

THE INVOLUNTARY, NON-THERAPEUTIC STERILISATION OF WOMEN AND GIRLS WITH AN INTELLECTUAL DISABILITY – CAN IT EVER BE JUSTIFIED?

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This paper examines whether the involuntary, non-therapeutic sterilisation of women and girls with an intellectual disability can ever be justified under international law. There has been a tendency by international human rights bodies and advocates who are opposed to this practice to argue that rights such as equality, non-discrimination and bodily integrity prohibit such treatment without free and informed consent. However, a substantive engagement with human rights reveals that in limited circumstances, an involuntary sterilisation of a woman or girl with a profound intellectual disability will be justified where there is no reasonably available alternative and the procedure is necessary to secure her right to health.

I: INTRODUCTION

Should a woman or girl ever be sterilised without her consent? The presumptive answer to this question is of course no. To suggest otherwise would be to contemplate a serious violation of her right to bodily integrity and potentially to condone a form of torture.¹ But is the strength of this presumptive answer the same when dealing with a woman or girl who suffers from a profound intellectual disability? In Australia, the High Court actually anticipates two scenarios in which the sterilisation of such women and girls will be legitimate. First, when the sterilisation is incidental to surgery performed in order to correct some ‘disease or malfunction’ (therapeutic sterilisation), and second, when it is a measure of last resort undertaken in order to secure the best interests of the woman or child (non-therapeutic sterilisation).² This position has remained a cause of concern for international human rights bodies which have repeatedly called on Australia to prohibit the non-therapeutic sterilisation of children and adults without their free and informed consent.³

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¹ See, eg, *VC v Slovakia* [2011] Eur Cour HR, (application no 18968/07) (judgment of the European Court of Human Rights in which a Roma woman was subjected to involuntary sterilisation. This was held to breach articles 3 (prohibition against torture) and 8 (right to privacy) of the *European Convention on Human Rights*).

² *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218 (*‘Marion’s Case’*) at 250 (per Mason CJ, Dawson, Toohey and Gaudron JJ).

³ See Human Right Council, *Report of the Working Group on the Universal Periodic Review: Australia*, UN Doc A/HRC/17/10 (24 March 2011) at [86.39] (recommending that Australia:

‘[c]omply with the recommendations of the Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women concerning the sterilization of women and girls with disabilities (Denmark); Enact national legislation prohibiting the use of non-therapeutic sterilisation of children, regardless of whether they have a disability, and of adults with disability without their informed and free consent (United Kingdom); Repeal all legal provisions allowing sterilization of persons with disabilities without their consent and for non-therapeutic reasons (Belgium); Abolish non-therapeutic sterilization of women and girls with disabilities (Germany)’).

See also Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, adopted by the Committee at its Tenth Session (2-13 September 2013), UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [39]-[40];

To date, the Australian Government has resisted such calls, arguing that the current Australian law is consistent with its obligations under international law.⁴ Moreover, the Senate Community Affairs References Committee ('Senate Committee'), which recently released its report on Involuntary or Coerced Sterilisation of People with Disabilities in Australia ('Senate Report'), concluded that the views with respect to the status of this practice under international law were 'in some ways contradictory' and 'not clear'.⁵ Interestingly, the Senate Committee rejected 'an outright ban of non-therapeutic sterilisation procedures without consent' on the ground that this 'removes the focus from the needs and interests of the individual' and 'potentially denies the rights of persons with disabilities to access ... medical support on an equal basis'.⁶ However, the Senate Committee did not arrive at this conclusion after a careful analysis of the competing views with respect to Australia's obligations under international human rights law. It simply listed these divergent views and acknowledged their contradictory nature. Thus a question remains as to whether an absolute ban is necessary under international law or whether there could be circumstances in which this practice is justified.

The aim of this paper is to address this question.⁷ This paper consists of two parts. Part I examines the relevance of human rights as a legal and moral paradigm by which to assess this issue and Part II examines the consequences of a substantive rights analysis of the issue. Three broad conclusions are drawn. First, the discourse of human rights represents an appropriate legal and moral framework by which to assess this practice. When viewed through the prism of human rights, the underlying values of dignity and bodily integrity are central to grounding such rights as privacy, protection from violence and non-discrimination.

Second, although human rights bodies and advocates employ these rights to justify their calls for the prohibition of involuntary non-therapeutic sterilisation, their rhetoric is invariably unaccompanied by any substantive analysis. As a consequence, there has been a tendency to overlook the fact that, subject to a few exceptions, human rights are not

Committee on the Rights of the Child, *General Comment No. 13: The Right of the Child to Freedom from All Forms of Violence*, UN Doc CRC/C/GC/13 (18 April 2011) at [23]; Committee on the Rights of the Child, *General Comment No. 9: The Rights of Children with Disabilities*, UN Doc CRC/C/GC/9 (27 February 2007) at [60]; Committee on the Elimination of all forms of Discrimination Against Women, *General Recommendation No 24: Article 12 Women and Health*, 20th sess (1999), [22]; Committee on the Elimination of all forms of Discrimination Against Women, *General Recommendation No 21: Equality in Marriage and Family Relations*, 13th sess (1994), [22]; and Committee on the Elimination of all forms of Discrimination Against Women, *General Recommendation No 19: Violence Against Women*, 11th sess (1992), [22].

⁴ See Australian Government Attorney-General's Department, *Australia's Formal Response to the UPR Recommendations* (8 June 2011), available at <www.ag.gov.au/RightsAndProtections/HumanRights/UniversalPeriodicReview/Pages/default.aspx> in which the Australian Government's response to recommendation 86.39 concerning non-therapeutic sterilisation was to accept this recommendation 'on the basis that *they are reflected in existing laws or policies* and that Australia will continue to take steps to achieve relevant outcomes (emphasis added)'.

⁵ See Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (2013) ('*Senate Report*'), at [4.35 & 4.36].

⁶ *Ibid* para [4.37].

⁷ The discussion will be confined to this practice as it applies to women and girls with an intellectual disability, owing to the reality that the overwhelming majority of children who are the subject of proceedings in which the welfare jurisdiction of the Australian Family Court is invoked in relation to sterilisation are girls with intellectual disabilities. See Linda Steele, 'Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability' (2008) 22 *Australian Journal of Family Law* 1, 1; Ronli Sifris, 'Conceptualising Involuntary Sterilisation as 'Severe Pain or Suffering' for the Purposes of the Torture Convention' (2010) 24 *Netherlands Quarterly of Human Rights* 523, 531 (noting that 'while theoretically both men and women may be subjected to involuntary sterilisation, in practice it is predominantly women who are subjected to this procedure' and arguing on this basis that the procedure 'may be conceptualised as a form of gender-based discrimination thereby satisfying the element of "purpose" in Article 1 of [the Convention Against Torture]').

absolute. Thus, an interference with rights such as privacy, equality and non-discrimination will be justifiable where the interference is reasonable; that is, where it takes place in furtherance of a legitimate aim and the means undertaken in order to achieve that aim are proportionate. An application of this test reveals that where all reasonably available alternative measures have been exhausted, the sterilisation of a woman or girl who is incapable of providing informed consent will be justified where it is necessary to secure her right to health.

Third, the persistence of the therapeutic/non-therapeutic nomenclature has contributed to the confusion and anxiety surrounding the law on involuntary sterilisations in Australia. By clarifying the meaning of these distinctions, and preferably dispensing with them altogether in favour of a focus on the rights of women and girls with intellectual disabilities, tensions between the respective views of the human rights bodies and the Australian Government might be reconciled. Significantly, these conclusions are aligned with the positions adopted in the Senate Report. However, unlike the Senate Report, which formed the view that international law remained unclear and contradictory, this paper demonstrates that a substantive, as opposed to a superficial, analysis of international law provides unambiguous guidance as to when the involuntary sterilisation of women and girls with an intellectual disability will be justified.

II: THE RELEVANCE OF RIGHTS – WHY DO THEY MATTER?

Three discrete paradigms have informed the conceptualisation of disability – eugenics, welfarism and, more recently, a rights-based approach. During the early to mid-twentieth century, eugenics called for the sterilisation of girls with often very mild intellectual disabilities.⁸ Indeed, an editorial from the *Medical Journal of Australia* in 1931 actually advocated ‘the sterilisation of mental defectives and of patients with a mental disease as a condition of discharge from hospital.’⁹ This approach was considered appropriate because eugenics viewed a girl or woman with an intellectual disability as abnormal and therefore incapable of using her reproductive capacity to enhance the status of the human species. Indeed, the realisation of their reproductive capacity represented a threat to the human species, which was therefore to be eliminated through involuntary sterilisation. Though it was claimed that this practice alleviated girls and women with intellectual disabilities from the burdens of menstruation and child-bearing, nothing can mask the fact that the genuine interests of these girls and women were entirely marginal to the eugenics project.

This abhorrent approach gradually gave way in the 1950s to a welfare model¹⁰ under which these girls and women were still considered ‘abnormal’ but were not explicitly considered to be a threat to the status and quality of the human species. On the contrary,

⁸ See, eg, *Buck v Bell* (1927) 274 US 200 (United States Supreme Court). In fact, the practice persisted throughout the twentieth century and was not abolished in Sweden until 1975: see generally Stephanie Hyatt, ‘A Shared History of Shame: Sweden’s Four Decade Policy of Forced Sterilisation and the Eugenics Movement in the United States’ (1998) 8 *Indiana International and Comparative Law Review* 475.

⁹ ‘Editorial’ (1931) 2 *Medical Journal of Australia* 655.

¹⁰ See, eg, *Skinner v Oklahoma* (1942) 316 US 535 (United States Supreme Court) (holding the compulsory sterilisation of habitual criminals to be unlawful).

they were seen as vulnerable objects in need of assistance and protection because of their perceived inability to care for children or deal with their menstrual cycle. The animating principle of this welfare approach was the concept of *best interests*. More specifically, parents, in collaboration with medical professionals, invariably determined that it would be in the best interests of a girl or woman with an intellectual disability to have the burdens caused by her reproductive system removed by way of sterilisation. In practice, this principle often operated as a ‘proxy’¹¹ for the interests of parents and other adults, and founded a vision of girls and women with intellectual disabilities as being necessarily incompetent and incapable of exercising any rights to reproductive autonomy.¹²

The wave of rights consciousness that emerged during the 1960s with respect to the treatment of women, racial groups and children also had implications for the conception of persons with disabilities under international law.¹³ They were no longer to be conceived of as mere objects in need of protection, but as subjects with entitlements to rights, irrespective of their mental capacity. Moreover, the historical emphasis on perceived abnormality, which had been facilitated by a medical model of disability, began to shift in response to an increased understanding that the concept of disability is often a consequence of a society’s inability to accommodate an individual’s functional impairment.¹⁴

The consequences of this move towards a rights-based conceptualisation of disability are profound. It reverses the perception of presumed incapacity and dependency in favour of presumed capacity and agency. This is recognised in the Senate Report, which considers the presumption of capacity to be a ‘threshold question’.¹⁵ It also affirms equality over discrimination, as reflected in the text of article 23(c) of the *Convention on Rights of Persons with Disabilities* (‘CRPD’),¹⁶ which was ratified by Australia in 2008 and provides that, ‘[p]ersons with disabilities, including children, retain their fertility on an equal basis with others’.¹⁷

¹¹ See American Academy of Pediatrics, Committee on Bioethics, ‘Informed Consent, Parental Permission and Assent in Pediatric Practice’ (1995) 95 *Pediatrics* 314, 315.

¹² For a discussion and critique of the ‘best interests’ principle see Senate Report, above n 5, [5.70-5.99].

¹³ For evidence of this trend at the international level see, eg, United Nations General Assembly, *Declaration on the Rights of Mentally Retarded Persons*, GA Res 2856 (XXVI) (20 December 1971). Despite its inappropriate and outdated terminology, this declaration is considered to provide the first signs of a shift from a ‘caring’ to a ‘rights-based’ approach with respect to persons with disabilities given its requirement in paragraph 1 that such persons are to enjoy the same human rights as other human beings: see Report of the Secretary General, *Progress of Efforts to Ensure the Full Recognition and Enjoyment of the Human Rights of Persons with Disabilities*, UN Doc A/58/181 (24 July 2003) at [14]. See also: *Declaration on the Rights of Disabled Persons*, GA Res 3447 (XXX), 30 UN GAOR Supp (No 34) at 88, UN Doc A/10034 (1975); *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, UN Doc A/RES/46/119, 75th plen mtg (17 December 1991); *UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, GA Res 48/96, 48th sess (20 December 1993), annex; and the *Convention on the Rights of People with Disabilities*, Opened for signature on 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008) (‘CRPD’). With respect to the emergence of rights within Australia see: Susan Brady, John Briton and Sonia Grover *The Sterilisation of Girls and Young Women in Australia: Issues and Progress* (Australian Human Rights Commission 2001) 8-9 (suggesting that *Marion’s Case* reflected a shift towards a rights-based approach in Australian law but that the decision could also be read as ‘endorsing a paternalistic child welfare approach’).

¹⁴ See Malcom Parker, ‘Forced Sterilisation’: Clarifying and Challenging Intuitions and Models’ (2013) 20 *Journal of Law and Medicine* 512, 522, referring to Linda Steele, ‘Making Sense of the Family Court’s Decisions on the Non-therapeutic Sterilisation of Girls with Intellectual Disability’ (2008) 22 *Australian Journal of Family Law* 1.

¹⁵ Senate Report, above n 5, [4.38].

¹⁶ See above, n 13, for full citation.

¹⁷ CRPD art 23(1)(c). Australia ratified the CRPD on 17 July 2008. See also each of the following provisions of the CRPD, which reaffirm the principle of non-discrimination with respect to the treatment of people with disabilities: article 3 (highlighting non-discrimination as a principle of the CRPD), article 5 (recognition of equality before the law and prohibition of discrimination on the basis of disability), article 6 (states’ commitment to take particular measures to counter discrimination against disabled women), article 7 (states’ commitment to take particular measures to counter discrimination

Importantly, as a party to this treaty, Australia is bound as a matter of international law to take the necessary measures to secure this entitlement¹⁸ – an obligation which is acknowledged in the Senate Report.¹⁹ Although the relevance of this international legal obligation is tempered by the fact that it is not enforceable domestically,²⁰ as the Senate Report specifically recognises, '[f]ailure to determine capacity strips persons with disabilities of their equality before the law ... [and] ... appears contrary to Australia's undertakings upon signing the Convention on the Rights of Persons with Disabilities.'²¹

Moreover, beyond Australia's obligations under international law, there are three further reasons why it would be inappropriate to marginalise international human rights law in the context of the sterilisation of a woman or girl with an intellectual disability. First, the Australian Government has publically committed itself to take the necessary steps to comply with its international human rights obligations.²² The National Human Rights Action Plan, released in 2012, provides that 'the Australian Government will work with states and territories to clarify and improve laws and practices governing the sterilization of women and girls with disability'.²³ Significantly, this commitment was echoed in the terms of reference for the inquiry leading to the Senate Report, which required consideration of 'Australia's compliance with its international obligations.'²⁴

Second, state and federal legislation has been adopted which legitimises the role of international human rights law in shaping domestic law and policy. For example, the *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth) requires that all federal legislation be scrutinised for compatibility with international human rights standards.²⁵ Similar requirements exist in the ACT and Victorian human rights legislation.²⁶ Whilst such measures may not fully

against disabled children and requiring that in doing so, their best interests be a primary consideration) and article 17 (the right of people with disabilities to physical and mental integrity on an equal basis with others).

¹⁸ See art 26 of the *Vienna Convention on the Law of Treaties*, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980), which states that '[e]very treaty in force is binding upon the parties to it and must be performed by them in good faith.'

¹⁹ See Senate Report, above n 5, [3.2].

²⁰ See *Minister of State for Immigration and Ethnic Affairs v Ah Hin Teoh* (1995) 183 CLR 273, 286-7 (per Mason CJ and Deane JJ), citing *Chow Hung Ching v The King* (1948) 77 CLR 449, 478; *Bradley v The Commonwealth* (1973) 128 CLR 557, 582; *Simsek v Macphree* (1982) 148 CLR 636, 641-642; *Koowarta v Bjelke-Peterson* (1982) 153 CLR 168, 211-212, 224-225; *Kioa v West* (1985) 159 CLR 550, 570; *Dietrick v The Queen* (1992) 177 CLR 292, 305; *JH Rayney (Mincing Lane) Ltd v Department of Trade and Industry* [1990] 2 AC 418, 500. Also noteworthy is Australia's declaration with respect to the CRPD that it allows for fully supported or substituted decision-making arrangements and compulsory assistance or treatment, where such treatment is necessary, as a last resort and subject to safeguards (see

<treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en>).

²¹ Senate Report, above n 5, [4.39].

²² See, eg, The Honourable Robert McClelland MP, 'Australia's Human Rights Framework', (Media Release, 21 April 2010); The Honourable Robert McClelland MP and Minister for Foreign Affairs Hon Stephen Smith, 'Reaffirming Our Commitment to International Human Rights Obligations' (Media Release, 21 April 2010).

²³ Australian Attorney-General, Nicola Roxon, *Australia's National Human Rights Action Plan* (Attorney-General's Department, Commonwealth of Australia 2012) at 65.

²⁴ See Terms of Reference for the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities*, at 1(f), available at

<www.aph.gov.au/Parliamentary_Business/Committees/Senate/Committees?url=clac_ctte/involuntary_sterilisation/tor.htm>.

²⁵ *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth) s 8(3). For a discussion of this legislation, see David Kinley and Christine Ernst, 'Exile on Main Street: Australia's Legislative Agenda for Human Rights' (2012) 1 *European Human Rights Law Review* 58.

²⁶ *Human Rights Act 2004* (ACT) ss 37 and 38; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 28. See also, Kinley and Ernst, above n 25, 61 (noting that '[b]oth define human rights by reference to a select list of rights, all of which are civil or political. This means that when Ministers attest that Bills are compatible with human rights, and when parliamentary committees scrutinise those attestations, they are conducting their assessments by reference to a limited group of rights that

implement Australia's international human rights obligations, they still elevate their relevance in the domestic context.

Finally, although international human rights law represents a legal expression of rights, it also reflects a particular moral conception of human rights which, although incompletely theorised, is often overlooked.²⁷ This moral conception reflects a profound commitment to the dignity and worth of every individual who is endowed with rights purely by virtue of his or her humanity.²⁸ Under this model, a woman or girl with an intellectual disability is not defined by her disability. Nor is she undeserving of rights because of her reduced cognitive capacity. She is first and foremost a person who is entitled both to respect for her dignity and to protection of her human rights. As such, a consideration of human rights is relevant to the sterilisation of such women and girls not simply because of the legal and political significance of this discourse – a point stressed in the Senate Report²⁹ – but also because of its consequences for the moral conceptualisation of this issue. This perspective demands that assumptions about the capacity of intellectually disabled women and girls to deal with their menstrual cycle and their capacity to have children must be re-evaluated.³⁰ It also demands recognition that these assumptions have historically been based on prejudices which ignore the reality that such women and girls have far greater capacity than was assumed.

However, while a rights-based approach demands greater respect for the value and capacity of women and girls with intellectual disabilities, it still concedes that there will be occasions when their disability is so profound that substituted, rather than merely supported, decision-making will be necessary.³¹ These circumstances raise the issue of whether the involuntary, non-therapeutic sterilisation of a woman or girl can ever be consistent with her human rights. It is to this issue that we now turn.

does not represent the full spectrum of international human rights law.'). For a discussion of the use of international human rights standards in legislative interpretation, see generally, Bryan Horrigan, 'Reforming Rights-Based Scrutiny and Interpretation of Legislation' (2012) 37 *Alternative Law Journal* 228.

²⁷ See John Tobin, *The Right to Health in International Law* (Oxford University Press, 2012), 49-50.

²⁸ See, eg, Jürgen Habermas, 'The Concept of Human Dignity and the Realistic Utopia of Human Rights' (2010) 41 *Metaphilosophy* 465; Christopher McCrudden, 'Human Dignity and the Judicial Interpretation of Human Rights' (2008) 19 *European Journal of International Law* 655.

²⁹ See, Senate Report, above n 5, [3.103].

³⁰ Ibid, chapter 2 (providing a discussion about the capacity of women with intellectual disabilities to parent child and the profound lack of sexual education and services to assist such women).

³¹ Briefly, supported decision-making occurs when an individual with a disability has the capacity to make decisions for him or herself, *with the assistance of another individual or third party*. Substituted decision-making entails a decision being made entirely by a third party or proxy, on behalf of the individual with a disability, who is incapable of taking the decision him or herself due to the nature of his or her disability. For further discussion of these approaches, see generally, Shih-Ning Then, 'Evolution and Innovation in Guardianship Laws' (2013) 35 *Sydney Law Review* 133; Terry Carney and Fleur Beaupert, 'Public And Private Bricolage – Challenges Balancing Law, Services and Civil Society In Advancing CRPD Supported Decision-Making' (2013) 36 *UNSW Law Journal* 175. Submissions were made to the Senate Inquiry to the effect that international law prohibited substituted decision making. However, the Senate Inquiry rejected this view in preference for the view expressed by the Australian Human Rights Commission to the effect that substituted decision making is justified provided adequate safeguards were in place to protect against abuse: see, Senate Report, above n 5, [5.20] and [5.26]-[5.27].

III: MOVING BEYOND THE RHETORIC – APPLYING A SUBSTANTIVE RIGHTS APPROACH

A: *Is an Absolute Position Justified?*

The response of the international human rights bodies to this question is unequivocal.³² During the Human Rights Council’s universal periodic review of Australia in 2011, several states called on Australia to prohibit *involuntary non-therapeutic sterilisation* of women and girls with an intellectual disability.³³ In 2012, the Committee on the Rights of the Child, the body of independent experts responsible for monitoring Australia’s compliance with the *Convention on the Rights of the Child* (‘CRC’),³⁴ made a similar call and condemned the practice as a form of violence which ‘seriously violates the right of the child to her physical integrity’.³⁵ Furthermore, in its recent concluding observations on Australia’s report under the CRPD, the Committee on the Rights of Persons with Disabilities was ‘deeply concerned that the Senate inquiry report into the involuntary or coerced sterilization of persons with disabilities ... puts forward recommendations that would allow this practice to continue.’³⁶ Accordingly, it recommended the adoption of ‘uniform national legislation prohibiting the sterilization of boys and girls with disabilities, and adults with disabilities, in the absence of their prior, fully informed and free consent.’³⁷ The committees responsible for monitoring the *Convention on the Elimination of Discrimination Against Women*³⁸ and the *International Covenant on Economic Social and Cultural Rights*³⁹ have also called for the practice to be banned.⁴⁰ Moreover, the Human Rights Committee, which is responsible for monitoring the *International Covenant on Civil and Political Rights*⁴¹ and the Special Rapporteur on Torture, have both suggested that the practice may violate the prohibition on torture, cruel, inhuman and degrading treatment.⁴²

³² For an overview of the views of the various international human rights bodies see Senate Report, above n 5, [3.19-3.37].

³³ See above, n 3.

³⁴ Opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).

³⁵ CRC Committee, General Comment No. 9: The Rights of Children with Disabilities, UN Doc CRC/C/GC/9 (27 February 2007) at [60].

³⁶ Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia* above n 3, [39].

³⁷ *Ibid* [40].

³⁸ Opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981).

³⁹ Opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

⁴⁰ See Committee on the Elimination of all forms of Discrimination against Women (‘CEDAW Committee’), *General Recommendation No 24: Article 12 Women and Health*, 20th sess (1999), [22]; CEDAW Committee, *General Recommendation No 21: Equality in Marriage and Family Relations*, 13th sess (1994), [22]; CEDAW Committee, *General Recommendation No 19: Violence Against Women*, 11th sess (1992), [22]; Committee on Economic Social and Cultural Rights, *General Comment No 5: Persons with Disabilities*, 11th sess (1994), [31]; Committee on Economic Social and Cultural Rights, *General Comment no. 14: The Right to the Highest Attainable Standard of Health* UN Doc E/C.12/2000/4 (2000) (noting at [8] 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’).

⁴¹ Opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

⁴² Manfred Nowak, *Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development: Report of the Special Rapporteur on Torture and Other Cruel, Inhuman Or Degrading Treatment Or Punishment*, UN Doc A/HRC/7/3 (2008) at [38]. See also Radhika Coomaraswamy, *Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences: Addendum - Policies and Practices that Impact Women’s Reproductive Rights and Contribute to, Cause Or Constitute Violence Against Women*, UN Doc E/CN.4/1999/68/Add.4 (1999) at [51].

This condemnation of the involuntary sterilisation of women and girls with an intellectual disability is motivated by a legitimate desire to protect the rights of these individuals. Indeed, to invoke the notion of torture represents an attempt to shift the narrative from welfare and concern for the woman or girl to violence and serious physical harm. This is understandable given the historical and indeed contemporary devaluation of women and girls with an intellectual disability. But is such a robust and uncompromising approach actually justified under international human rights law?

B: *The Need for Balance*

The integrity of the increasingly common rights-based conceptualisation of intellectual disability is compromised by the fact that its application is often superficial and fails to engage in a sufficiently detailed analysis of the scope and nature of the affected rights, or the extent to which any interference with them might be justified. This lack of analysis is a feature of the recommendations of the various human rights bodies with respect to the involuntary sterilisation of women and girls with intellectual disabilities.⁴³ Their calls for an absolute prohibition on this practice, are often premised on an assertion that the practice violates a raft of human rights, without any detailed assessment of whether there might ever be circumstances in which the practice is legitimate.

A substantive rights-based approach, in contrast, entails two stages: first, an assessment of whether any rights are engaged by the practice of involuntary sterilisation and second, if so, whether interference with these rights can be justified as being reasonable.⁴⁴ Significantly, the Senate Committee undertook the first stage of this approach, that is, it listed the relevant rights, but it failed to engage in the second stage of the assessment.⁴⁵ The reasonableness of any interference under the second limb of this analysis will depend on the extent to which it was necessary to achieve a legitimate aim and if so, whether the measures undertaken in furtherance of that aim were proportionate. An assessment of proportionality, in turn, requires consideration of whether there was a rational connection between the aim and the measure undertaken and whether an alternative, less intrusive measure was reasonably available (the *minimal impairment test*). Our analysis now turns to the rights engaged by the practice of involuntary sterilisation.

⁴³ Furthermore, as the Senate Report notes, the comments of such committees are non-binding (Senate Report, above n 5, at [4.12]). There nevertheless remain authoritative interpretations of the relevant treaties which should not be disregarded (see also Senate Report, above n 5, [4.14]).

⁴⁴ For a more detailed discussion of this methodology see Tobin, above n 27, 180-184.

⁴⁵ See Senate Report, above n 5, [3.1]-[3.18] (listing the various rights engaged by the practice of involuntary sterilisation).

C: Which Rights are Engaged?

It would be possible to draw up a rather long list of rights under the various international human rights treaties that are engaged by the involuntary sterilisation of women and girls with intellectual disabilities.⁴⁶ For example, under the CRC alone, this list might include a child's right to non-discrimination (article 2); to survival and development (article 6); to ensure his or her best interests are a primary consideration (article 3); to respect for privacy, including his or her physical and bodily integrity (article 15); to protection against violence (article 19); to the highest attainable standard of health (article 24); and a disabled child's right to enjoy a life of dignity (article 23). This list could go on.⁴⁷ Indeed, the question of engagement risks the adoption of a shopping list approach. Ultimately, however, the more complex issue is not the identification of the rights engaged, but whether interference with these rights is justified.

In this regard it is important to mention again article 23(c) of the CRPD, the only provision under international law to address the issue of sterilisation directly, which requires that:

State parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, parenthood and relationships, on an equal basis with others so as to ensure that ... *[p]ersons with disabilities including children retain their fertility on an equal basis with others.*⁴⁸

There is a tendency for this provision, with its emphasis on equality, to be interpreted as requiring an absolute prohibition on the involuntary non-therapeutic sterilisation of women and girls with an intellectual disability. This understanding of article 23 arises from an application a 'but for' test; that is, *but for* the existence of the disability, would the woman or girl have been subjected to the procedure? Under this approach, the mere existence of differential treatment on the basis of a disability is considered determinative of whether the prohibition against discrimination and the right to equality have been violated.

Although the 'but for' test is intuitively appealing, differential treatment alone will not amount to discrimination under international human rights law. Importantly, article 2 of the CRPD defines 'discrimination on the basis of disability' as:

any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

⁴⁶ See Senate Report, above n 5, [3.1]-[3.18].

⁴⁷ With respect to the CRPD, potential rights which are engaged by the practice include articles 6 (right to gender equality), 7 (right to equality generally), 15 (right to freedom from torture), 17 (right to integrity of the person) and 23 (right to freedom from discrimination in matters concerning marriage, family, parenthood and relationships and to retain fertility on an equal basis with others).

⁴⁸ See also article 12 CRPD, which provides a general right to persons with a disability to legal recognition and to enjoy legal capacity on an equal basis with others and article 25 which demands free and informed consent to medical procedures for people with a disability.

Accordingly, it is the *impairment* or *nullifying* of the enjoyment of rights which amounts to the proscribed form of discrimination. This does not, however, preclude *per se* differential treatment on the basis of disability. On the contrary, such treatment will be permitted where it is in furtherance of a legitimate aim (such as the fulfilment of the rights of women and girls with an intellectual disability) and where the measures undertaken to achieve that aim are proportionate.⁴⁹ Importantly, these considerations are the same whether the issue is framed in terms of the right to equality and non-discrimination or the right to privacy and respect for bodily integrity. The central question remains: can involuntary non-therapeutic sterilisation of a woman or girl with an intellectual disability ever be justified?

D: Is the Aim Legitimate?

Three primary reasons are commonly given to justify involuntary sterilisation: protection against sexual abuse; protection against unwarranted pregnancies; and control of a woman or girl's menstrual cycle. The assumption underlying each of these is that a woman or girl with an intellectual disability lacks the autonomy and capacity to care for herself or any children that she might conceive. Thus, those responsible for her welfare must take measures to secure her *best interests*. This welfare principle is certainly an advance on the eugenics project but, as noted above, the best interests principle has often operated as a proxy for the interests of others. In contrast, a rights-based approach rejects assumptions and speculative assessments about the best interests of women and girls with intellectual disabilities and demands that the determination of their best interests be informed by a number of specific considerations, which serve to reduce the perceived indeterminacy of this principle.⁵⁰ These are:

- a) any other rights under international law, such as equality, non-discrimination and respect for private life, since the best interests of woman or girl will not be served where there is a corresponding violation of other rights;
- b) due weight being given to the views of the woman or child, to extent that she is able to express them, in any assessment of her best interests; and
- c) any research to support an evidence-based, as opposed to speculative, assessment of best interests.⁵¹

⁴⁹ See Human Rights Committee General Comment on Discrimination, *General Comment No 18: Non-Discrimination*, 37th sess (1989) [13]. It is acknowledged that the Human Rights Committee was referring to the International Covenant on Civil and Political Rights here, however the interpretive principle of external system coherence demands that interpretation of the meaning in a human rights treaty should be consistent with the understanding of the term where it appears in another human rights treaty: see John Tobin, 'Seeking to Persuade: A Constructive Approach to Human Rights Treaty Interpretation' (2010) 23 *Harvard Human Rights Journal* 1, 34-37.

⁵⁰ Cf Brennan J's comments in *Marion's Case*, above n 2, that 'in the absence of legal rules or a hierarchy of values, the best interests approach depends upon the value system of the decision-maker. Absent any rule or guideline, that approach simply creates an unexaminable discretion in the repository of the power' (at 227).

⁵¹ For a more detailed discussion of these considerations see John Tobin, 'Judging the Judges: Are they Adopting the Rights Approach in Matters Involving Children?' (2009) 33 *Melbourne University Law Review* 579, 588-592.

The application of such an approach reveals that women and girls with intellectual disabilities are often more capable of managing their sexual and reproductive autonomy than has historically been assumed. It is for this reason that international law begins with a presumption of formal equality with respect to a woman or girl's sexual and reproductive rights, irrespective of ostensible intellectual capacity. It also demands that states take positive measures to support women and girls with an intellectual disability in the substantive enjoyment of these rights. Moreover, it is generally accepted that appropriate education about sexual and reproductive health, menstrual management techniques and parenting support for women and girls with an intellectual disability can significantly enhance their capacity to enjoy their sexual and reproductive rights on an equal basis.⁵²

At the same time, the reality is that for some women or girls with a profound intellectual disability, substituted rather than supported decision-making will be inevitable, irrespective of the education or services afforded to them, or the granting of additional time in order to allow their capacities to evolve.⁵³ These circumstances will arguably be less common under a rights-based approach relative to a welfare-based approach, owing to the increased recognition of the capacity of women and girls with an intellectual disability. Nevertheless, they will still arise. In such cases, it will be legitimate for the parents or other responsible persons to take appropriate measures to secure the best interests *and rights* of women and girls with intellectual disabilities. Indeed, with respect to girls, parents actually have an explicit obligation to do so under international law.⁵⁴ However, neither a beneficent motivation nor a legal obligation will be sufficient grounds to justify involuntary non-therapeutic sterilisation in order to secure a woman or child's rights and best interests. Such a measure must still be necessary and proportionate for the achievement of this aim.

Before turning to this issue of proportionality, it is important to mention a factor which is increasingly considered taboo in discussions about the sterilisation of women and girls with intellectual disabilities, namely, the rights and interests of carers. As recognised by the American Academy of Pediatrics, 'third parties have rightful interests'⁵⁵ which must not be overlooked in the quest to atone for past sins which saw the interests of women and children with disabilities serve as a proxy for the interest of their carers. Furthermore, human rights law actually anticipates that the rights of others, including a carer's rights to family life, assistance in the provision of care⁵⁶ and indeed their own health, may legitimately be

⁵² See, eg, Senate Report, above n 5, chapter 2 especially recommendations 2.118 & 2.119. See also: Royal Australasian College of Physicians submission, *Submission to the Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (5 February 2013), [2]; Department of Paediatric and Adolescent Gynaecology at the Royal Children's Hospital, Melbourne, *Submission to the Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (March 2013) at 4 (noting that education of parents siblings and carers is one of the most important components of care).

⁵³ It is acknowledged that this position may be contentious for those who adopt a social model of disability. It is accepted that functional impairment is often caused by social structures and values which are unable to accommodate variations in physical or mental ability. But the position adopted in this paper is based on an interactional model of disability in which that biological factors still have a role to play in contributing to functional impairments experienced by persons who have disabilities.

⁵⁴ See CRC, art 18.

⁵⁵ American Academy of Pediatrics Committee on Bioethics, 'Sterilization of Minors' (1999) 107 *Pediatrics* 337, 339.

⁵⁶ See CRC, art 18, which requires that states recognise parents' responsibilities for the upbringing of their children, and art 27, which recognises that parents have the primary responsibility to secure adequate living conditions for the child's development. See also *International Covenant on Economic, Social and Cultural Rights* opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) ('ICESCR') art 10, which requires that the widest possible protection and assistance be accorded to the family, as the natural and fundamental group unit of society ICESCR; and the Universal

considered when assessing the justification of sterilisation in this context. Legitimacy of the aim, however, only satisfies the first limb of the test and the real issue concerns the proportionality of the procedure. It is to this issue that we now turn.

E: *The Question of Proportionality*

When determining the proportionality of a sterilisation, there are two key considerations. First, is there a rational connection between the end being sought and the means being undertaken to achieve that end? With respect to the protection of a woman or girl against sexual abuse, no such connection exists. There is simply no evidence to suggest that sterilisation will reduce the incidence of sexual abuse.⁵⁷ Sterilisation will, however, clearly prevent pregnancy and control a woman or girl's menstrual cycle and in doing so, will also address her carer's concerns. Thus the real question becomes, is there another *reasonably available* measure to prevent pregnancy and control the menstrual cycle of women or girls with a profound intellectual disability, which involves less interference with their rights?

Within human rights law, this *minimal impairment principle* is similar to the 'measure of last resort' paradigm which frames discussions about involuntary sterilisation within the context of medical ethics and which also influenced the High Court of Australia's decision in *Marion's Case*,⁵⁸ Australia's declaration to the CRPD⁵⁹ and the recommendations of the Senate Report.⁶⁰

However, what is striking about many of the calls to prohibit the involuntary non-therapeutic sterilisation of women and girls with an intellectual disability by international human rights bodies,⁶¹ the Australian Human Rights Commission⁶² and many of the submissions to the Senate Inquiry,⁶³ is that they effectively overlook this test.

Declaration of Human Rights, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plan mtg, UN Doc A/810 (10 December 1948), art 16 of which recognises the family as the natural and fundamental group unit of society, which is entitled to protection by society and the state. In light of this theme within international human rights law, which recognises the rights and responsibilities of parents, it is any unfortunate irony that the CRPD does not grant carers with any right to assistance in the provision of care to a disabled child (barring article 24, under which states are required to provide alternative care where a family is wholly unable to care for a child with a disability).

⁵⁷ The American Academy of Pediatrics notes that sterilisation will not guard against sexually transmitted diseases and will be less effective a safeguard against abuse than the creation of a safe environment which minimises the scope for abuse to occur: see American Academy of Pediatrics, above n 55, 339. See also Senate Report, above n 5, [2.117] (recommending that protection against sexual abuse must never be used to justify involuntary sterilisation).

⁵⁸ The Senate Report notes that the Australian 'reservation' to the CRPD also adopts this test and accepts that this reservation informs the nature of Australia's obligations under the CRPD: see Senate Report, above n 5, [3.7] and [4.45]. But the Senate Report does not actually apply this test and prefers a self-styled test to the effect 'laws and procedures may permit the sterilisation of persons with disabilities, but the circumstances in which this may occur must be narrowly circumscribed, and based on the protection and advancement of the rights of the person': para [4.45].

⁵⁹ Available at <http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en> ('Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards') (emphasis added).

⁶⁰ See Senate Report, above n 5, [4.45] and [5.1].

⁶¹ See above, n 3.

⁶² See Australian Human Rights Commission, *The Involuntary or Coerced Sterilisation of People with Disabilities in Australia: Australian Human Rights Commission Submission to the Senate Community Affairs References Committee* (20 November 2012).

⁶³ See, eg, Amnesty International Australia, *Submission to the Committee Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (7 March 2013); People with Disability Australia, *Senate Standing Committee on Community Affairs: Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia Submission* (March 2013).

To be fair, this prohibitionist approach finds support in the 1986 decision of the Canadian Supreme Court in *Re Eve*,⁶⁴ which was unswayed by claims that sterilisation could potentially be necessary to secure the best interests of a woman or girl with an intellectual disability:

The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilisation without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can *never* safely be determined that such a procedure is for the benefit of that person.⁶⁵

This approach was rejected, however, by the UK House of Lords in *Re B (A Minor)*,⁶⁶ which shied away from the idea that the procedure could 'never' be justified, and of course the Australian High Court in *Marion's Case*, which contemplates the legitimacy of non-therapeutic sterilisation as a measure of last resort.

However, these cases were decided more than 20 years ago and in the interim there has been significant advocacy by disability groups and international human rights bodies to prohibit involuntary non-therapeutic sterilisation. Significantly, despite this trend, the position of medical professionals still tends to favour regulation over absolute prohibition. In defending this view, the representative bodies for medical professionals have embraced the language of rights and emphasised the availability of alternative, less invasive methods to address concerns associated with unwanted pregnancies and a woman's menstrual cycle. Yet they still entertain the possibility that in some, albeit, extremely limited circumstances, sterilisation may be justified as a measure of last resort. For example, the Royal Australasian College of Physicians has recommended that:

The most appropriate procedures are reversible ones and these will always be preferred to surgical options that are permanent, such as sterilisation. As such, reversible methods including subdermal progestogen implants and progestogen intrauterine system *should* always be considered preferential treatments.⁶⁷

The American Academy of Pediatrics has also emphasised that with respect to unwanted pregnancies 'less permanent means may be available including 'barrier methods, pills, injections, intrauterine devices or subdermal implants'.⁶⁸ Moreover, the Academy has suggested that 'as methods of contraception that provide alternatives to sterilisation increase the available options, permanent sterilisation becomes increasingly difficult to justify'.⁶⁹

These bodies have stopped short, however, of advocating an absolute and unconditional prohibition on the practice. For example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists has stressed that:

⁶⁴ [1986] 2 SCR 388 (Supreme Court of Canada).

⁶⁵ Ibid [86] (emphasis added).

⁶⁶ [1988] 1 AC 199.

⁶⁷ Royal Australian College of Physicians, *Submission to the Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (5 February 2013), [5] (emphasis added).

⁶⁸ American Academy of Pediatrics, above n 55, 339.

⁶⁹ Ibid 338.

The availability of safe and effective long-acting reversible contraceptives (LARCs), contraceptives that have the added benefit of reducing or eliminating menstrual flow, has greatly reduced the need for surgical sterilisation or hysterectomy of younger women in the last decade. However, no method of menstrual regulation or sterilisation is perfect, and a small number of disabled girls or women *may still have their best interests served by hysterectomy or sterilization* (emphasis added).⁷⁰

The Australian Medical Association adopts a similar approach, as does the American Academy of Pediatrics, which has conceded that the appropriateness of alternatives will depend ‘on the functional abilities of the person with [the] developmental disability and the reactions of the patient ... to nonsurgical methods to prevent pregnancy’.⁷¹

The position of medical bodies is therefore inclined to support the regulation, rather than absolute prohibition, of the involuntary non-therapeutic sterilisation of women and girls with intellectual disabilities. These bodies still favour a presumption against the procedure and recognise that the aims of this practice can almost always be achieved by alternative, less invasive measures involving education and, where necessary, long acting, reversible contraceptives. Yet they still accept the remote possibility that these alternative measures, though available, may not always be effective. For example, the medical treatment being received by a woman or a girl for a separate medical condition may be incompatible with medication required to control and regulate her reproductive health.⁷² As such, the risk of side effects from some forms of long acting reversible contraception may preclude their use.⁷³ In such circumstances, the only measure *reasonably available* to address the legitimate concerns with respect to the reproductive health of a woman or girl with an intellectual disability may be sterilisation. Importantly, this position, which is evidence-based, is consistent with a substantive analysis of the legitimacy of this practice under international law.

Does this mean, however, that the calls for the abolition of this practice, motivated as they are by a genuine desire to address the often maligned status of women and girls with intellectual disabilities, are unjustified? These calls may not be informed by a substantive engagement with the relevant legal principles to determine whether interference with particular rights might be justified under international law. But does this necessarily mean that the Australian Government’s claim that the current law within Australia is consistent with its international obligations is justified? Or can the apparent tension between the positions adopted by the Australian Government, human rights bodies, medical professionals and indeed the courts be reconciled? A closer analysis of the issue suggests that reconciliation is possible and that the current tensions arise from the persistence of the therapeutic/non-therapeutic distinction.⁷⁴ It is to this issue that we now turn.

⁷⁰ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Submission to the Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (20 February 2013) at 1 (emphasis added).

⁷¹ American Academy of Pediatrics, above n 55, 339.

⁷² Malcolm Parker email to John Tobin, 15 May 2013 (copy on file with authors).

⁷³ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, above n70, 2.

⁷⁴ This distinction has been the subject of criticism over an extended period of time. See, eg, Brady, Britain and Grover, above n 13; Western Australia Law Reform Commission, ‘Report on Consent to the Sterilisation of Minors’ (Project No 77

F: *Questioning the Therapeutic/Non-Therapeutic Distinction*

In *Marion's Case*, the Australian High Court created a distinction between therapeutic and non-therapeutic sterilisations. The Court held that whereas a sterilisation which was a 'by-product' of surgery to treat 'some malfunction or disease' (a therapeutic sterilisation) was justified, the non-therapeutic sterilisation of a girl who is incapable of providing her consent can only be justified where it was a measure of last resort and necessary to secure her best interests.⁷⁵ The Court's reference to the presence of malfunction or disease as a prerequisite for therapeutic sterilisation arguably places the bar too high for two reasons. First, its emphasis on the threat to the physical health of a woman or girl with an intellectual disability does not recognise the potential for psychological harm to stem from her inability to control her menstrual cycle and/or avoid pregnancy. Second, it does not offer a methodology by which to resolve situations which may not be life threatening, but for which sterilisation may offer the only viable remedy to address the physical or mental harm being experienced.

In translating *Marion's Case* into practice, the Family Law Court and several jurisdictions within Australia have adopted regimes which seek to restrict the circumstances in which non-therapeutic sterilisations may be authorised.⁷⁶ Each of these regimes reaffirms the principles of 'best interests' and 'measure of last resort'.⁷⁷ Importantly though, they also emphasise the obligation to consider the impact on the child's physical *and* psychological health when determining whether a sterilisation is justified.⁷⁸ In doing so, they address the concerns associated with the parameters articulated by the High Court in *Marion's Case*. More importantly in practice, sterilisations authorised by, for example, the Family Court, have tended to be authorised on the basis of the overall health benefits to the child, encompassing a holistic view of those benefits which extends to mental health considerations.

For example, the most recent such authorisation in *Re Angela*⁷⁹ involved an order for the sterilisation of a twelve year-old girl with Rhett Syndrome, a progressive neurological disorder resulting in severe intellectual and physical impairment and epilepsy. Angela was unable to talk and lacked the intellectual or physical capacity to use sign language. Her behaviour and cognitive capacity were equivalent to that of a three month-old baby and there

Part II, October 1994) 94-96; Australian Family Law Council, *Sterilisation and Other Medical Procedures on Children – A Report to the Attorney-General* (Australian Government Publishing Service 1994) 44-45.

⁷⁵ *Marion's Case*, above n 2, [48].

⁷⁶ The Family Court of Australia articulated the following set of factors to guide the determination of a child's best interests in *Re Marion* (No 2) (1992) 17 FamLR 336: the particular condition of the child who requires the treatment; the nature of the proposed treatment; the reasons for the proposed treatment; the available, alternative treatments; the desirability and effect of authorising the proposed treatment rather than the available alternatives; the physical effects on the child and the psychological and social implications for the child of both authorising the proposed treatment and not authorising the treatment; the nature and degree of any risk to the child of either authorising or not authorising the proposed treatment; and any views expressed by the parents, other carers or the child about the proposed treatment and the alternative. See also relevant state legislation: the *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175 applies to children under the age of 16. The *Guardianship Act 1987* (NSW) ss 45 and 45A apply to children aged between 16 and 18. See also *Guardianship and Administration Act 2000* (Qld) s 70; *Guardianship and Administration Act 1993* (SA) s 61; and *Guardianship and Administration Act 1995* (Tas) s 46.

⁷⁷ See in particular, *Guardianship Act 1987* (NSW) s 45(d); *Guardianship and Administration Act 2000* (Qld) s 70(3)(a); *Guardianship and Administration Act 1993* (SA) ss 61(1)(B) and 61(5).

⁷⁸ See, eg, *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(3); and *Guardianship Act 1987* (NSW) ss 45(2)(b).

⁷⁹ (2010) 43 Fam LR 98.

was no prospect that this would improve. She also experienced epileptic seizures during heavy menstruation that left her anaemic. Medical experts testified that for ‘some years’ attempts had been made to improve her quality of life, and reversible forms of contraception such as Implanon, Depo Provera and the pill had been tried, without success.⁸⁰ The Court therefore authorized sterilisation on the basis that it was necessary to improve the pain and suffering associated with menstruation, which seriously diminished Angela’s quality of life.⁸¹

The emphasis on the relative health benefits to a woman or girl to justify her sterilisation indicates that an order for this procedure in such circumstances is best characterised as being therapeutic, rather than non-therapeutic, because the procedure is necessary to secure the highest attainable standard of health for a woman or girl. It therefore follows that involuntary sterilisation of a woman or girl with a profound intellectual disability will be legitimate when it is authorised as a measure of last resort in order to:

- a) save the life of a woman or girl with an intellectual disability; and/or
- b) alleviate the serious health burden, whether physical or psychological, associated with menstruation or the prospect of pregnancy as experienced by a woman or girl with an intellectual disability.

In contrast, non-therapeutic sterilisations should be taken to refer to those procedures that have no health benefit and are performed primarily for reasons of convenience.

Convenience will never justify the sterilisation of a woman or girl with an intellectual disability who lacks the capacity to consent to such a procedure.⁸² As such, a *non-therapeutic* sterilisation would never be legitimate under international law. Thus, the prohibitionist calls by human rights bodies and advocates with respect to this practice, although lacking in substantive analysis, are partially justified. Where their argument fails however is with respect to the claim that an *involuntary* sterilisation or a sterilisation without *free and informed consent* can never be justified.

However, it is the persistence of the therapeutic/non-therapeutic distinction that continues to create ambiguity and confusion. It creates the impression that a sterilisation classified as being *involuntary* and *non-therapeutic* will be lawful if certain criteria are satisfied, when in practice the satisfaction of these criteria will be sufficient grounds for the authorisation of a sterilisation classified as *involuntary* and *therapeutic*. Indeed in *Marion’s Case*, the sterilisation was ultimately justified on what could be described as therapeutic grounds (when a broader conception of this term is adopted), namely that the procedure was necessary to minimise the potential for further neurological damage to the child resulting

⁸⁰ Ibid at [1] and [20] (Angela was nearly 12 when the order was sought and had started menstruation at age 9 although it is unclear from the decision when medical intervention to manage her menstrual cycle had commenced).

⁸¹ See ibid [54]–[61].

⁸² This position will offer little solace to carers of women and girls with an intellectual disability, however the inconvenience that they experience can always be addressed by measures such as respite care, financial assistance and other measures which are less invasive than an irreversible medical procedure. Indeed international human rights law provides such persons with a right to claim assistance for their caring responsibilities by virtue of provisions which affirm the importance of the family and the obligation to provide family members with support and assistance: see, eg, CRC arts 18 and 27; ICESCR art 10; and *International Covenant on Civil and Political Rights* opened for signature 19 December 1966, 999 UNTS 302 (entered into force 23 March 1976) art 24. Oddly the CRPD does not include an article that would require states to provide assistance to persons caring for people with disabilities.

from her epilepsy. Thus, there appears to be little reason to maintain the therapeutic/non-therapeutic distinction and good reason to abandon it entirely in preference for an alternative model.⁸³ What then would an alternative model look like if it were fashioned in light of international human rights law?

G: The Alternative Model: A Rights-Based Approach

It should now be clear that a rights-based approach proceeds from the starting point that, consistent with the principle of equality and non-discrimination, a woman or girl with an intellectual disability is *prima facie* entitled to enjoy their sexual and reproductive rights without interference. Thus, where she demonstrates competency, or there is evidence that her capacity for competency can be supported or will improve sufficiently over time, she has a right to refuse sterilisation *and just as importantly*, a right to consent to this procedure. Significantly the Senate Report also adopts this position.⁸⁴

The real issue arises where a woman or girl with a profound intellectual disability, as was the case in *Marion's Case* and *Re Angela*, lacks capacity to consent to or refuse sterilisation, and there is no reasonable prospect that she will ever develop this capacity. In such circumstances, international law requires the state to safeguard a woman's rights to health, bodily integrity, including fertility, and non-discrimination. With respect to a girl with an intellectual disability, a further obligation is imposed on the child's parents to provide direction and assistance in the realisation of these rights and to act in the girl's best interests.⁸⁵ The conundrum arises where there is a conflict between these rights, that is, between a woman or girl's right to enjoy physical and mental health *and* the right to enjoy her bodily integrity, including her fertility. Interestingly the Senate Committee affirmed the idea of a 'best protection of rights test' when determining whether it is appropriate for a woman or girl with a profound intellectual disability to undergo sterilisation.⁸⁶ But the Senate Report provides no recognition of or guidance about how to resolve the conflict that will arise between the woman or girl's rights in this context.

⁸³ The Family Law Council has long advocated this approach: *Sterilisation and other medical procedures of children* (November 1994) [4.18]. The Senate Report also recognized the contentious nature of this distinction but the Committee failed to adopt an explicit recommendation that it be abandoned: see Senate Report, above n 5, [1.35]-[1.46].

⁸⁴ See Recommendations 6 and 7 in the Senate Report, above n 5, at [4.43] and [4.44].

⁸⁵ See CRC arts 3, 5, 18. See also CRPD, art 2, which requires that in all actions concerning children with disabilities, the best interests of the child be a primary consideration. It is important to note that the CRPD does not impose a general obligation on states to consider the best interests of adults with disabilities in all actions concerning them. This omission reflects the intention of those drafting the CRPD to insist on a rights-based approach emphasising equality, rather than a welfare-based approach which is traditionally associated with the best interests principle. This result is unfortunate for two reasons. First, the best interests principle as it appears in the CRC is not simply an expression of the welfare principle. On the contrary it is a dynamic principle that must be exercised in a way which is consistent with a child's rights. See John Tobin, 'Justifying Children's Rights', *International Journal of Children's Rights* (forthcoming 2013). Second, the CRPD creates a vacuum with respect to the treatment of persons who lack the capacity to exercise their rights on their own behalf and, as is the case with children who lack competency, must therefore rely on others to take measures in their best interest which protect their rights.

⁸⁶ Senate Report, above n 5, [5.121]. The Senate Report also rejects the use of a best interests test because of the risk of 'a skewed interpretation': [5.119]. Two points need to be made in relation to this approach. First, the best interests principle is affirmed in article 3 of the CRC and as such cannot be 'dropped' from an assessment of the practice of sterilisation by reference to international human rights law. Second, the concerns relating to the potential of 'skewed interpretation' can be mitigated by the adoption of an appropriate methodology to determine the best interests of a child.

This conflict will arise in two broad scenarios: first, where a woman or girl has a life threatening condition which can only be addressed by sterilisation and second, where she experiences severe physical pain and/or mental anguish because of her menstrual cycle or an unwanted pregnancy. With respect to the first scenario, sterilisation has always been justified on the basis that it is necessary to save the life of the woman or girl. Interestingly, there has been limited acknowledgement that a *woman without an intellectual disability* would be entitled to *refuse such treatment*. This is because the assumption within legal and medical discourse has simply been that life is always a preferable option to death and thus sterilisation for a woman or girl with a profound intellectual disability will be justified where this is medically *necessary* to secure life (assuming that a less intrusive measure is unavailable). Importantly, this approach is consistent with international human rights law, which reserves a special place for the right to life, described by the Human Rights Committee as the ‘supreme right from which no derogation is permitted’.⁸⁷ Thus, when resolving a conflict between the right to life *and* the right to bodily integrity and fertility of a woman or girl who lacks competency due to her intellectual disability, the right to life will always prevail. To hold otherwise would lead to death, which would defeat both the right to life *and* the rights to bodily integrity and fertility.

With respect to the second scenario, which involves a sterilisation that is not *medically necessary* but merely *medically indicated*, the balancing exercise is more complex. At what point does the physical pain, psychological distress or other health condition triggered by the menstrual cycle (such as epileptic fits) justify sterilisation? In the case of a woman or girl who demonstrates competency or the capacity to exercise competency, the law defers this decision to the individual, which is consistent with their right to respect for private life and bodily integrity. It is her choice, albeit one that is likely informed by medical opinion. In those cases where substituted decision-making is the only feasible option for a woman or a girl with a severe intellectual disability, a question remains as to what test is appropriate to determine when her general right to physical and mental health should take precedence over her specific right to fertility. The answer must be that when her right to physical and mental health is seriously or severely compromised by her menstrual cycle or a potential pregnancy, then in the absence of reasonably available less invasive measures, sterilisation will be justified as measure of last resort to secure her general right to health at the expense of her fertility. Thus far from nullifying or impairing the enjoyment of her rights (for the purposes of article 2 of the CRPD, noted above), the differential measures adopted in this context will in fact secure her right to health and thereby ensure that she is able to enjoy that right on an equal basis to those without disabilities.

Of course, a further issue relates to the level of physical and mental harm that can be characterised as serious or severe. The first point to note is that statutory regimes within Australia have already adopted this standard and it has proven to be workable.⁸⁸ Moreover, medical professionals are able to assess and advise women and girls *without* intellectual disabilities as to when, in their expert opinion, sterilisation would be medically indicated. The

⁸⁷ Human Rights Committee, *General Comment No. 14: Nuclear Weapons and the Right to Life* (Art. 6), 23rd sess (1984) at [1].

⁸⁸ *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 175(2)(a) and 175(3); *Guardianship Act 1987* (NSW) ss 45(1) and 45(2)(b); *Guardianship and Administration Act 2000* (Qld) s 70(1); *Guardianship and Administration Act 1993* (SA) s 61(2); and *Guardianship and Administration Act 1995* (Tas) s 45(1)-(2). See also, *Re Angela*, above n 79, [54].

same advice would be applicable with respect to women and girls who lack the capacity to consent to such a procedure. Moreover, if sterilisation would not be medically recommended for a competent woman or girl *without an intellectual disability*, it could never be justified for a woman or girl *with an intellectual disability who lacks competency* to consent or to refuse such a procedure.⁸⁹

Within this context, it is important to adopt an appropriate process to assess the veracity of the medical evidence and ensure that all alternative measures have been exhausted before sterilisation could be authorised, as is the case in the Family Court and under the various statutory regimes. A rights-based approach, however, does not require the therapeutic/non-therapeutic distinction to be part of this process. Instead, the focus must be on how to strike an appropriate balance between the various rights to which a woman or girl with a profound intellectual disability is entitled. Importantly, this model is evidence-based and seeks to align as closely as is reasonably practicable, the options available for the regulation of the fertility of a woman or girl with a profound intellectual disability with those of a woman or girl who demonstrates full medical competency.

IV: CONCLUSION – DOES INTERNATIONAL LAW OFFER GUIDANCE?

The treatment of international human rights law in the Senate Report is typical of its role in many debates about contentious social practices. The discourse was embraced in the submissions of both proponents and opponents of the practice to advance their agendas. A shopping list of the various human rights under the international treaties, which were considered relevant to the practice, was outlined in the Senate Report alongside a summary of the ‘jurisprudence’ of the numerous international human rights bodies with respect to the issue. To its credit, the Senate Committee declared that ‘Australian law and practice must be viewed through the lens of international legal and policy requirements’.⁹⁰ But when it sought to clarify these requirements it found that ‘views differed as to the scope and effect of relevant human rights principles’.⁹¹ What the Senate Committee lacked was a methodology by which to critique the legitimacy of these differing views with respect to the sterilisation or women or girls with an intellectual disability under international law.

This paper has sought to provide this methodology by outlining the steps required for the adoption of a substantive rights-based approach to this issue. Such an approach shifts the discussion beyond a superficial understanding of the meaning of concepts such as discrimination, equality and bodily integrity. It recognises that the sterilisation of a woman or girl with a profound intellectual disability in the absence of her free and informed consent is *not necessarily* a violation of these standards if this treatment can be *justified as being reasonable and necessary* to protect her right to health. Importantly, when assessing reasonableness, the medical evidence must support the need for such a procedure and the option of all other reasonably available reversible contraceptive treatments must have been exhausted.

⁸⁹ As noted by Sonia Grover in an email to John Tobin, 28 May 2013 (copy on file with authors).

⁹⁰ See Senate Report, above n 5, [3.103].

⁹¹ See Senate Report, above n 5, [4.1].

Interestingly the Senate Report itself adopted a 'best protection of rights test' as the preferred method to determine when a sterilisation without the free and informed consent of a woman or girl with an intellectual disability would be justified.⁹² But it did not offer a methodology by which to resolve the tension between a woman or girl's general right to health and her specific right to enjoy her fertility consistent with the rights to equality and non-discrimination. This paper outlines this methodology. In doing so it demonstrates that international human rights law is capable of offering guidance with respect to when involuntary sterilisation will be justified. Although, it is reassuring that the Senate Committee arrived at a recommendation which largely aligns with the position under international human rights law, it is still disappointing that the opportunity to enlist international law to affirm its recommendations was not taken up.

The challenge now remains to adopt a rights-based approach within each Australian jurisdiction in order to ensure a coherent and consistent approach to the issue. This paper is not the place to map out the details of this scheme. Rather, it is sufficient to note the apparent willingness of legislators, advocates and medical professionals to achieve such an approach. The references to international human rights in the Senate Report, though lacking in substantive analysis, still evince a strong willingness to draw upon human rights as a guiding principle in this area. Moreover, the existing regulatory schemes in New South Wales, Queensland, South Australia and Tasmania and the guidelines of the Family Law Court offer a useful springboard from which to advance this common agenda. There is agreement that women and girls with an intellectual disability must be treated with dignity and equality; that measures such as education, menstrual management techniques and long lasting reversible contraception must always be preferred to sterilisation and that this procedure is only ever justified where it is a measure of last resort and necessary to avert a threat to life or serious harm to health. Thus, we have travelled a long way since the days of eugenics and the welfare principle. Have we arrived at the rights response yet? Perhaps not, but there is every indication, given the emphasis on human rights in the Senate Report, that this destination is well within our grasp.

⁹² See Senate Report, above n 5, [5.126].