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Sites of Exclusion:

Disabled Women's Sexual, Reproductive and Parenting Rights

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I. Introduction

“Women with disabilities commonly find themselves precluded from performing the major life functions commonly assigned to women”.ⁱ This is nowhere more true than in the areas of sexuality, reproduction and parenting. While women generally are identified with, and indeed valorized for, their nurturing roles, sexual attractiveness and reproductive capacities, women with disabilities are all too often regarded as lacking in each case. Disability affects whether and how women are permitted to participate in sexual, reproductive and nurturing activities. In a culture where women are still defined, to a significant extent, as sexual beings, reproducers and nurturers, the, “general culture limits disabled women’s maternal occupation and leaves them ‘roleless’”.ⁱⁱ Thus, even in contemporary society, women with disabilities are denied the roles most commonly assigned to their gender and the characteristics most valued in women.

There is increasing awareness within the international human rights community about the sexual and reproductive health needs of women. International human rights law has expressly recognised women’s rights to intimate relations and reproductive choice by promulgating protections and obligations with respect to marital status, access to contraceptives, family planning, pre and post-natal care, sexual violence and sexually transmitted diseases. For example, one United Nations Human Rights Committee has acknowledged that, “[t]he realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health”.ⁱⁱⁱ Yet, despite the particular relevance of these topics for women with disabilities, the international community has given scant attention to barrier removal and the promotion of rights for women with disabilities in the areas of sexual and reproductive health.

The failure of States to apprehend the interests of women with disabilities has been noted: “persons with disabilities are sometimes treated as genderless human beings, and as a result, the double discrimination suffered by women with disabilities is often neglected”.^{iv} That women with disabilities are routinely regarded as asexual implies that they do not, or should not, have any aspirations to motherhood. In theory, women with disabilities, like all people, enjoy the full spectrum of human rights guaranteed by international law. However, in order for women with disabilities to secure meaningful inclusion and participation in society, special attention must be accorded, as a matter of human rights, to enhancing the dignity and self-determination of women with disabilities as sexual citizens, and to facilitate their equal access and opportunity to sexual and reproductive health services.

We use as a starting point the fundamental human rights values of equality, dignity and inclusion, and we explore the promotion of these values in the areas of sexual citizenship, reproductive care and decision-making and parenting for women with disabilities. We argue that self-determination about reproductive health and sexual well-being are integral human rights for women with disabilities. We begin with a brief overview of the various international human rights instruments that speak to sexual health and reproductive rights. Next, we examine barriers existing in education, law and health services that hinder the sexual, reproductive and parenting rights of women with disabilities in Canada. Through this analysis, we seek to articulate how the interests of women with disabilities regarding their bodies, sexuality and reproductive capacities must be informed by the human rights values of equality, dignity and inclusion. By focusing on sexuality, reproduction and parenting in the lives of women with disabilities, we seek to gain additional purchase in understanding how gender and disability intersect, and aim to call attention to new practices, attitudes and institutional arrangements which will enable women with disabilities to participate fully and experience intimate fulfillment in our society.

II. International Standards Regarding Sexual, Reproductive & Parenting Rights

The legal interests of women with disabilities to sexual and reproductive health have been described as the, “new frontiers for the advancement of human rights”.^v Complicating the advancement of these rights is the lack of consensus as to what sexual and reproductive rights might entail for women with disabilities; nowhere are they captured in a single, explicit, legally codified provision. Rather they must be traced from various freedoms, entitlements, and principles that address an array of human rights issues, such as bodily integrity, privacy and non-discrimination.

Promoting and protecting the interests of women with disabilities, in regards to parenting and sexual and reproductive health, involves a myriad of positive and negative legal, social, economic and political rights.^{vi} The Center for Reproductive Rights (CRR) describes sexual and reproductive rights as “embedded in” and “supported by” a number of internationally recognised human rights principles that relate to health and self-determination.^{vii} Consequently, a broad range of international instruments, declarations and covenants, reflecting human rights standards must be consulted to ascertain the legal rights of women with disabilities to sexual citizenship and reproductive health.^{viii} According to Cook, Dickens and Fathalla, “rights are interactive, in that each depends to a greater or lesser degree on the observance of others,” and therefore this assortment of international rights and principles needs to be “read interactively” and “applied cumulatively” to advance the interests of women in sexual and reproductive health.^{ix}

Among the international human rights principles that encompass legal, social, economic and political rights and which may therefore give legal force to fundamental human rights to parenting, sexual citizenship and reproductive health, are:

- the right to life, liberty and security of the person;^x
- the right to equality and non-discrimination;^{xi}
- the right to marry and found a family;^{xii}
- the right to highest standard of attainable health;^{xiii}

- the right to reproductive health, including family planning and maternal health services;^{xiv}
- the right to information and education about sexual health, family planning and reproductive services;^{xv}
- the right to privacy;^{xvi} and
- the right to not be exploited, subjected to inhuman or degrading treatment, or non-consensual medical treatment.^{xvii}

As this list suggests, the rights of women with disabilities with respect to parenting, and sexual and reproductive health are related to and dependent upon the observance of a diverse range of complementary human rights principles^{xviii} that are articulated in several international instruments and consensus documents ranging from the 1948 *Universal Declaration of Human Rights* to the recent 2006 *Convention on the Rights of Persons with Disabilities*.^{xix}

While most of these international instruments address rights related to broad principles of physical and psychological integrity and non-discrimination, one document draws particular attention to the parenting, sexual and reproductive concerns of the disability community. The *Standard Rules* begin by emphasising that States must promote the right of people with disabilities to, “personal integrity and ensure that laws do not discriminate against persons with disabilities with respect to sexual relationships, marriage and parenthood”.^{xx} The *Standard Rules* further provide that, “[p]ersons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood”.^{xxi}

In addition to the foregoing declarations and covenants, international human rights Committees have put forward a number of important statements and recommendations salient to issues of sexual and reproductive self-determination and parenting rights of women with disabilities.^{xxii}

In 1994, the CESCR Committee issued *General Comment No. 5*, a document devoted entirely to elucidating the human rights of people with disabilities.^{xxiii} The Committee noted that the right of people with disabilities to marry and have their own family “...are frequently ignored or denied, especially in the case of persons with mental disabilities”.^{xxiv} The Committee further reinforced the principles regarding sexual and reproductive health, first articulated in the *Standard Rules*, by emphasizing that, “[w]omen with disabilities also have the right to protection and support in relation to motherhood and pregnancy,” and that their sexual, “needs and desires ... should be recognized and addressed in both the recreational and the procreational contexts”.^{xxv} The Committee emphasised that non-consensual sterilisations and abortions on women with disabilities are serious violations of the right to health under Article 12.^{xxvi}

Six years later, in *General Comment No. 14*, the CESCR Committee elucidated that the “right to health” consists of the freedom to control one's body, which also entails sexual and reproductive self-determination.^{xxvii} The Committee highlighted that the “right to health” must be interpreted to include equality and non-discrimination in the delivery of health services, physical accessibility, affordability and, “access to health-related

education and information, including on sexual and reproductive health”.^{xxviii} The Committee concluded that these components of the right to health are fundamental human rights indispensable for the exercise of other human rights.

The recent *Convention on the Rights of Persons with Disabilities (CRPD)* provides that States Parties need to ensure that persons with disabilities have equality with respect to fertility, independent decision-making and responsibility regarding the number and spacing of their children.^{xxix} The *CRPD* further elucidates that the right of persons with disabilities to appropriate and affordable health must include sexual and reproductive health and population based public health programmes.^{xxx}

It is apparent from the above survey that sexual and reproductive rights encompass a broad range of human rights issues, and a variety of international instruments and statements can be read to embrace the interests of women with disabilities to parenting, sexual citizenship and reproductive health. While the identified documents are not an exhaustive inventory of the potential legal foundations upon which sexual, reproductive and parenting rights can be built, these documents indicate that the integral components of the right to equality and physical and psychological integrity are built on the values of dignity, inclusion and self-determination. Rooted in the fundamental principles of equal citizenship, sexual and reproductive rights for women with disabilities seek to enhance the ability of women with disabilities to access, participate in and control safe and satisfying intimate relations and promote their freedom to choose and capacity to reproduce.

III. Right to Sexual Health Education

It is widely accepted that education is an essential tool for promoting healthy attitudes and beliefs about sexual identity, intimacy and reproduction, as well as a means to prevent and protect against sexual abuse and exploitation. In commentaries regarding the significance of sex education to the rights of women, children and racialized communities, numerous United Nations Committees have urged governments to prioritise sexual and reproductive health education and systematise sex education in schools.^{xxxi} Rule 9(2) of the *Standard Rules* state that, “[p]ersons with disabilities must have the same access as others to family planning methods as well as to information in accessible form on the sexual functioning of their bodies”. Although such human rights instruments are unequivocal about the importance of the right to education in areas of sexual health and reproduction, the enshrined principles are far removed from the reality of sex education for people with disabilities. Research substantiates that women with disabilities do not receive accessible and non-judgmental information and counselling responsive to their sexual and reproductive health needs.

In Canada, while all provinces currently have school curricula that address sexual health, due to conservative social and religious ideology, sex education has been a contentious issue until recent decades. The controversy and shortcomings in the provision of sex education historically have been aggravated for the disability community because of the erroneous perception that sex education is inappropriate and unnecessary for people with disabilities.^{xxxii} A World Health Organization (WHO) document indicates that society, families and educational institutions tend to openly “ignore or repress” the needs and self-

realisation of youths with disabilities regarding their sexuality and that sexual education for adolescents with disabilities, “remains in nobody’s land”.^{xxxiii}

According to research findings regarding the general population, people normally learn about sex from their peers, although among young people it is becoming more common to learn about sex from school and parents.^{xxxiv} With increased inclusive education in Canada, disabled girls today have more informal opportunities to learn about sex from school friends.^{xxxv} However, girls with disabilities continue to face significant barriers to obtaining formal sex education. As sex education continues to be a component of physical education classes, young women with disabilities who are not included in these classes or who are in segregated educational settings often do not receive this information.^{xxxvi} Sex education is also taught in other inaccessible ways or fails to address the needs of people with disabilities. For example, generic teaching materials that document the physiological functions of able-bodied women may not include accurate information or depict images about bodily differences in women with disabilities, such as episodic menstrual cycles, loss or lack of sensation or prosthetic limbs.^{xxxvii} Further, sex education relies to a significant extent on the presentation of visual illustrations, graphs and diagrams, but persons with vision disabilities require materials in alternate formats, which are not readily available.^{xxxviii} Persons with learning disabilities in particular often do not receive thorough information, because they are often infantilised and overprotected.^{xxxix} Moreover, prejudicial social mores persist to cast doubt on the propriety and necessity of providing girls with disabilities with comprehensive and candid sex education.^{xl}

In a study about women with disabilities, sexual health and rehabilitation services, the United States Center for Research on Women with Disabilities (CROWD) observed that women who received sex education in rehabilitation programs noted that the rehab programs did not address their needs because they predominantly dealt with men’s issues, and were offered too early during their recovery, at a time when they had more pressing concerns.^{xli} Very little Canadian research has specifically examined the nature and extent of sex education available to women with disabilities. A 2004 report studying issues of sexuality and abuse amongst persons with severe speech impairments, however, signals the systemic inadequacy of sex education for people with disabilities.^{xlii} This study documented that amongst people who use augmentative and alternative communication (AAC) systems there were extensive gaps in the knowledge and experience related to the expression of healthy sexuality.^{xliii} Thirty-four per cent of the participants identified that they required assistance to simply locate and access sexual health education, and this was a particular obstacle for older participants who were excluded from educational programs because of age restrictions.^{xliv} The majority of the AAC participants (73–88%) had no vocabulary (pictures or symbols) to communicate about sexual matters, such as privacy, body parts, feelings, sexual activities, as well as issues of abuse.^{xlv} Most participants reported that they received no sex education from their parents, at school or from their health care professionals and, “expressed an overwhelming need to learn about and discuss aspects of healthy sexuality”.^{xlvi} The report documented that the lack of information compounded the participants’ communication difficulties and heightened their exposure to sexual abuse.

The importance of sex education for women with disabilities is underscored by the fact that women with disabilities experience disproportionate physical and sexual abuse.^{xlvii} A recent WHO report highlights that, “[f]actors, such as increased physical vulnerability, the need for attendant care, life in institutions, and the almost universal belief that disabled people cannot be a reliable witness on their own behalf make them targets for predators”.^{xlviii} Women with disabilities are 1.5 to 10 times as likely to be abused as non-disabled women,^{xlix} and likely to experience longer durations of abuse than women without disabilities.¹ Research reveals that women with developmental disabilities face the highest risks of sexual abuse and, “studies further indicate that women who are unable to have children because of sterilization or birth control use might be at higher risk for sexual abuse if perpetrators know their actions will not be detected through pregnancy”.^{li} Although it is widely recognised that a key component for prevention of sexual abuse is sex education, a recent report confirms that sex education courses tend to take place in venues not accessible to people with disabilities and, “the lack of information on sexuality and women with disabilities makes such discussions more difficult”.^{lii} Thus, despite the explicit provision in the *Standard Rules* that people with disabilities should be educated about how to protect themselves from abuse,^{liii} society remains oblivious to how the absence of timely and relevant sex education systematically heightens the vulnerability and victimisation of women with disabilities.

Health Canada recently disseminated *Canadian Guidelines for Sexual Health Education (Guidelines)*, a teaching tool promoting comprehensive sex education to encourage positive outcomes such as self-esteem, respect for others, non-exploitative and rewarding sexual relations.^{liv} The *Guidelines* are based on a philosophy that emphasises balancing personal desire, the rights and needs of others, and societal expectations, as well as the absence of discrimination based on race, gender, sexual orientation, religion, ethno-cultural background or disability. This philosophy is that effective sex education, “[p]rovides accurate information to reduce discrimination”.^{lv} The *Guidelines* recognise the importance of education that occurs in conjunction with access to clinical services, counselling and social services, community support, and physical resources that are required to support individual efforts to enhance sexual health and avoid sexual problems.

Thus, a vital component of appropriate sex education is not just teaching disabled individuals about their own sexual health, but also educating non-disabled people, including family members, counsellors, health care and other service providers, to respect the sexuality of people with disabilities. The 2004 AAC report noted that, due to inadequacies of information and education, non-disabled people hold significant misconceptions about the sexuality of persons with speech disorders. In order to promote healthy sexuality and prevent abuse, the report recommended that family and service providers must also be educated about the sexual needs of people with disabilities.^{lvi} The recent WHO document indicates that families often avoid reference to sexuality in relation to their adolescent children with disabilities, refuse to reply to questions regarding puberty and developing bodies or, “even worse ... project their own fear and anxieties in their replies”.^{lvii}

It is well-established in Canadian disability rights jurisprudence that inequality can manifest both from differential treatment that results in exclusion or because of a failure to

take into account a group's already disadvantaged position within society.^{lviii} We see that both forms of discrimination occur due to deficiencies in the provision of sex education to women with disabilities. Inadequate sex education discriminates against women with disabilities by disregarding their right to equal treatment in education and simultaneously rendering them vulnerable to sexual abuse. This lack of comprehensive and accessible sex education undermines the human rights interests of women with disabilities, particularly in regards to their right to make informed choices about their personal health and bodies, and further exacerbates their disadvantaged status as a population systemically at risk of sexual violence.

Women with disabilities must be guaranteed a right to equal access to, and benefit from, sex education, including education about sexual and reproductive health, sexual orientation, contraceptives and sexually transmitted diseases. Failure to provide sex education perpetuates the marginalisation of women with disabilities, diminishes their capacity for self-determination, exposes them to risk of sexual abuse, and accordingly constitutes a form of systemic discrimination that jeopardises their physical and psychological integrity.

IV. Right to Intimate Relationships

Social inclusion is recognised as an integral component of the individual's and society's well-being.^{lix} Moreover, the principle of social inclusion lies at the heart of all rights and freedoms articulated for and about people with disabilities in international human rights law. Despite the myriad of international documents and declarations that seek to promote the full and effective participation of people with disabilities in social life, we see that women with disabilities continue to experience tremendous isolation, exclusion and marginalisation in one important area of social inclusion, specifically, involvement in emotional, personal and intimate relationships.

Women with disabilities encounter significant obstacles to social participation, including negative attitudes and physical barriers, which hinder their opportunity to meet people and form friendships, and thereby limit their capacity to enjoy social relationships and sexual expression. As one author points out:

[t]he degree to which an individual with a physical, sensory, or cognitive disability is capable of exploring and expressing her/his sexuality can depend upon the ability to meet potential partners. Environmental and monetary factors (e.g., architectural barriers to social gatherings, lack of money for transportation and/or sign-language and voice interpreters) can prevent people with disabilities from exploring sexual relationships.^{lx}

Most activities in which adults participate to meet others are simply inaccessible to women with disabilities. Research confirms that accessible transportation is a serious problem throughout Canada and that women with disabilities experience barriers in using local conventional and specialised transit up to twice as much as men.^{lxi} Recreational venues and sports clubs popular for group-based social activities, such as restaurants, clubs, bowling alleys and movie theatres, are routinely inaccessible to people with physical disabilities.^{lxii} Barriers to employment that women with disabilities face also limit their social interaction. Employment is a source of independence. It generates the

money to afford social activities, as well as providing a social context within which to meet potential friends, partners and lovers, but also the sense of worth and accomplishment required to form healthy relationships.^{lxiii} However, Canadian statistics indicate that, in the year 2000, only 23.2% of women with disabilities held full-time, full year employment.^{lxiv}

Difficulties in accessing adequate housing create further barriers. Limited housing opportunities force women to live relatively far from their friends and acquaintances and result in fewer chances to socialise.^{lxv} Women who live in institutional settings face barriers to developing intimate relationships because they often do not have the possibility of expressing their sexuality.^{lxvi} Those who live independently, but who require the services of personal assistants, may face additional difficulties in building relationships and intimacy given that their privacy is impacted.^{lxvii}

All of the foregoing barriers, compounded by stereotypes and myths, limit social interaction, curtailing opportunities for women with disabilities to form sexual and intimate relationships. Assumptions also abound about the sexual orientation of women with disabilities, who are viewed as uniformly heterosexual. If a woman is known to be lesbian, her sexuality is perceived as her failure to be a real woman.^{lxviii} Lesbian women with disabilities face even more difficulties establishing relationships as a minority within a minority that often feel they belong in neither group. They may feel unwelcome in the disability movement where they sometimes experience prejudice and homophobia.^{lxix} On the other hand, they are also excluded from the lesbian social arena. They are excluded in the same manner that heterosexual disabled women are socially excluded (transportation and architectural barriers, exclusion from employment, lack of housing, etc.) and, in addition, are not considered “proper” lesbians because it is believed that their disabilities preclude them from having an independent sexuality. As a result, they often feel lonely and isolated in a community that celebrates sexuality and physical appearance.^{lxx} This situation presents greater complications for women who are not accepted in their families and need to create a “chosen family” for themselves.^{lxxi}

The right to freely express and exercise one’s sexuality is a developing area of law. In 2004, the United Nations Commission on Human Rights affirmed that an, “understanding of fundamental human rights principles, as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights”.^{lxxii} The previous year Health Canada similarly confirmed that “[s]exuality is a central aspect of being human throughout life,” and that, “[s]exual health is a state of physical, emotional, mental and societal well-being related to sexuality”.^{lxxiii} Thus, Health Canada adopts the notion that, “[f]or sexual health to be attained and maintained, the sexual rights of all persons must be protected and fulfilled”.^{lxxiv} Cook, Dickens and Fathalla point out that, “human sexuality serves more than the purpose of reproduction. It enhances human bonding, spouse or partner attraction, intimacy, affection and fidelity, and social stability, thereby maximizing human development and security.”^{lxxv}

This acknowledgement of the fundamental nature of sexuality to human identity is the central justification for extending human rights protection to intimate relationships and activities concomitant with sexual expression. Given that sexual health is a critical dimension of human identity, failure to respect, or unjustifiable interference with, this

aspect of a person's identity is inconsistent with human rights principles regarding the physical and psychological integrity of people with disabilities. Accordingly, for women with disabilities, an important feature of this right to sexual health involves protecting and promoting their ability to control and exercise sexual expression on their own terms. This conception of human sexuality however, is in stark contrast with the reality that women with disabilities face. Anne Finger argues: “[s]exuality is often the source of our deepest oppression; it is also the source of our deepest pain”.^{lxxvi} Women with disabilities, like children and elderly people, are generally seen as dependent persons who are not fully active participants in society. As such, their sexuality is undermined and their capacity for sexual feeling and activity denied.^{lxxvii}

The right to sexual expression and assisted sexual activity is an emerging issue for people with disabilities. One author posits, “[r]eceiving Personal Assistance Services (PAS) for sexual activity is becoming of increasing importance to the disability community and to mental health professionals”.^{lxxviii} The World Health Organization has argued that all persons should be able to enjoy and control their sexual and reproductive behaviour, and that sexuality should be part of health care.^{lxxix} The issue of assisted sexual expression raises a multitude of complicated questions and ethical tensions regarding private and public interests. As McSherry and Somerville suggest for people with disabilities, “[t]he existence of a right to freedom of sexual expression is more controversial than that of a right to marry or a right to physical integrity. No legal document enshrines such a right”.^{lxxx} However, given existing human rights protection for sexual health, privacy, personal relationships^{lxxxii} and the right to equality for people with disabilities, a right to assisted sexual expression is grounded in human rights principles that promote the physical and psychological autonomy and integrity of people with disabilities and guarantee their equal treatment in services.

The *Canadian Charter of Rights and Freedoms*^{lxxxii} and the various human rights codes enacted by the provinces and the federal government prohibit discrimination on the basis of disability in the provision of services, including disability-related health services and social programs.^{lxxxiii} Thus, it is well-established in Canadian human rights law that people with disabilities are entitled to receive equal access to treatment and accommodation in services, and this freedom from discrimination applies to both private and public sector services. The Supreme Court of Canada has stressed the importance of the role of accommodation in advancing the inclusion and participation of people with disabilities in society has recognised that achieving meaningful equality in receipt of services often requires accommodation in the provision of the service.^{lxxxiv} The Supreme Court has described disability accommodation as a highly individualised process, which must be sensitive to the unique needs and interests of individuals with disabilities in order to respect and promote their dignity, integrity and empowerment.^{lxxxv}

Approximately 22% of adult Canadians with disabilities receive supports and services from public and private agencies and organisations that provide assistance in the home for carrying out everyday activities.^{lxxxvi} In the context of attendant supports for people with disabilities, the right to equal treatment in services may involve augmenting the service and/or adapting delivery methods in order to assist the client to receive and benefit from the service. The Supreme Court of Canada has held that when a service provider, such as a

local government agency, chooses to supply a service or accord a benefit, they must do so on a non-discriminatory basis.^{lxxxvii} If sexuality is an integral component of human identity, and personal attendant care is a service provided to facilitate independence and meaningful inclusion, it may be argued from a disability rights perspective that in order to benefit from the service and achieve equal citizenship, the person involved must be provided access to, and accommodation in, care services so that they may enjoy intimate fulfilment and sexual expression.^{lxxxviii}

It has been argued that assisted sexual expression comes within the ambit of personal care attendant services and therefore the provision of such services must be conferred in a non-discriminatory manner.^{lxxxix} Howe contends that care providers should help their clients prepare for social situations, and that an equity argument can be made to support public financing for sexual facilitation and sexual surrogacy.^{xc} The range of services encompassed by assisted sexual expression are as broad and varied as the range of impairments for which attendant services are provided, and may include: sex education, transportation, removal of clothing, transferring from wheelchair to bed, purchasing or applying birth control, etc.^{xc} As one author asserts, “[b]ased on general notions of PAS, sexual positioning certainly appears to be a component of personal daily life activity”.^{xcii}

In seeking assisted sexual expression, people with disabilities are simply invoking their right to equal treatment with respect to service provision and are availing themselves of an existing benefit; namely attendant services, a program explicitly created to provide support in daily living and personal care to enhance the integration and independence of people with disabilities into mainstream society.^{xciii} According to human rights principles, if assisted sexual expression was accepted as part of the right to equality in services, then the only exemption that would permit the proscription of this service would be the exception of reasonable accommodation short of undue hardship.^{xciv} This means that the right to equal treatment in services, and the duty to accommodate in such services, is qualified only to the extent that the service provider experiences “undue hardship”. Given the fundamental importance of ensuring that people with disabilities achieve equality, the Supreme Court has articulated a high standard for proving undue hardship.^{xcv}

The basic problem that people with disabilities in Canada face, before even securing attendant services to facilitate sexual expression, is simply ascertaining their rights and their agency’s policies and procedures regarding assistance with sexual practices.^{xcvi} For example, the 2004 AAC study involving persons with speech disabilities revealed that a number of adult participants living in group homes did not know if they were “allowed” to have sexual relationships within that setting.^{xcvii} The AAC study revealed that 65% of the participants had questions about an attendant’s role in assisting them with sexual activities, such as preparation, positioning, using safer sex supplies, birth control, bathing after sex and masturbation.^{xcviii}

Due to prevailing social prejudices that negate the sexuality of people with disabilities, most service agencies have either largely overlooked this issue or deliberately refused to address the concerns of people with disabilities to assisted sexual activity. A survey of clinicians’ attitudes on sexual relations between patients showed that attitudes were primarily influenced by prejudices around the nature and location of the sexual act, as well as the gender of the patients. The researchers found that competence and consent were not

correlated to staff attitudes, even though those are the norms of law and due process.^{xcix} Similarly, group homes and other disability housing units also have failed to address the issue of sexual activity amongst residents and on the premises. A content analysis of policies on sex between inpatients in psychiatric hospitals found that only 16% dealt with staff training.^c

It is critical that attendant agencies and assisted living centres develop policies and guidelines to address these issues so as to foster a healthy living environment and ensure that their services are provided in a discrimination-free manner. As McSherry and Somerville posit, “[h]aving a policy at the very least helps to establish a consensus regarding the way staff members should behave toward sexual activity among persons in their care, and reduces the problem of individuals in institutions having constantly to adjust their behaviour to differing attitudes of staff members”.^{ci} Mechanisms and policies must be created to assist people with disabilities to make decisions and access services that enhance their independence and capacity to engage in sexual expression.

V. Right to Marry

Contemporary Western society has observed significant changes regarding the concept of marriage, the right to marry, who is considered “marriageable” and what are considered to be proper intimate relationships. For example, in North America, legal prohibitions against inter-racial or inter-religious marriage no longer exist and, in some jurisdictions, legislation has been enacted recognising the validity of same-sex marriages.^{cii} Social attitudes are more tolerant of different types of relationships, such as common law relationships, care relationships, age differences between partners, marriage amongst seniors and even matters of consanguinity. However, while social and legal understandings of marriage and personal relationships are dramatically evolving, society continues to hold negative ideas about the propriety of marriage for people with disabilities, and in particular, people with mental disabilities.^{ciii}

The decision to marry and found a family is a right enshrined in Article 16 of the *UDHR* and this right is reinforced in other international human rights instruments.^{civ} Rule 9 of the *Standard Rules* requires States to ensure that laws do not discriminate against people with disabilities with respect to marriage and further exhorts, “[t]aking into account that persons with disabilities may experience difficulties in getting married and setting up a family, States should encourage the availability of appropriate counseling”. Given these international pronouncements seeking to promote self-determination and dignity for people with disabilities with respect to marriage, restrictions on the right to marry must never be imposed based on stereotypical and discriminatory notions about people with disabilities. The decision to marry is a deeply personal matter that involves the individual in a socially honoured pledge and legally recognised contract.

The stereotype that people with disabilities lack mental capacity to understand the nature of marriage is invoked frequently and globally to deprive people with disabilities of their right to marry and found a family.^{cv} For example, marriage and guardianship laws in certain parts of the United States prohibit the marriage of individuals with intellectual and mental disabilities.^{cvi}

However, this stereotypical presumption and its enactment in legislation conflicts with international human rights values of equality and full citizenship. The *Principles for the Protection of Persons with Mental Illnesses* clearly provide that a determination of mental illness does not equate with wholesale lack of capacity and that persons with mental illness have equal legal, economic, social and political rights as guaranteed to all persons in human rights law.^{cvii} The right to marry and found a family, as well as the right to privacy and family life, are entitlements guaranteed to people with disabilities in a variety of international treaties. A number of human rights documents have recognised that the rights to marry and found a family have particular relevance to people with mental disabilities because of society's tendency to correlate mental disability with lack of capacity. As McSherry and Somerville posit, “[i]t is one thing to have a requirement that marriage be fully consensual, but another matter entirely to have a provision restricting the right of individuals with intellectual disabilities or mental illness to marry”^{cviii}

Marriage laws that directly or indirectly presume persons with mental illness lack capacity to marry are discriminatory. Such laws violate the psychological integrity of people with mental disabilities by interfering with a profoundly intimate and personal choice and undermining the individual's basic freedom and autonomy to make life decisions about their future. By linking incapacity to marry with mental disability, such marriage laws not only deny people with mental disabilities autonomy in a profoundly personal matter, but appear to suggest that such persons are not entitled to the respect and rights accorded to others. This is inconsistent with the fundamental values of inherent dignity and equality for people with disabilities recognised in international human rights law.

Furthermore, by spotlighting people with mental disabilities and treating them differently, any marriage legislation that does so, effectively implies that the mental condition renders the person “unmarriageable” and in so doing, stigmatises and demeans their human dignity. A WHO report points out that, “[e]xtreme poverty and social sanctions against marrying a disabled person mean that they are likely to become involved in a serious of unstable relationships,”^{cxix} thereby exacerbating their vulnerable status.

The right to marry is one example of where social prejudices about disability, gender and sexuality intersect and adversely impact on the power of women with disabilities to enjoy intimate relations and experience the rights and responsibilities concomitant with marriage. There are strong misconceptions about the relationships of women with disabilities: if a woman with a disability is single or living alone, this cannot be by choice but rather because no one wants her; if she is in a relationship with a non-disabled person, he or she must be a special person who takes care of her or, conversely, a person who has a suspicious desire to hide his or her own inadequacies or some other form of neurosis; if she lives with a disabled partner, they must have chosen each other simply because they are both disabled rather than for any other qualities they might have, and their relationship must be non-sexual.^{cx}

The prevalence of negative stereotypes that question the mental capacity of those with disabilities to enter into a marriage are especially problematic for women with disabilities. Women with disabilities are disproportionately and routinely labelled as incompetent, particularly with respect to issues of consent, sexuality and reproduction.^{cxii} Feminist and disability research highlight that women generally, and women with disabilities in

particular, are at “special risk” of being constructed as incompetent.^{cxii} The leading Supreme Court of Canada case on sterilization, *E. (Mrs.) v Eve*,^{cxiii} provides a clear example of this problem. Despite the positive outcome of the decision which endorsed a disability-rights approach to sterilisation, the Supreme Court nevertheless accepted the lower court’s characterisation of Eve, an adult female with an intellectual disability, as incompetent. Notwithstanding evidence that the young woman was fully integrated in her community, regularly attended a school for adults with disabilities and was interested in a romantic relationship with a peer pupil, the lower court found, and the Supreme Court did not question, that Eve was incapable of making decisions regarding her personal relations and reproductive health. Discriminatory laws regarding marriage reinforce and further entrench such negative stereotypes about women with disabilities, while simultaneously violating their human rights.

Marriage laws can no longer operate on the paternalistic assumptions that people with mental disabilities and women with disabilities do not have capacity to understand personal and intimate relationships and that therefore it is in their best interests for society to ensure that they refrain from engaging in such arrangements and forging such a bond. Such stigmatisation, loss of autonomy and interference with personal relationships violates the psychological integrity of people with disabilities and is contrary to human rights principles which seek to, “break down the barriers that stand in the way of equality for all”.^{cxiv} As stipulated by the *Standard Rules*, governments need to develop and institute social and legal measures that enable people with disabilities, by means of education, counselling and appropriate services, to make informed choices with regard to intimate relations and marriage. A presumption of incapacity present in marriage laws offends the dignity of people with disabilities. To be in harmony with other disability rights protections entrenched in international human rights law, marriage legislation must be interpreted to promote independence and dignity of people with disabilities and therefore should operate on a presumption that people with disabilities have the capacity to make personal decisions.^{cxv}

VI. Right to Sexual & Reproductive Health

International human rights law recognises, through Article 12 of the *ICESCR*, the “right of every person to the highest attainable standard of physical and mental health”. This right to health has been interpreted to include the right to, “a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health”.^{cxvi} In Canada, section 3 of the *Canada Health Act* states that, “[i]t is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers”.^{cxvii} Concomitantly, provincial health insurance plans provide universal, comprehensive and accessible health care to all Canadian residents.

However, while the majority of Canadians receive the medical services they need, women with disabilities experience significant barriers in accessing sexual and reproductive health services. Physicians often lack knowledge about sexuality issues particular to women with disabilities and do not know how to adapt their practices in order to serve

them better. Despite laws and policies that prohibit discrimination in services on the ground of disability,^{cxxviii} medical facilities are often physically inaccessible,^{cxxix} or services are provided in an inaccessible manner.^{cxxx} One author describes how women with disabilities are denied necessary health services because of numerous:

environmental, attitudinal and information barriers. For example, many physically disabled women can't access standard diagnostic equipment. We can't stand before scanners, climb onto high tables, or wrench our legs into stirrups. Consequently, we are less likely to have mammograms and regular Pap tests.^{cxxxi}

Moreover, because women with disabilities are seen as asexual and unable to procreate, the sexual and reproductive aspects of their health care are often neglected.

In accordance with the right to health and human rights principles, women with disabilities in Canada must be provided equality in accessing and benefiting from health care services. This is consistent with the equality rights values articulated by the Supreme Court of Canada in a variety of cases about disability services and health care. The Court has stated that public officials must be sensitive to differences in the actual needs of vulnerable groups in order to protect their equality rights and the government is under a positive duty to provide accommodation to address those differences.^{cxxxi} The Supreme Court has also held that discrimination may accrue from a failure to ensure that the people with disabilities benefit equally from services offered to the general public.^{cxxxi} We see that women with disabilities are routinely denied these rights in the area of contraception, obstetrical care and reproductive health.

i) Contraception

Women with disabilities experience difficulty in accessing accurate information about contraceptive options and gaining access to contraceptives. While it is standard practice for gynaecologists to ask their patients of reproductive age about birth control, this matter is not automatically put to women with disabilities, especially those who have physical disabilities, as it is often assumed that they are not sexually active.^{cxxiv} Women with disabilities therefore are compelled to raise the subject themselves, which can be uncomfortable for some individuals.^{cxxv}

Research indicates that, as with other issues of gynaecological care, when prescribed contraceptives, such as birth control pills and Depo-Provera injections, women with disabilities are routinely given little or no explanation and description about why and how contraceptives are to be used, the side effects, or alternative forms of contraception.^{cxxvi} Doctors, parents and caregivers often fail to provide adequate education regarding birth control. Consequently, not only are women with disabilities deprived of important information about contraception usage, they can be unaware of what it is that they are using and even left ignorant about the fact that that they are, indeed, using it.^{cxxvii} For women with disabilities this situation, “serves to perpetuate a lack of control over reproductive choices just as forced sterilization did in the past”.^{cxxviii} This failure to ensure fully informed access to appropriate birth control undermines the ability of disabled

women to control their fertility, impinges on their right to self-determination and strikes at their physical and psychological security.

There is also a lack of information among health care professionals about the most appropriate contraceptive methods for women with disabilities.^{cxxxix} The impact of hormonal agents such as non-estrogenic contraceptives (for example, Norplant) on underlying disabilities has not been well studied.^{cxxxix} It is believed that estrogen-containing oral contraceptives may not be appropriate for women with mobility impairment because of their increased risk of thrombotic predisposition.^{cxxxix} According to some researchers, estrogen and progesterone have an impact on seizure thresholds.^{cxxxix} These issues require further research in order to establish guidelines for contraception methods for women with disabilities.

The Supreme Court of Canada issued a strong pronouncement in *Eve* that non-therapeutic and non-consensual surgical sterilisation must never take place. However, women with disabilities continue to experience the same pervasive social prejudices and attitudes that shaped and justified past sterilisation practices with respect to their sexual and reproductive capacity. In most cases, these attitudes are a reflection of the concerns of society, and in particular the individual's family, about the impact of a pregnancy on the disabled woman and her caregivers. The fear is that the disabled woman will not be able to manage her own fertility to prevent pregnancy or, especially in an institutional setting, that her vulnerability will make her an easy target of sexual abuse leading to pregnancy. In both cases, the woman with a disability is regarded as an object of care and reconfiguration. To literally carve out the reproductive capacity of the body of the disabled woman is viewed as the better and more convenient option rather than placing responsibility on those who are entrusted with her care and protection.

While it is clear that Canadian courts will not approve the non-therapeutic sterilisation of persons who are mentally disabled, courts appear to accept less intrusive methods to secure similar results. In an Alberta case called *Re C.M.L.*,^{cxxxiii} the Surrogate Court determined the propriety of the Public Guardian's decision to consent to the insertion of an Intrauterine Device (IUD) for C.M.L., a 45 year-old sexually active woman, who was under guardianship. According to the judgment, C.M.L. stated that she did not want to get pregnant but was having difficulty with birth control pills and condoms. The Court concluded that the insertion of an IUD was the best and least intrusive method of complying with C.M.L.'s wish to avoid a pregnancy. Regarding the criteria to be applied however, the Court suggested that there was a lower threshold concerning consent when dealing with "functional sterilization" of an IUD as opposed to surgical sterilization. The Court stated the consideration was simply the best interests of the dependent adult.^{cxxxiv} Despite the lack of consent, the Court appears to conclude that non-therapeutic "functional sterilization" was in C.M.L.'s best interests. The Court's finding clearly implies that the reproductive rights and rights to bodily integrity of adults with mental disabilities may be infringed more easily in cases where less drastic means than surgical sterilisation exist.

This line of reasoning leaves open the possibility that Norplant implants, for example, could be justified on this basis, notwithstanding the multitude of complications and side effects that are often associated with their use. We need to question why medical

interventions, even those less invasive than surgery, should ever be justified on the basis of best interest unless there is a reason for the intervention beyond the existence of disability. And, when the procedure in question is one which affects the reproductive capacity of non-consenting women with mental disabilities we need to be particularly vigilant to ensure that it is carried out for therapeutic reasons only. Although the language of the Court implies a paternalistic prejudice against a woman with disability exercising reproductive choice, *Re C.M.L.* can instead be viewed as the Court respecting the reproductive wishes of a dependent woman, thus enhancing her dignity.

(ii) Obstetric Care

Consistent with human rights legislation, the *Code of Ethics* of the Canadian Medical Association (CMA) imposes a duty on physicians to not discriminate against a patient in providing medical services. Section 17 of the Code provides that while a physician may refuse to accept a patient for legitimate reasons, a doctor must not discriminate against a patient on protected grounds, such as medical condition, physical or mental disability.^{cxxxv} These laws and policies confirm the right of women with disabilities to have access to the services and support of health care professionals when they are, or wish to become, pregnant. However, the reality that women with disabilities experience is entirely different. In addition to the physical inaccessibility of doctors' offices, hospitals and birthing centres, women with disabilities contend with degrading messages and stereotypes about their ability to fulfil the role of a parent. The pervasive biases that women with disabilities face include:

fears that a disabling condition may be passed on to a child; assumptions that disabled women cannot nurture, care for, or discipline children; the belief that mobility is essential for childrearing; and notions that a mother's disability would be a hardship to her children.^{cxxxvi}

Health care professionals and others routinely opine that a woman with a disability should not get pregnant or continue the pregnancy if there is a risk that the child could inherit the disability.^{cxxxvii} These pejorative assumptions and judgments undermine women's sense of self-worth and intensify their insecurities about motherhood.^{cxxxviii}

The difficulty that women with disabilities experience in gaining access to meaningful obstetrical care also reflects the paucity of knowledge and research about the specific issues related to pregnancy and birth for them.^{cxxxix} Though the SOGC and the CMA have established guidelines for obstetrical care, these do not address the particular needs of women with disabilities.^{cxl} This omission signals at least three misapprehensions about women with disabilities and their reproductive health needs. Firstly, disabled women will not, or do not, get pregnant. Secondly, disabled women who are pregnant, or who are contemplating pregnancy, have needs and interests that are generic to all women. Lastly, since disabled women have no needs or interests that ought to be considered by obstetricians and gynaecologists, there is no reason to fashion guidelines specific to the condition of women with disabilities. However, while women with disabilities who are pregnant share concerns with all prospective mothers - concerns about their own health maintenance and that of their future child, in addition to concerns about their ability to care for their babies - some women with disabilities must also contend with the, "possible

interactions between pregnancy and disability”.^{cxli} This failure to address the unique needs of women with disabilities in securing obstetrical care suggests pregnant disabled women are unworthy of care and attention, reinforces stereotypical assumptions about their ability to become parents and denies them equality in health services.

Because physicians remain the primary source of information about pregnancy, childbirth and parenting, and because they are the primary arbiters of care, physicians need further and better information about the unique implications of pregnancy for women with disabilities. The particular risks of pregnancy for women with various disabilities, the mutual impact of the disability and pregnancy and, in particular, the accommodations necessary to make care physically accessible and more supportive all require further exploration and research.

Given the multitude of attitudinal and physical barriers that women with disabilities face in reproductive services, they need, not only physically accessible, but also psychologically supportive, obstetrical care. This approach views women with disabilities as knowledgeable about their own bodies, health needs and experiences. It is also an approach where women with disabilities who wish to enjoy the experiences of pregnancy, childbirth and parenting are not prejudged as incapable mothers, but are supported in meeting the challenges that these experiences inevitably bring. This approach is consistent with disability rights and equality principles in that it shifts the focus away from the so-called expertise of the medical professional to respecting and accommodating the needs, interests and decisions of the woman as integral to providing her with the best obstetric care.

(iii) Reproductive Assistance

Though most disabilities do not directly impact fertility, many women with disabilities have difficulty in achieving pregnancy. And just as they struggle to find an obstetrician who will take them on as a patient during their pregnancy, women with disabilities also face barriers when trying to find a specialist who will help them become pregnant.^{cxlii}

In Canada, the *Assisted Human Reproduction Act (AHR Act)*^{cxliii} regulates the use of assisted human reproductive technologies. This legislation is particularly relevant to women with disabilities in at least two respects, each of which is found under the Act’s statement of principles. First, the *AHR Act* recognizes that, “women more than men are directly and significantly affected,” by these technologies,^{cxliv} and that, “the health and well-being of women must be protected in the application of these technologies”.^{cxlv} Second, the *AHR Act* declares that “human individuality and diversity” must be preserved and protected.^{cxlvi} This principle could be relied upon by women with disabilities who wish to avail themselves of assisted reproductive technology. At the same time, the first principle declares that the health and well-being of children created through these technologies must be given priority in any decision-making regarding their use. While this principle has not been interpreted by any court, it could be construed negatively against women with disabilities if the social perception prevails that their potential children would be at a disadvantage, either due to the risk of inheriting a disability themselves, or the alleged challenges of having a parent with a disability. The *AHR Act* is also problematic in that it explicitly proscribes certain uses of reproductive technology, including sex-

selection, while implicitly allowing the use of technology to test for and abort fetuses with genetic markers for certain conditions or to select against embryos identified with genetic markers for undesired traits or conditions. Women with disabilities in particular may feel pressure to make use of reproductive services for these ends.^{cxlvii}

The *Canadian Charter of Rights and Freedoms* and provincial human rights statutes also apply to assisted reproductive services, and mandate that there be equal access to such services without discrimination.^{cxlviii} The *Joint Policy Statement on Social Screening and Reproductive Technologies*^{cxlix} adopted by the SOGC and the Canadian Fertility and Andrology Society provides some guidance regarding when physicians can refuse to provide access to reproductive services to a woman. It states that no groups of individuals should be denied, as a group, access to reproductive technologies. However, individuals who are believed to be potentially incapable parents should be denied. The policy states: “The primary concern should always be, not for the ability of a person to have a child, but for the prospective child to have a responsible parent”.^{cl} Though the policy prohibits blanket discrimination against groups of persons, it does offer a physician the option to refuse to provide services to a woman with a disability should he or she believe that the individual lacks the capacity to be a responsible parent. Given the biases that women with disabilities face when they want to become mothers, the possibility for physicians to refuse their assistance seems very real. In effect, the policy entitles a physician to exercise extra scrutiny in determining the potential for parenthood of women who are disabled, something which is not immediately apparent with others.

A further barrier to access to assisted reproductive services is the characterisation of these services as not medically necessary, and therefore not covered by provincial health insurance programs. In all provinces (except for Ontario which covers the cost of three treatment cycles of *in vitro* fertilisation (IVF) in cases of bi-lateral fallopian tube blockage^{cli}) patients (or their private health insurance plans) must bear the cost of assisted reproductive services and of the required fertility drugs and hormones. As few women with disabilities have the financial resources to assume such costs, their access to these services is even further limited.^{clii}

The struggle for reproductive choice was one of the primary political battles of feminism in the twentieth century. Yet, for women with disabilities the struggle for reproductive choice is still far from over. Matters which have long been affirmed as areas of private and intimate decision-making in the wider society - access to and choice of contraceptive methods, and decisions about becoming a parent, for example - must still be fought for in public by women with disabilities. Moreover, matters which are widely regarded as social rights in Canada, such as access to quality reproductive health and antenatal care, are not routinely provided to women with disabilities; still less available are access to leading edge technologies and therapies for infertility treatment. For there to be a meaningful right to exercise self-determination with respect to sexual and reproductive health, women with disabilities should, like their non-disabled cohorts, be able to freely choose to be sexually active without fear of pregnancy, as well as be able to choose if, when and how to become pregnant. In order to achieve equality with respect to reproductive rights and sexual citizenship, women with disabilities must be given equal opportunity to and benefit of contraceptive options, obstetric care and reproductive support services.

VII. Right to Found a Family

The myths and assumptions that hamper efforts of women with disabilities to access sexual and reproductive health services also impose barriers to their parenting activities. Indeed, while society generally views family life and parenting as desirable roles for women, it is less understanding of, and much less accommodating to, women with disabilities who wish to parent. According to Anita Silvers, “[w]hile other women are expected to become mothers and may even be called upon to defend their choice to remain childless, women with disabilities are criticized for becoming pregnant”.^{cliii} Once they do have children, women with disabilities are, “expected to prove that retaining their maternal roles is compatible with their children’s welfare”.^{cliv} Often it is assumed that women with disabilities are incapable of caring for their children because they are perceived as passive and dependant. The assumption is that rather than being caregivers to their children, they must be cared for by them.^{clv}

Some women with disabilities report that even when they are with their children, their motherhood is denied. The people they meet assume that the children are not their own: that they are their personal attendants or someone else’s children. Moreover, their decision to have children may be judged as selfish or unfair given their perceived shortcomings as disabled persons, but also given the possibility that they would give birth to a disabled child.^{clvi} In addition to these attitudinal barriers, women with disabilities face various challenges in their roles as parents. These may be linked to a multitude of factors including: the nature of their disability; changes to their health status; relationships with their partners (or lack thereof); the security or precariousness of their economic status; the (un)availability of supports and services; their child’s unique needs; and changes in their children as they mature.

Various international instruments speak of the right to found a family, the importance of the parent-child relationship, and the need of *all* parents to be supported in their efforts to nurture and care for their children.^{clvii} Rule 9(2) of the *Standard Rules* emphasises that States should promote the full participation of people with disabilities in family life and, in particular, disabled persons must not be denied the opportunity to experience parenthood. Rule 9(3) of the *Standard Rules* provides that, “States should promote measures to change negative attitudes towards marriage, sexuality and parenthood of people with disabilities, especially of girls and women with disabilities, which still prevail in society”. One international document even addresses the rights of children who have parents with disabilities. The *Convention on the Rights of the Child* recognises that the family is, “the fundamental group of society and the natural environment for the growth and well-being ... of children,” and that children should not be discriminated against because of their parents’ identities, including when the parent has a disability.^{clviii} By recognising that parenting is a challenging responsibility for everyone and that a diverse range of supports are crucial in order to succeed in this role, international human rights principles implicitly endorse the rights of people with disabilities to support services to facilitate their parenting duties. However, even within international human rights discourse and literature, greater recognition must be paid to the linkages between social prejudices, systemic discrimination and barriers that cause the isolation and

marginalisation of parents with disabilities and thereby contribute to the victimisation of their children.

Mothers with disabilities confront challenges in accessing the services and assistance they need to enable their parenting activities. These challenges reflect the myth of the self-sufficient family perpetuated in western culture. As Theresa Glennon states, “families are regarded as self-sufficient, able to provide for all the needs of their family members”.^{clix} In this view of the family, dependence on external resources is not normal; it is exceptional and generally must be temporary in nature. Parents must therefore be able to fulfil the needs of their children on their own. As society accepts this myth, mothers with disabilities are penalised if they cannot achieve self-sufficiency without having recourse to external assistance for their parenting activities. They risk being identified as neglectful or abusive and having their children removed from their care.^{clx} They may also face discrimination as they attempt to form a family, either in forming a relationship, bearing their own children or in trying to adopt.

Just like non-disabled mothers, women with disabilities require supports to be good parents. Unfortunately, unlike non-disabled mothers, women with disabilities are viewed as less maternal and unfit to parent and reliance on social supports is perceived to be a sign of weakness. In *Eve v Eve*, the Supreme Court of Canada expressly highlighted the need to infuse human rights values into society’s understanding of what it means to be a “fit” parent. Responding to the government’s argument that sterilisation may be necessary where the disabled individual’s “fitness to parent” was in doubt, Justice La Forest confronted negative stereotypes regarding the ability of persons with mental disabilities to be suitable parents and explicitly acknowledged that this inquiry is “value-loaded”.^{clxi} La Forest J. further recognized that, while disability has a tendency to correlate with poverty, the problem of lack of financial resources to be a proper parent, “is a social problem, and one, moreover, that is not limited to incompetents”.^{clxii} These *obiter* comments reveal the Supreme Court’s sensitivity to the fact that childhood deprivation has more to do with household poverty, and less to do with whether the parent has a mental disability.

One of the principal areas where mothers with disabilities confront systemic discrimination is in their interaction with the child protection system. Mothers with disabilities are often subjected to increased scrutiny from child protection agencies as they are often assumed to be incapable of caring for children, believed to be “unfit,” or viewed as poor role models. In addition, child protection workers, who may have little or no training in disability, may transfer their negative assumptions about the parenting abilities of women with disabilities into their encounters with the women they are investigating.^{clxiii} Furthermore, the child protection system can be insensitive to the socioeconomic context of the family, including lack of supports, poor health, unemployment and abuse, which place parents with disabilities and their children at increased risk of neglect and harm.

Pursuant to Canadian child welfare legislation,^{clxiv} if a child is thought to be in need of protection because the child has suffered or risks suffering at the hands of his or her caregiver, a warrant may be issued authorising a child protection worker to remove the child from his or her home and bring him or her to a place of safety until a hearing is conducted to determine whether the child is in need of protection.^{clxv} A variety of actors and circumstances may therefore initiate the child protection process.

The case of 27-year old single, deaf mother whose newborn child was apprehended illustrates how the system can work to the detriment of women with disabilities. The deaf woman was the subject of a negligence complaint by her landlord, who complained to the local Children's Aid Society (CAS) that the mother did not respond to her infant's crying and that her baby-monitoring device was not functioning. The police and CAS workers apprehended the infant and because the authorities were not accompanied by an interpreter, they were unable to communicate with the mother. She did not understand why or where they were taking her child. She was merely handed a business card. The mother, arguing that her baby, like many others, simply cried more during the night, obtained help from social agencies for the deaf. Her child was eventually returned to her after a hearing before the family court.^{clxvi} These events are disturbing in their illustration of the prejudices that mothers with disabilities must endure: because she was perceived as a suspect mother from the start, her credibility was judged inferior to that of the landlord and consequently, there was little need to ensure due process by obtaining her version of the events or informing her of the reasons for the apprehension of her child. The authorities' biases against and indifference to the mother's rights is evidenced by their failure to bring a trained interpreter to explain the process and legal basis and ramifications of the apprehension. Clearly, the deaf mother had already been judged unfit.

A determination by the courts on the question of whether a child is in need of protection under the *Child and Family Services Act* involves a consideration of the available evidence about the parent's skills and ability to care for and to meet the child's needs. In *Nova Scotia (Minister of Community Services) v F. (B.)*, a 2003 case involving two parents with mental disabilities, the Court held that the parents' disabilities should not be a concern if they can provide a loving, caring and risk-reduced home.^{clxvii} The parents were found to have limited cognitive ability, and after several years of involvement with home care support services and parenting skills programs, the Minister of Community Services sought to place their children under permanent care and custody. The Court found that it would not be in the children's best interests to remove them from their parents' care and recognised that there were external, informal supports that contributed to the children's upbringing. This approach represents an example of where the legal system was prepared to eschew disability stereotypes and undertake a contextual analysis of the situation. The majority of cases, however, do not explicitly question the suitability of support services for women with disabilities and rarely do the courts delve into the question whether the support services provided to the disabled parent correspond to her needs and capacities, and truly enable her to care for her children.

Time is a factor that may pose an additional challenge to mothers with disabilities involved with a child protection society. Many women with disabilities may require long-term or ongoing support, an option which may be rejected by the courts and the child protection societies who hold the view that parents should be self-sufficient.^{clxviii} Once their child has been apprehended, disabled mothers may have difficulty securing the child's return. Under the *Child and Family Services Act*, a child may be kept as a ward up to 12 months for children who are less than 6 years old and to 24 months for children aged 6 and over (section 70). The objective of these provisions is to provide as much stability as possible to the children who are under the state's care. However, this may place women with disabilities in general, but particularly those who have mental disabilities, at a

disadvantage given that they may need longer to develop the abilities deemed necessary to care for their children.

Examples of such situations include *Children's Aid Society of the Niagara Region v M.C.*,^{clxix} wherein the Court recognised that, while the intellectually disabled mother had made some progress, “[b]ut time is her enemy. [Her children] need a stable relationship now. They cannot wait”.^{clxx} Similarly in the case of *Children's Aid Society of the County of Simcoe v S*, the mother, who had cognitive limitations and personality disorder, lost her children even though she had taken steps to stabilise her life and undergone treatment. The Court found that the necessary changes with respect to mother's abilities could not be concluded in the necessary time frame which would permit the child to be returned to his mother's care. The Court concluded that the importance of the biological relationship and the child's development of a bond in relationship with his mother are outweighed by the need to promote his overall development in a safe environment.^{clxxi}

The foregoing analysis reveals that disabled mothers, especially those with mental disabilities, often find themselves embroiled in a surveillance system that is ill equipped to address their disability-related needs. Not only is their competence to mother already questioned by operation of myths and stereotypes about disability, but often services and supports which might be of assistance in carrying out their parenting role are not available or are inadequate to meet their specific needs. This is not to suggest that the involvement of child welfare officials in the lives of disabled mothers is never appropriate or that orders in favour of the state for guardianship are never warranted. The experience of women with disabilities suggests quite plainly that an adversarial relationship with the state and state agencies does not meet the needs of children or those of mothers with disabilities. The problem is how to redirect the attention of the state and state agencies towards an enabling role, which recognises the abilities of women with disabilities as mothers and enters into dialogue with them over the most appropriate supports to assist them in devoting the kind of care and attention to their children they are capable of giving.

VIII. Conclusion

International human rights law has endorsed women's rights to sexual education, reproductive health services and the right to found a family. Indeed, several international Human Rights Committees have recognised the integral connection between the right to access and benefit from sexual and reproductive information, counselling and health services and the ability of women to enjoy equal citizenship in society. However, this understanding has not translated into advancing and protecting the rights of women with disabilities. Due to the tendency to view women with disabilities as genderless and sexless, society has marginalised the social and economic issues that are critical to promoting their parenting, sexual and reproductive rights, including access to sexual education and reproductive services. Further, strong myths continue to prevail about the sexual and intimate lives of women with disabilities. Because women with disabilities are seen as asexual (or sexually inadequate), not desirable, and incapable of ovulating, menstruating, conceiving or giving birth, it is imagined that women with disabilities do not need information or services with respect to contraception, safe sex, or childbearing.

In many instances with respect to nurturing, sexual and reproductive rights, the law in Canada does not actively discriminate against women with disabilities. Instead, we see that the law imposes burdens or erects barriers which adversely affect or impede women with disabilities from exercising and enjoying sexual and reproductive citizenship. The harmful effects of such indirect discrimination must not be underestimated. Canadian disability and equality rights jurisprudence makes clear that failure to accommodate the needs and interests of the disability community undermines the capacity of people with disabilities to participate in society and constitutes a violation of their human rights. Little scholarship, and even less jurisprudence, has tackled the concerns of discrimination experienced by women with disabilities in relation to their sexual and reproductive rights. The disability rights movement itself has not prioritised issues of sexuality and reproduction, instead focusing on the elimination of discrimination in employment, education and housing.^{clxxii}

Thus, despite international pronouncements enshrining women's rights in these areas, we see that in most situations involving their sexual, parenting, and reproductive interests, women with disabilities are denied the benefits and services that are ordinarily available to other women. This differential treatment often springs from the conception that disabled women are genderless and sexless, and is further precipitated by negative views about the propriety and ability of women with disabilities to engage in intimate relations and to become parents. The time has come to see women with disabilities differently and to recognise the fundamental role of parenting rights and sexual and reproductive health in enabling women with disabilities to secure full citizenship.

In an environment that already restricts the social interaction of women with disabilities through barriers to mobility and communication, women with disabilities find their social isolation compounded by the denial of their sexuality and by the deprivation of opportunities for intimacy. Health professionals and family members appear acutely uncomfortable with the prospect of educating and enabling women with disabilities to fulfil themselves as sexual and reproductive human beings. It is as if society's gaze cannot encompass the capacity of women with disabilities for intimate fulfilment as sexual partners and parents. By erasing intimate relations from the lives of women with disabilities, broader society detaches them from the important bonds through which members of society relate to one another.

Women with disabilities have inherent dignity and worth and are entitled to equal access and opportunity to the supports and services that meaningfully enable their full participation in intimate relations and social inclusion. This involves recognising that sexuality is essential to identity, social and personal interaction and physical and mental health. The right of women with disabilities to sexual and reproductive citizenship includes the right to exercise and express sexuality freely; to be safe from sexual abuse and discrimination; to have access to reproductive health information and services; to make informed decisions about one's own body; and, if one choose to do so, to experience parenting. Upholding these important rights requires sensitivity to the unique challenges women with disabilities experience in participating in sexual and reproductive activities, ensuring accessible sexual education and reproductive health services and parenting supports and services. Further, the right to self-determination and autonomy in deciding

whether to engage in intimate contacts and establish long-term relationships or marriage are fundamental rights of all citizens. These rights must be promoted and protected to ensure that women with disabilities can reach their full potential as equal and valued members of society.

ⁱ Silvers, A (1998) “Reprising Women’s Disability: Feminist Identity Strategy and Disability Rights” 13 *Berkeley Women’s Law Journal* 81, 86.

ⁱⁱ Ibid.

ⁱⁱⁱ UN Committee on Economic, Social and Cultural Rights (2000) General Comment No. 14: “The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)” Doc. E/C.12/2000/4 para 21.

^{iv} UN Committee on Economic, Social and Cultural Rights (1994) General Comment No. 5: “Persons with Disabilities” Doc. E/1995/22 para 19.

^v Cook, RJ, Dickens, BM & Fathalla, MF (2003) *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law* Clarendon Press, Oxford, 209.

^{vi} Traditionally, negative rights constitute civil and political rights, which are considered to be guarantees of “freedom from” state interference, such as non-consensual sterilisation. Positive rights are affirmative obligations, usually in the area of social and economic rights, whereby state action is required to protect and promote human rights, such as a minimum level of health care.

^{vii} Center for Reproductive Rights (2002a) *Bringing Rights to Bear: An Advocate’s Guide to the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights* Center for Reproductive Law and Policy, New York, 4 online: Center for Reproductive Rights <http://www.reproductiverights.org/pdf/pub_bp_brb.pdf>

^{viii} *Universal Declaration of Human Rights* ((*Universal Declaration*)); the *International Covenant on Civil and Political Rights* (*ICCPR*); the *International Covenant on Economic, Social and Cultural Rights* (*ICESCR*); the *Declaration on the Rights of Disabled Persons*; the *Convention on the Elimination of All Forms of Discrimination Against Women* (*CEDAW*); the *Convention on the Rights of the Child* (*CRC*); the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (*Mental Health Principles*); the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* (*Standard Rules*); and *Convention on the Rights of Persons with Disabilities* (*CRPD*)

^{ix} Cook et al (2003) *supra* note 5 at 159.

^x Guaranteed by Articles 3 & 5 of the *Universal Declaration of Human Rights* (UN 1948), Articles 6 & 9 of the *ICCPR* (UN 1996a) and Articles 10 & 14 of *CRPD* (UN 2006).

^{xi} Guaranteed by Article 7 of the *Universal Declaration of Human Rights* (UN 1948), Articles 2 & 3 of the *ICESCR* (UN 1996b), Article 26 of the *ICCPR* (UN 1966a), paragraph 3 of the *Declaration on the Rights of Disabled Persons* (UN 1975), Rule 5 of

the *Standard Rules* (UN 1993), Principle 1.4 of the *Mental Health Principles* (UN 1991) and Articles 5 & 6 of *CRPD* (UN 2006).

^{xii} Guaranteed by Article 16.1 of the *CEDAW* (UN 1979), Article 22 of the *Universal Declaration of Human Rights* (UN 1948), Article 23 of the *ICCPR* (UN 1966a), Article 10 of the *ICESCR* (UN 1966b), Rule 9 of the *Standard Rules* (UN 1993) and Article 23 of *CRPD* (UN 2006).

^{xiii} Guaranteed by Articles 10 & 12 of the *ICESCR* (UN 1966b), Article 25.1 of the *Universal Declaration of Human Rights* (UN 1948), Rule 2 of the *Standard Rules* (UN 1993) and Article 25 of *CRPD* (UN 2006).

^{xiv} Guaranteed by Article 25(2) of the *Universal Declaration of Human Rights* (UN 1948), Articles 10, 12 & 16 of the *CEDAW* (UN 1979), paragraph 41 of the *Vienna Declaration and Programme of Action* (World Conference on Human Rights 1993) and Article 25 of *CRPD* (UN 2006).

^{xv} Guaranteed by Article 10 of the *CEDAW* (UN 1979), Article 13 of the *ICESCR* (1966b), Rule 6 of the *Standard Rules* (UN 1993) and Article 23 of *CRPD* (UN 2006).

^{xvi} Guaranteed by Article 17 of the *ICCPR* (UN 1966a), paragraph 12(d) of the *CEDAW Committee General Recommendation 18* (CEDAW 1991), Principle 13 of *Mental Health Principles* (UN 1991) and Article 22 of *CRPD* (UN 2006).

^{xvii} Guaranteed by Article 7 of the *ICCPR* (UN 1966a), paragraph 10 of the *Declaration on the Rights of Disabled Persons* (UN 1975) and Articles 16 & 17 of *CRPD* (UN 2006).

^{xviii} Petchesky, RP (2000) “Human Rights, Reproductive and Sexual Health and Economic Justice – Why They Are Indivisible” 8(15) *Reproductive Health Matters* 12-17.

^{xix} Note this analysis simply reviews major United Nations human rights documents and does not constitute a comprehensive survey of international instruments. In particular, we do not discuss the import of regional documents or treaties, such as the European Convention.

^{xx} Rule 9 of the *Standard Rules* (UN 1993).

^{xxi} Rule 9.2 of the *Standard Rules* (UN 1993).

^{xxii} As international monitoring bodies, these Committees evaluate and comment about how States uphold their obligations under a ratified treaty or covenant. The General Comments/Recommendations produced by the Committees clarify and interpret the nuances of specific covenant provisions and suggest future steps for States to promote the realisation of particular obligations.

^{xxiii} UN Committee on Economic, Social and Cultural Rights (1994) General Comment No. 5: “Persons with Disabilities” Doc. E/1995/22.

^{xxiv} *Ibid.*

^{xxv} *Ibid* para 31.

^{xxvi} *Ibid.*

^{xxvii} UN Committee on Economic, Social and Cultural Rights(2000) General Comment No. 14: “The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)” Doc. E/C.12/2000/4 para 8.

^{xxviii} *Ibid* para 11.

^{xxix} Article 23 (*CRPD*,UN 2006)

^{xxx} Article 25 (CPRD, UN 2006)

^{xxx}_i See for example, Center for Reproductive Rights (2002a) which details the numerous published statements by four United Nations human rights committees, including the CEDAW Committee, Committee on the Rights of the Child, Committee on the Elimination of Racial Discrimination and the Human Rights Committee, all of which have encouraged States to implement sexual education.

^{xxx}_{ii} Crawford and Ostrove indicate that general cultural attitudes characterise the sexuality of disabled persons as “inappropriate” or “nonexistent”. See Crawford, D and Ostrove, JM (2003) “Representations of Disability and the Interpersonal Relationships of Women with Disabilities” 26 (3-4) *Women & Therapy* 179, 182. See also Irwin, MM (1997) “Sexuality and People with Disabilities” Center for Disability Information & Referral, online: Indiana Institute on Disability and Community. Irwin notes that, “myths about people with disabilities and sex abound. One view is that people with disabilities are either not interested in sex or are not capable. At the other end of the spectrum, people with disabilities are sometimes viewed as being overly interested in sex and out of control in their sexual behaviour. Accurate information, free of stereotypical perceptions, must be available to each person who is disabled so he/she can develop a healthy view of who he/she is as a sexual being”. <<http://www.iidc.indiana.edu/cedir/sexuality.html>>.

^{xxx}_{iii} Montero, F (2006) “Sexual and Reproductive Health for Persons with Disabilities” (slide presentation) 36-37 online: Geneva Foundation for Medical Education and Research, World Health Organization (WHO) Collaborating Centre in Education and Research in Human Reproduction
< http://www.gfmer.ch/400_Publications_En.htm>.

^{xxx}_{iv} Nosek, MA (2003) “National Study of Women with Physical Disabilities: Final Report 1992-1996” Center for Research on Women with Disabilities (CROWD), Baylor College of Medicine, Houston, online: Baylor College of Medicine
<<http://www.bcm.edu/crowd/?pmid=1408>>.

^{xxx}_v Ibid at 11-12.

^{xxx}_{vi} Notwithstanding integration in regular classes, students with disabilities are routinely withdrawn from non-core classes, like gym, to receive special education instruction.

^{xxx}_{vii} For example, amputations, catheters, prostheses or other equipment are rarely, if ever, represented.

^{xxx}_{viii} Irwin (1997) *supra* note 32. See also Collier, McGhie-Richmond & Odette (2004) *Reducing the Risk of Sexual Abuse for People Who Use Augmentative Communication: A Community Response* The Speak Up Project, Toronto, online: Augmentative Communication Community Partnerships-Canada
<<http://www.aacsafeguarding.ca/SUPSummaryReport.pdf>> which documents how symbols, graphics and other visual aids regarding sexuality are not available for people relying on augmentative communication systems.

^{xxx}_{ix} Shakespeare, T, Gillespie-Sells, K, & Davies, D (1996) *The Sexual Politics of Disability: Untold Desires* Cassell, London 24-25.

^{xl} See Collier, McGhie-Richmond and Odette (2004) *supra* note 38. A recurring theme highlighted in the ACC report was the prejudicial attitudes of health and service providers.

One female participant expressed feeling degraded and humiliated when her attendant saw her sexuality vocabulary and referred to it as “dirty pictures” (at 4).

^{xli} CROWD (2003) *supra* note 34 at 11-12.

^{xlii} Collier et al (2004) *supra* note 38.

^{xliii} *Ibid* 7.

^{xliv} *Ibid* 16. Note that this finding showed almost equal numbers of men and women.

^{xlv} *Ibid* 10.

^{xlvi} *Ibid* 7-8.

^{xlvii} Elman, RA (2005) “Confronting the Sexual Abuse of Women with Disabilities” National Resource Center on Domestic Violence, 3 on-line: VAWnet Applied Research Forum

<http://www.vawnet.org/SexualViolence/Research/VAWnetDocuments/AR_SVDisability.pdf> Citing Stimpson, L and Best, MC (1991) *Courage Above All: Sexual Assault Against Women with Disabilities* DisAbleD Women’s Network, Toronto. After analysing numerous studies regarding sexual abuse and women with different types of physical and mental disabilities, these Canadian researchers concluded, “that more than 70% of women with a wide variety of disabilities have been victims of violent sexual encounters at some time in their lives”,

^{xlviii} Montero (2006) *supra* note 33 at 26.

^{xlix} Sobsey, D (1988) “Sexual Offences and Disabled Victims: Research and Practical Implications” 6(4) *Vis-à-vis* 1.

^l Young, ME et al (1997) “Prevalence of Abuse of Women with Physical Disabilities” 78 (Suppl.) *Archives of Physical Medicine and Rehabilitation* S34.

^{li} Dotson, LA, Stinson, J & Christian, L (2003) “‘People Tell Me I Can’t Have Sex’: Women with Disabilities Share Their Personal Perspectives on Health Care, Sexuality, and Reproductive Rights” 26(3-4) *Women & Therapy* 195, 199.

^{lii} Elman, RA (2005) *supra* note 47 at 7.

^{liii} Rule 9.

^{liv} Health Canada (2003) *Canadian Guidelines for Sexual Health Education* Centre for Infectious Disease Prevention and Control, Health Canada, Ottawa, online: Health Canada <http://www.phac-aspc.gc.ca/publicat/cgshe-ldnemss/pdf/guidelines_e.pdf>.

^{lv} *Ibid* 8.

^{lvi} Collier et al (2004) *supra* note 38.

^{lvii} Montero (2006) *supra* note 33 at 38.

^{lviii} See *Eaton v Brant County Board of Education*, [1997] 1 S.C.R. 241 at para 66., *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City)*, [2000] 1 S.C.R. 665 and *Granovsky v. Canada*, [2000] 1 S.C.R. 703.

^{lix} United Nations (2001) *Human Rights of Persons with Disabilities* Background Paper, Division for Social Policy and Development, online: UN Enable <http://www.un.org/esa/socdev/enable/rights/humanrights.htm>>.

^{lx} Mona, LR (2003) “Sexual Options for People with Disabilities: Using Personal Assistance Services for Sexual Expression” 26(3-4) *Women & Therapy* 211, 212.

^{lxi} Chadha E (2005) “Running on Empty: The ‘Not So Special Status’ Of Paratransit Services In Ontario” 20 *Windsor Review of Legal and Social Issues* 1at12.

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- ^{lxii} See for example, *Turnbull v Famous Players Inc.* (2001) 40 C.H.R.R. D/333 (Ont. Bd. Inq.); *Brock (Litigation Guardian of) v Tarrant Film Factory Ltd.* [2000] O.H.R.B.I.D. No. 5, wherein two human rights tribunals found that popular movie cinemas discriminated against persons with disabilities by having theatres that were inaccessible to wheelchair users or barred admission to wheelchair users; and *Youth Bowling Council of Ontario v McLeod* (1990), 75 O.R. (2d) 451 (Div. Ct.), aff'd (1994) 20 O.R. (3d) 658 (C.A.) where the Ontario Court of Appeal affirmed the right of a young girl with a disability to play in a bowling league. See also Shakespeare et al *supra* note 39 at 30.
- ^{lxiii} *Ibid* at 32.
- ^{lxiv} Canadian Council on Social Development (2005) *Disability Information Sheet No. 18*, online: <<http://www.ccsd.ca/drip/research/drip18/drip18.pdf>> using data from Statistics Canada's 2001 Census.
- ^{lxv} Shakespeare, *supra* note 39 at 31.
- ^{lxvi} *Ibid* at 33-34.
- ^{lxvii} Lesbians in this situation have the additional problem of either hiding their sexual orientation or risk losing their assistant because of prejudice and homophobia: *Ibid* at 167-168.
- ^{lxviii} Because she is not a real woman, the only person who can fall in love with her is another woman: *Ibid* at 154-155. See also O'Toole CJ (1996) "Disabled Lesbians: Challenging Monocultural Constructs" in Krotoski, DM, Nosek, MA & Turk, MA (eds) *Women with Physical Disabilities: Achieving and Maintaining Health and Well-Being* Paul H. Brooks Publishing, Toronto, 137.
- ^{lxix} Shakespeare et al *supra* note 39 at 165.
- ^{lxx} *Ibid* 163-165.
- ^{lxxi} O'Toole *supra* note 68 at 139.
- ^{lxxii} United Nations Commission on Human Rights (2004) *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt* 60th Sess, UN Doc. E/CN.4.2004/49 para 54 online: <[http://www.unhchr.ch/Huridocda/Huridoca.nsf/\(Symbol\)/E.CN.4.2004.49.En?Opendocument](http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.2004.49.En?Opendocument)>.
- ^{lxxiii} Health Canada (2003) *Canadian Guidelines for Sexual Health Education* Centre for Infectious Disease Prevention and Control, Health Canada, Ottawa, 4-5 online: Health Canada <http://www.phac-aspc.gc.ca/publicat/cgshe-ldnemss/pdf/guidelines_e.pdf>.
- ^{lxxiv} *Ibid* 5, citing French, J (1990) "Boundaries and Horizons, The Role of Health Education within Health Promotion" 49 *Health Education Journal* 7.
- ^{lxxv} Cook et al *supra* note 5 at 173.
- ^{lxxvi} Finger, A (1992) "Forbidden Fruit" 233 *New Internationalist* 8, 9.
- ^{lxxvii} Shakespeare et al *supra* note 39 at 10.
- ^{lxxviii} Mona *supra* note 60 at 211.
- ^{lxxix} Earle, S (2001) "Disability, facilitated sex and the role of the nurse" 36(3) *Journal of Advanced Nursing* 433, 434.
- ^{lxxx} McSherry, B and Somerville, MA (1998) "Sexual Activity Amongst Institutionalized Persons in Need of Special Care" 16 *Windsor Yearbook of Access to Justice* 90, 105.

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- ^{lxxxix} Sheppard, C (2004) “Intimacy, Rights and the Parent-Child Relationship: Rethinking Freedom of Association in Canada” 16(1) *National Journal of Constitutional Law* 103.
- ^{lxxxii} *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.) 1982 c. 11. Section 15(1) provides: “Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and in particular, without discrimination based on ... mental or physical disability”.
- ^{lxxxiii} See for example, *Eldridge v British Columbia (Attorney General)* [1997] 3 S.C.R. 624. See also *Rojas v British Columbia (Ministry for Children and Families)* [2001] B.C.H.R.T.D. No. 17 and *Hutchinson v British Columbia (Ministry of Health)* [2004] B.C.H.R.T.D. No. 55.
- ^{lxxxiv} *British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights)* [1999] 3 S.C.R. 868 at para 44, wherein the Court stated, “those who provide services subject to the Human Rights Code must adopt standards that accommodate people with disabilities where this can be done without sacrificing their legitimate objectives and without incurring undue hardship”.
- ^{lxxxv} *Nova Scotia (Workers’ Compensation Board) v Martin*, [2003] 2 S.C.R. 504.
- ^{lxxxvi} Statistics Canada (2003) *Disability Supports in Canada, 2001*, Catalogue No. 89-580-XIE, Statistics Canada, Ottawa, 7 online: <<http://www.statcan.ca/english/freepub/89-580-XIE/89-580-XIE03001.pdf>>
- ^{lxxxvii} *Eldridge*, *supra* note 83.
- ^{lxxxviii} Mona (2003) *supra* note 60, 213, citing the World Institute on Disability (1999) *Personal Assistance Services 101: Structure, Utilization and Adequacy of Existing PAS Programs*, Oakland, CA, defines personal assistance services as, “involving a person assisting someone with a disability to perform tasks aimed at maintaining well-being, personal appearance, comfort, safety, and interaction with the community and society as a whole”. In the Canadian context, Kerzner (2004) indicates examples of attendant services include bathing, transfers, toileting, essential communications and meal preparation.
- ^{lxxxix} *Ibid* 251-252; Earle *supra* note 79 at 437.
- ^{xc} Howe, EG (2004) “Disability” 15(4) *Journal of Clinical Ethics* 239.
- ^{xcii} Mona *supra* note 60 at 213.
- ^{xciii} *Ibid* 214.
- ^{xciv} In the provincial human rights context, see for example, *Rojas v British Columbia (Ministry for Children and Families)*, *supra* note 90, where the Tribunal found that government funded personal care delivered in the person’s home by a personal caregiver constituted, on a *prima facie* basis, a “service” to which the obligation of equal treatment applied. See also the recent decision of *Hutchinson v British Columbia (Ministry of Health)*, *supra* note 90, wherein the Tribunal held that the provincial government’s policy prohibiting the hiring of family members as caregivers constituted discrimination regarding a “service”.
- ^{xcv} *Eldridge v British Columbia (Attorney General)*, *supra* note 83.
- ^{xci} *Ibid*. Only a limited number of factors have been identified in Canadian human rights jurisprudence as appropriate considerations for evaluating undue hardship. Under Ontario human rights law, the key factors are: (1) costs of accommodation, including the

availability of outside sources of funding; and (2) health and safety issues with respect to accommodation, including issues of assumption of risk. Claims of business convenience, contractual agreements, staff morale and third party preference (other employees, customers, etc.) are not valid considerations. These factors are not relevant considerations and are deemed to diminish and detract from the dignified accommodation of persons with disabilities.

^{xcvi} Collier et al *supra* note 38.

^{xcvii} *Ibid*

^{xcviii} *Ibid* at 8.

^{xcix} Commons, ML, Bohn, JT, Godon, LT, et al (1992) “Professional’s attitudes towards sex between institutionalized patients” 46(4) *American Journal of Psychotherapy* 471.

^c Buckley, PF & Robben, T (2000) “A Content Analysis of State Hospital Policies on Sex Between Hospital Inpatients” 51(2) *Psychiatric Services* 243, 244.

^{ci} McSherry et al *supra* note 80 at 131.

^{cii} *An Act respecting certain aspects of legal capacity for marriage for civil purposes* (“*Civil Marriage Act*”) S.C. 2005, c. 33, as assented to 20 July 2005.

^{ciii} We use the phrase “mental disability” here and in other parts of the chapter to refer to a broad category of mental disabilities, including intellectual, cognitive, neurological, emotional and psychiatric disabilities. If a specific term or label is employed, as opposed to mental disability, the particular identification is used to reflect the language of the cited research.

^{civ} For example, Article 10 of the *ICESCR* mandates that States must accord “[t]he widest possible protection and assistance ... to the family”. The CESRC Committee has interpreted this provision to mean that States are obligated to ensure that laws, social policies and practices do not impede the realisation of the rights of people with disabilities to marry and form a family, UN Committee on Economic, Social and Cultural Rights (1994) General Comment No. 5: “Persons with Disabilities” Doc. E/1995/22.

^{cv} Amnesty International (2004) “Albania: Disability and the Right to Marry”(Press Release, 11 November) Amnesty International, London, online: news.amnesty<<http://news.amnesty.org/index/ENGEUR110052004>>.

^{cvi} Churchill, MA (2001) “Marriage Laws Discriminate Against the Disabled” *Michigan Bar Journal* 12, online <http://www.michbar.org/journal/pdf/pdf4article249.pdf>.

^{cvi} United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, adopted by General Assembly Resolution 46/119, 17 December 1991, online: Office of the United Nations High Commissioner for Human Rights <<http://www.ohchr.org/english/law/principles.htm>>.

^{cvi} McSherry et al *supra* note 80 at 111.

^{cix} Montero *supra* note 33 at 25.

^{cx} Shakespeare et al *supra* note 39 at 9; DAWN (Disabled Women’s Network) (1993) *Women with Disabilities Talk About Sexuality* (brochure) DAWN Ontario, Toronto; Basson, R (1998) “Sexual Health of Women With Disabilities” 159 *Canadian Medical Association Journal* 359.

^{cx} Stefan highlights how capacity doctrine is premised on a false neutrality, which assumes that capacity is internal to the individual (that is, mental illness or alcoholism)

and therefore wrongly concludes that lack of competence can be objectively assessed: Stefan, S (1993) “Silencing the Different Voice: Competence, Feminist Theory and Law” 47 *University of Miami Law Review* 763. Feminist disability theorists urge the recognition of social factors that engender and exacerbate competence concerns, in particular the powerlessness, abuse and violence experienced by women with disabilities.

^{cxii} See Secker (1999) who argues that competence is a gendered and relational construct and that women, due to their subordinate status in society, are susceptible of being labeled incompetent.

^{cxiii} *E. (Mrs.) v Eve*, [1986] 2 S.C.R. 388. Eve’s mother applied for a court order seeking that her 24-year-old “mentally retarded” daughter, Eve, be sterilised to prevent the possibility of pregnancy. The Court of Appeal approved a full-scale hysterectomy for Eve. The Supreme Court refused to authorise non-medically necessary sterilisation and overturned the Court of Appeal. Eve was described as “mildly to moderately retarded” and involved in a relationship with a male, who she met at her school for adults with mental disabilities. The Supreme Court noted, at paras 2-4, that Eve and her male friend talked about marriage, however the matter was brought to an end when the situation was identified by school authorities. The Supreme Court held that sterilisation should never be authorised for non-therapeutic purposes. The irreversible nature of the intervention, the ensuing physical damage and the grave intrusion on the individual’s basic rights all outweighed the highly questionable benefits of a non-therapeutic sterilisation.

^{cxiv} *British Columbia (Superintendent of Vehicles) v British Columbia (Council of Human Rights)*, *supra* note 84 at para 2.

^{cxv} Generally, the law treats issues of capacity on a case by case basis and incapacity must be proven with respect to the specific choice and inherent risks in the specific decision. Thus, an individual with a disability may be incompetent for certain matters, for example, financial decisions, while remaining competent for other matters, such as health decisions. See Kerzner, L., “Mental Capacity Through a Disability Law Lens” in McColl, MA & Jongbloed L (eds) (2006) *Disability and Social Policy in Canada* (2nd edn) Captus Press.

^{cxvi} UN Committee on Economic, Social and Cultural Rights (2000) General Comment No. 14 explains at para 8, “The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable level of health”.

^{cxvii} *Canada Health Act*, R.S. 1985, c. C-6.

^{cxviii} See discussion of Right to Intimate Relations.

^{cxix} See for example, *Quesnel v London Educational Health Centre* (1995) 28 C.H.R.R. D/474 (Ont. Bd. of Inq.).

^{cxx} See for example, *Eldridge v British Columbia (Attorney General)* *supra* note 83.

^{cxxi} Hershey, L (2003) “Rights, Realities, and Issues of Women with Disabilities” in Morgan, R (ed) *Sisterhood is Forever; The Women’s Anthology for the New Millennium*, Washington Square Press, New York, 233, 239.

^{cxxii} *Eaton v Brant County Board of Education*, *supra* note 58; *Eldridge v British Columbia (Attorney General)* *supra* note 83; *British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights)* *supra* note 84.

^{cxxiii} *Eldridge v British Columbia (Attorney General)* *supra* note 83 is a landmark decision for the application of a positive right in the allocation of health care and disability services. The Supreme Court held that the provincial government's failure to fund sign language interpreters for deaf patients in a hospital constituted discrimination on the basis of a disability. The Court held that once the state provides a benefit, it is obliged to do so in a non-discriminatory manner. Writing on behalf of a unanimous court, Justice LaForest held that, in certain circumstances, governments may be, "require[d]... to take *positive action*, for example by extending the scope of a benefit to a previously excluded class of persons" [emphasis added] (para 73). The Court concluded that the provincial government had not reasonably accommodated the claimants' disabilities to the point of undue hardship.

^{cxxiv} While the Society of Obstetricians and Gynaecologists of Canada (SOCG) has published a set of guidelines for contraception, which includes specific reference to counselling and treatment of individuals with mental and intellectual disabilities, they do not address the needs of women with other types of disabilities, SOGC (Society of Obstetricians and Gynaecologists of Canada) (2004) "Canadian Contraception Consensus: Clinical Practice Guidelines No. 143" 26(2) *Journal of Obstetrics and Gynaecology Canada (JOGC)* 143 (Part 1 of 3), 26(3) *JOGC* 219 (Part 2 of 3), 26(5) *JOGC* 347 (Part 3 of 3), online: SOGC <http://www.sogc.org/sogcnet/sogc_docs/common/guide/index_e.shtml#gynaecology>. The guidelines do however address issues particular to the prescription of oral contraceptives to women who have chronic diseases such as lupus erythematosus, diabetes mellitus and sickle cell disease, and conditions such as epilepsy: see Part 2 of 2, pp. 245-246.

^{cxxv} Welner, S (1996) "Contraception, Sexually Transmitted Diseases, and Menopause" in Krotoski, DM, Nosek MA & Turk, MA (eds) *Women with Physical Disabilities: Achieving and Maintaining Health and Well-Being*. Paul H. Brooks Publishing, Toronto, 81.

^{cxxvi} Dotson et al *supra* note 51 at 198.

^{cxxvii} *Ibid* 198.

^{cxxviii} *Ibid* 198.

^{cxxix} Welner *supra* note 125 at 81.

^{cxxx} *Ibid* 84.

^{cxxxi} *Ibid* 81; Basson *supra* note 110 at 362.

^{cxxxii} Welner *supra* note 125 at 84.

^{cxxxiii} *Re C.M.L.* [2001] A.J. No. 331 (Surrogate Ct. Alta.) (para 20) online: QL (AJ).

^{cxxxiv} *Ibid* para 20.

^{cxxxv} Canadian Medical Association (2004) *Code of Ethics (Update 2004)* Canadian Medical Association, Ottawa, online: <<http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>>.

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- ^{cxxxvi} Hershey, L (2000) “Women With Disabilities: Health, Reproduction and Sexuality” in *International Encyclopedia of Women: Global Women's Issues and Knowledge* Routledge Press, Scarborough.
- ^{cxxxvii} Carty notes that “[s]ome women have reported being offered termination of pregnancy before any assessment of their desires or abilities”. Carty, EM (1998) “Disability and Childbirth: Meeting the Challenges” 159(4) *Canadian Medical Association Journal* 363,364
- ^{cxxxviii} Rogers, JG (1996) “Pregnancy and Physical Disabilities” in Krotoski, DM, Nosek MA & Turk, MA (eds) *Women with Physical Disabilities: Achieving and Maintaining Health and Well-Being* Paul H. Brooks Publishing, Toronto 102.
- ^{cxxxix} Carty *supra* note 137 at 367.
- ^{cxl} Society of Obstetricians and Gynaecologists of Canada (2000) *Healthy Beginnings: Guidelines for Care During Pregnancy and Childbirth* SOGC, Ottawa; Canadian Medical Association (1998) *Obstetric Care (Update 1998)* Canadian Medical Association, Ottawa, online: <<http://policybase.cma.ca/PolicyPDF/PD98-07.pdf>>.
- ^{cxli} Carty *supra* note 137 at 364.
- ^{cxlii} Basson *supra* note 110 at 362.
- ^{cxliii} *Assisted Human Reproduction Act* (2004) S.O. c.2.
- ^{cxliv} section 2(c).
- ^{cxlv} section 2(e).
- ^{cxlvi} section 1(g).
- ^{cxlvii} Mossof, J (1993) “Reproductive Technology and Disability: Searching for the Rights and Wrongs in Explanation” 16 *Dalhousie Law Journal* 98.
- ^{cxlviii} See for example, *Korn v Potter* (1996) 134 D.L.R. (4th) 437, wherein the British Columbia Supreme Court affirmed a human rights complaint against a physician for failing to provide artificial insemination services to a lesbian couple as a violation of the right to be free of discrimination in health services as protected under provincial human rights law.
- ^{cxlix} Society of Obstetricians and Gynaecologists of Canada (1999) “Joint Policy Statement: Social Screening and Reproductive Technologies” 21(1) *Journal of the Society of Obstetricians and Gynaecologists of Canada* 36, 36.
- ^{cl} *Ibid* 38. The policy also states “If a physician cannot accept the inclusion of a certain group of individuals based on social factors because of personal conscience, the physician is obligated to inform the patient, and to refer him or her to other qualified medical professionals who will assist the patient in addressing the medical problem” at 39.
- ^{cli} *Health Insurance Act General Regulation*, R.R.O. 1990, Reg. 552 at para 24(1)(23). The cost of the drugs is not covered however.
- ^{clii} See *Cameron v Nova Scotia (Attorney General)* (1999) 204 N.S.R. (2d) 1, leave to appeal to S.C.C. refused [1999] S.C.C.A. No. 531 [QL (SCCA)] wherein a Nova Scotia couple brought an action against the province to recover the cost of IVF related treatments received outside of the province arguing that the province’s refusal to provide hospital insurance coverage for the treatments was a breach of their constitutional right to equal treatment under health insurance law, discriminating against them on the basis of their physical disability, namely infertility. The Majority of the Court of Appeal recognised

infertility as a disability and that the plaintiffs' equality rights had been infringed, but found the infringement justified as a reasonable and proportionate limit due to rationed health care funding. See also *Auton (Guardian ad litem of) v British Columbia (Attorney General)* [2004] 3 S.C.R. 657, wherein the province's failure to fund a specific type of autism treatment was challenged as a violation of the constitutional right to equality. The Supreme Court concluded that the treatment was not a "core" medical benefit and thereby not provided under Canada's health care laws, arguing that there was no evidence that the government's refusal to fund the autism therapy was any different from the approach the government would take in regards to other emerging, novel therapies.

cliii *Silvers supra* note 1 at 92

cliv *Ibid.*

clv *Shakespeare et al supra* note 39 at 107.

clvi *Ibid* 107-108.

clvii Article 16(3) of the *Universal Declaration* states that, "[t]he family is the natural and fundamental group unit of society and is entitled to protection by society and the State".

clviii CRC Preamble and Article 2.

clix Glennon, T (manuscript on file with authors) at 3.

clx *Ibid* 4.

clxi *E. (Mrs.) v Eve, supra* note 113 at 431.

clxii *Ibid.*

clxiii *Shakespeare et al supra* note 39 at 111-112.

clxiv While the child welfare regime is similar across the Canadian provinces, for purposes of this chapter the specific example of Ontario *Child and Family Services Act*, R.S.O. 1990. c. C.11 will be used.

clxv This risks include physical and emotional harms resulting from neglect, failure to adequately care for, provide for, supervise or protect the child, or from a pattern of neglect in caring for, providing for or supervising a child. *Child and Family Services Act*, R.S.O. 1990. c. C.11, ss. 37(2), 40(2) & 40(6).

clxvi Keung (2002).

clxvii *Nova Scotia (Minister of Community Services) v F(B)* (2003) 219 N.S.R. (2d) 67.

clxviii Glennon *supra* note 175 at 12.

clxix *Children's Aid Society of the Niagara Region v M.C.* [2000] O.J. No. 3268 (O.C.J.) online: QL (FAMQ).

clxx *Ibid* para 113. See also *Children's Aid Society of Simcoe v L.A.M.* [2000] O.J. No. 389 (S.C.J.) online: QL (FAMQ); *Children's Aid Society of Owen Sound and the County of Grey v B.H.* [2000] O.J. No. 5308 (O.C.J.) online: QL (FAMQ); *Children's Aid Society of Ottawa-Carleton v A.* [2001] O.J. No. 2887 (S.C.J.) online: QL (FAMQ).

clxxi *Children's Aid Society of Simcoe v. L.A.M.* [2000] O.J. No. 389 (S.C.J.) paras 184 & 196.

clxxii *Shakespeare et al supra* note 39 at 5-6.