectual disabilities, as well as specific groups such as women of short stature, and has been used to justify forced sterilization and sexual violence in institutional settings. Naming both stereotypes is important because it provides a clear example of how women and especially particular groups of women, face a wide range of stereotypes that are often internally contradictory. In this specific example of women with disabilities – that can be extrapolated to other contexts and groups of women – contradictory stereotypes can vary depending on socially constructed ideas about different types of disability.

• **Paragraph 20:** We recommend including specific examples of documented stereotypes affecting LBTI women in health care, as well as the barriers and discrimination they face in the enjoyment of their right to health. For example, stereotypes concerning how bodies "should" look, together with binary conceptions of genitalia and sex characteristics, disproportionately affect intersex persons, who are often unnecessarily medicalized and subjected to non-consensual "normalizing" surgeries. These interventions can have irreversible consequences for their reproductive capacity and long-term impacts on their physical and mental health. Moreover, trans women face serious barriers to the enjoyment of their right to health due to the pathologization of their identities and the lack of legal and social recognition of their gender identity. Stigma and stereotypes often lead health professionals to associate trans persons only with specific health needs, particularly sexually transmitted infection (STI) services or transition-related care. This can also result in the limited availability of healthcare services adapted to their specific needs, leading to neglect or avoidance of care. In addition, these stereotypes are reinforced through so-called "Sexual Orientation and Gender Identity Change Efforts" (SOGICE), which seek to modify a person's sexual orientation or gender identity. These practices harm the right to health, and States have an obligation to eradicate them through legal, policy, and other practical measures.

• **Paragraph 22:** We suggest specifically including examples of how racial biases and stereotypes affect the enjoyment of the right to health, as these dynamics have been extensively documented within healthcare systems. It is important to highlight both the impact of racial stereotyping on individual health experiences and its role in shaping structural inequalities. Afro-descendant women are frequently perceived as less compliant with medical advice, irresponsible, or "difficult patients," and are often assumed to have a greater capacity to endure pain. These biases adversely affect patient–provider interactions, undermine trust, and ultimately impact the quality and course of treatment. They have also been linked to structural health inequalities, including unequal access to sexual and reproductive health services.

• **Paragraph 23:** To illustrate the stereotypes affecting the health of migrant women, we recommend incorporating how they are often perceived as having "inevitable" health consequences due to precarious living conditions. We also suggest highlighting how migrants with chronic health conditions are portrayed as "unfit," "a hazard to public health," or undeserving of residency.

• **Paragraph 25:** Given that stereotypes related to expectations of motherhood have been linked to impacts on sexual and reproductive health, it is important to explicitly highlight these effects in this paragraph (even if they are referenced in paragraph 30). In this regard, we suggest incorporating language on how these stereotypes undermine access to sexual and reproductive health services, as gendered expectations of motherhood imposed on women and girls have been associated with the denial of contraception and abortion. Such norms perpetuate the view that women must carry pregnancies to term at all costs, even when doing so poses risks to their health and lives. This also supports the recommendations included in paragraph 56(c) regarding the decriminalization of abortion. Moreover, we suggest highlighting how these stereotypes are often reflected in cultural practices, as well as in legal provisions.

• **Paragraph 30:** To reflect a more comprehensive understanding of the right to health, we suggest:

- **Including an explicit framing of gender stereotypes as a determinant of health**, recognizing that they shape social norms, roles, and power relations that influence exposure to health risks, health-related behaviors, and access to healthcare services. In this regard, the Committee on the Elimination of Racial Discrimination (CERD) has recognized that racial discrimination constitutes both a distinct health risk and a structural determinant of health, as it "produces and exacerbates health inequities, leading to, or increasing the incidence of, preventable disease and death."[1] A similar approach could be applied to gender stereotypes, given their systemic impact on the enjoyment of the right to health.

- **Addressing the impact of gender stereotyping on the autonomy dimension of the right to health**, as the current paragraph focuses primarily on diagnosis, treatment, and access to services. Gender stereotypes may constitute barriers to the full exercise of autonomy and informed decision-making by restricting women's ability to make free and informed choices regarding their health. This includes, but is not limited to, sexual and reproductive health.

- **Recognizing the role of medical education in the persistence or eradication of gender stereotyping**, as this supports the recommendations provided in paragraph 56 related to education and training.

[1] CERD Committee, General recommendation No. 37 (2024) on equality and freedom from racial discrimination in the enjoyment of the right to health, CERD/C/GC/37.

• **Paragraph 32**. We recommend incorporating health care as a dimension significantly impacted by stereotypes in digital technologies and artificial intelligence (AI), as well as addressing the gaps in women's access to these technologies.

• **IV. Health, paragraph 56.**

(a) To prevent a fragmented approach and in line with the language used in paragraph 53(a)(iii), we suggest framing the actions presented in this paragraph within the implementation of a "comprehensive and well-resourced national strategy." We recommend explicitly stating that this strategy should aim to eliminate gender stereotypes across all health care settings, including by dismantling those that lead to disparities in diagnosis and treatment, pain management, medical research, data gaps, and access to services.

(a) (i) We recommend clarifying that training and education programs on gender stereotypes directed at health professionals must also be "human rights-based."

(a) (ii) In line with CEDAW General Recommendation No. 24[2], we recommend specifying that protocols and guidelines aimed at preventing gender-based discrimination and violence in health care settings should ensure the appropriate provision of health services to victims of gender-based violence, including sexual violence. Moreover, we suggest clarifying that these protocols should adopt an "intersectional approach," incorporating intercultural, disability, and LBTI perspectives.

(a) (iii) We recommend specifying that protocols for health professionals should also ensure respect for professional secrecy, as well as confidentiality and privacy, across all health services, in accordance with current international human rights standards.

We also suggest adding the following items to this section:

(a)(iv) A recommendation that States develop data collection initiatives and conduct research to better understand diseases, health conditions, and hazards that affect women, or certain groups of women, differently. This recommendation aims to mitigate the existing effects of the lack and/or biased scientific research regarding women's health.

(a)(v) A recommendation that States refrain from using gender-biased data and information in the development of health and social policies, programs, and frameworks[3].

[2] CEDAW Committee, General recomnedation No. 24 (1999) Article 12 of the Convention (Women and Health), para. 15

[3] For a similar recommendation see the CERD Committee, General recommendation No. 37 (2024) on equality and freedom from racial discrimination in the enjoyment of the right to health, CERD/C/GC/37, para. 51.

(b) We suggest specifically mentioning "ethical and self-regulatory bodies" as feasible accountability mechanisms aimed at eradicating biases and violent practices perpetuated by health professionals.

(c) As this recommendation is directed at the transformation of public policy, we recommend including explicit reference to the identification and elimination of all policies or legal provisions that perpetuate or give rise to gender-based stereotypes and discrimination. The paragraph could also include provisions on the State's obligation to prohibit and recognize obstetric and gynecological violence as a form of gender-based violence that is frequently enhanced by gender stereotyping.

Respectfully,

Silvia Serrano-Guzmán

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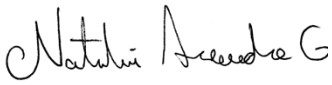

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