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FORCED STERILISATION OF WOMEN WITH DISABILITIES: BETWEEN MEDICAL PRACTICE AND HUMAN RIGHTS VIOLATIONS IN PORTUGAL

ESTERILIZAÇÃO FORÇADA DE MULHERES COM DEFICIÊNCIA: ENTRE A PRÁTICA MÉDICA E AS VIOLAÇÕES DOS DIREITOS HUMANOS EM PORTUGAL

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ABSTRACT:

Objective: The article aims to examine the practice of forced sterilisation of women with disabilities in Portugal, assessing its ethical, legal, and social implications. It seeks to highlight the contradiction between national legislation and international human rights standards, and to propose measures to ensure reproductive autonomy and informed consent.

Methodology: A qualitative, normative, and doctrinal approach was adopted, involving a critical analysis of Portuguese legislation, international conventions (such as the CRPD and the Istanbul Convention), case law from the European Court of Human Rights, and relevant bioethical principles. The study also reviewed reports and recommendations issued by international bodies and national institutions.

Results: The investigation reveals that forced sterilisation continues to be permitted under certain conditions in Portugal, despite international condemnation. Gaps in national legislation, ethical dilemmas between autonomy and beneficence, and persistent discriminatory attitudes were identified. The findings demonstrate that current practices violate fundamental rights, including dignity, physical integrity, and reproductive self-determination.

Conclusions: The article concludes that Portugal must urgently criminalise forced sterilisation, implement supported decision-making mechanisms, and promote cultural and educational measures to combat prejudice. Legislative reform, professional training, and inclusive public policies are essential to guarantee informed consent and equal rights for women with disabilities.

KEYWORDS: Forced sterilization; Women with disabilities; Human rights; Reproductive autonomy; Informed consent; International conventions; Portugal.

RESUMO:

Objetivo: O artigo tem como objetivo analisar a prática da esterilização forçada de mulheres com deficiência em Portugal, avaliando as suas implicações éticas, jurídicas e sociais. Pretende evidenciar a contradição entre a legislação nacional e os padrões internacionais de direitos humanos, propondo medidas para garantir a autonomia reprodutiva e o consentimento informado.

Metodologia: Adotou-se uma abordagem qualitativa, normativa e doutrinária, com análise crítica da legislação portuguesa, das convenções internacionais (como a CRPD e a Convenção de Istambul), da jurisprudência do Tribunal Europeu dos Direitos Humanos e dos princípios bioéticos relevantes. O estudo também incluiu a revisão de relatórios e recomendações de organismos internacionais e instituições nacionais.

Resultados: A investigação revela que a esterilização forçada continua a ser permitida em determinadas condições em Portugal, apesar da condenação internacional. Identificam-se lacunas na legislação nacional, dilemas éticos entre autonomia e beneficência e atitudes discriminatórias persistentes. Os resultados demonstram que as práticas atuais violam direitos fundamentais, incluindo a dignidade, a integridade física e a autodeterminação reprodutiva.

Conclusões: O artigo conclui que Portugal deve criminalizar urgentemente a esterilização forçada, implementar mecanismos de apoio à tomada de decisão e promover mudanças culturais e educativas para combater preconceitos. Reformas legislativas, formação profissional e políticas públicas inclusivas são essenciais para garantir o consentimento informado e a igualdade de direitos das mulheres com deficiência.

PALAVRAS-CHAVES: Esterilização forçada; Mulheres com deficiência; Direitos humanos; Autonomia reprodutiva; Consentimento informado; Convenções internacionais; Portugal

1 INTRODUCTION

Forced sterilisation of women with disabilities is one of the most serious forms of human rights violation, directly affecting their reproductive autonomy, dignity, and physical integrity. Despite legislative advances and increasing awareness of the rights of persons with disabilities, this practice still occurs in many parts of the world, including Portugal (Rodrigues, 2022). Provided for in certain circumstances in the Code of Ethics of the Portuguese Medical Association (Order of Physicians, 2009), forced sterilisation is often justified on medical, social, or eugenic grounds that disregard the capacities and rights of the women concerned.

The international community has repeatedly condemned this practice, classifying it as a form of gender-based violence and a violation of the rights enshrined in instruments such as the Convention on the Rights of Persons with Disabilities (United Nations, 30 March 2007) and the Istanbul Convention (Council of Europe, 2011). It should be emphasised, as Rodrigues & Cabete (2024) point out, that the Council of Europe has played a driving role in European legislative developments in the field of human rights promotion, directly influencing regulatory harmonisation between Member States and the European Union. These normative frameworks emphasise the need to guarantee free and informed consent, as well as the provision of appropriate support to enable persons with disabilities to exercise their legal capacity fully and on an equal basis with others.

This article offers an in-depth analysis of the Portuguese context, highlighting the discrepancy between international human rights standards, national legislation, and actual practices. From an ethical and legal perspective, it examines the challenges involved in protecting women with disabilities from forced sterilisation, reflecting on the

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role of public policies, the health-care system, and society in ensuring full respect for these women's autonomy and rights.

Ultimately, the analysis presented highlights the urgency of criminalising forced sterilisation and implementing mechanisms that promote reproductive self-determination, thereby bringing Portugal into line with international human rights standards.

2 PEOPLE WITH DISABILITIES AND THEIR AUTONOMY

Persons with disabilities are defined, according to Article 1 of the Convention on the Rights of Persons with Disabilities, as those

> "Who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others" *(UNICEF, 2006).*

According to the World Health Organization (WHO, 2001), disability is characterised by any loss or abnormality of psychological, physiological, or anatomical structure or function, including organic and functional changes. The WHO distinguishes three dimensions of disability — physical, mental, and situational (handicap) - which may restrict both the exercise of rights and the fulfilment of duties by persons with disabilities.

In the legal sphere, persons with disabilities may have their capacity to exercise their rights limited — that is, their ability to act legally, acquire and exercise rights, and assume and fulfil obligations on their own behalf, whether independently or through a voluntary representative.

The Convention on the Rights of Persons with Disabilities seeks to promote the autonomy of persons with disabilities and to overcome the ableism traditionally associated with them. This approach is also adopted by the national legislator through the Regime for Accompanied Adults, introduced by Law No. 49/2018 of 14 August (Assembleia da República, 2018).

Recommendation (99) 4 of the Council of Europe, adopted on 23 February 1999, established as guiding principles the maximum preservation of the individual's capacity, respect for the wishes and feelings of the person with a disability, and the primacy of their interests and well-being (Mesquita, 2024).

The Charter of Fundamental Rights of the European Union also addresses this issue in Article 26, stating that

> *"*The Union recognises and respects the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration, and participation in the life of the community*" (European Commission & Marques, 2020).*

Bearing in mind that persons with disabilities may be children or women, and thus subject to multiple vulnerabilities or forms of discrimination, the Convention on the Rights of Persons with Disabilities also contains provisions specifically dedicated to these groups (Articles 6 and 7 of the Convention; Rodrigues, 2022; Rodrigues, 2022a; Rodrigues & Cabete, 2023).

3 FORCED STERILISATION OF WOMEN

Sterilisation is a process or act that renders an individual permanently incapable of sexual reproduction, with forced sterilisation being a procedure carried out without the knowledge, consent, or authorisation of the person subjected to it, and without any serious threat or risk to their life or health (European Disability Forum, 2017).

Forced female sterilisation thus involves performing a surgical procedure intended to render a woman sterile, typically through tubal ligation or hysterectomy, without the knowledge and/or informed consent of the person concerned. Regarding the concept of sterilisation, José António Seoane Rodríguez defines it as an intervention, usually surgical, that causes the loss of reproductive capacity (*capacitas generandi*) without affecting the sexual organs of the individual, who retains the ability to copulate (Seoane Rodríguez, 1998, p.17).

Coercive sterilisation differs from forced sterilisation in that the woman, due to her circumstances, consents to sterilisation, often as a result of misinformation, difficulties in accessing healthcare and/or family planning, intimidation, or even work-related or financial pressures (Kendall & Albert, 2015, p.1). Forced and coercive sterilisation can occur in different contexts and be driven by various motivations, including economic, governmental, and even eugenic considerations (Seoane Rodríguez, 1998, pp.14–16). According to Ricardo André Alves Coelho

> “Several laws have been passed around the world, particularly in the United States of America, based on eugenic arguments, where sterilisation was considered necessary to prevent certain people from reproducing and thereby create a ‘better’ society, with perceived social and economic benefits. Thousands of involuntary sterilisations were carried out in the United States and across Europe, especially during the Second World War in Germany. Today, despite the implementation of state programmes and measures to prevent sterilisation for eugenic purposes, in some countries, such as China and India, sterilisation is still performed on certain social groups, depriving them of their right to reproductive freedom. Despite being a violation of fundamental human rights, involuntary sterilisation continues to be practised on specific groups, such as people with intellectual disabilities” (Coelho, 2017, p.11).

José António Seoane Rodríguez classifies sterilisation as:

> *"Voluntary sterilisation* refers to sterilisation carried out with the consent of the person undergoing the procedure, as opposed to *coercive sterilisation*, which is imposed on an individual or performed without their knowledge, and may also be *compulsory* when ordered by a court. Sterilisation can further be categorised as *therapeutic* or *non-therapeutic*. Therapeutic sterilisation is performed to prevent further harm to the patient’s health or to avert a risk to their life. Non-therapeutic sterilisation can occur in various forms: accidental — resulting from unforeseen events such as a car or workplace accident; culpable — caused by medical error; malicious — driven by revenge or other hostile motives; coercive — motivated by political, economic, or demographic considerations (including eugenic objectives); and voluntary — undertaken at the request of the individual for reasons such as contraception, negative eugenics (e.g., prevention of hereditary diseases), or other personal motives.
> Eugenics forms part of a complex set of ideas and practices aimed at “improving the genetic quality” of the human population, often through the control of reproductive rights — attempting to prevent the reproduction of individuals with “undesirable characteristics.” The belief in superior or genetically “fit” races, contrasted with those deemed inferior, constitutes the ideological foundation of eugenic thought. This belief has historically justified and facilitated certain practices, including the deliberate implementation of forced sterilisation.*”* (Seoane Rodrígues, 1998, pp.14-16; Portuguese Association Voice of the Autistic, n.d.).

In the case of *V.C. v. Slovakia*, for example, a Roma woman was sterilised without her consent during childbirth care. The hospital where the procedure was performed presented her with an informed consent form while she was in labour, in a supine position, and her signature appeared unsteady. The woman believed that the procedure was intended to save her life; however, she later attempted unsuccessfully to become pregnant and discovered that she had been rendered sterile (European Court of Human Rights, 8 November 2011).

In general terms, this case can be summarised as follows: the complainant underwent a tubal ligation following a caesarean section after the birth of her second child. As she had previously delivered her first child by caesarean section, the doctors claimed to have discussed the possibility of tubal ligation with her, citing the risk of uterine rupture in a future pregnancy. The woman was always approached on the basis that the procedure was necessary to save her life, but she was not properly informed about what a tubal ligation entailed, as the doctors assumed she already knew, which was not the case.

In its defence, the hospital maintained that the procedure was life-saving and that her informed consent was not required. The judgment notes that “The procedure complied with the relevant provisions of the 1972 Sterilisation Regulations. The decision as to whether sterilisation was necessary was, in such circumstances, a matter for the chief medical officer. Prior approval by a sterilisation committee was only required when sterilisation was carried out on healthy reproductive organs. However, this was not the case with the applicant.” The European Court of Human Rights ruled in favour of the applicant, finding a violation of Article 8 (Right to respect for private and family life) of the ECHR, but not Articles 3 (Prohibition of torture), 12 (Right to marry), or 13 (Right to an effective remedy), despite the domestic courts having dismissed her action (European Court of Human Rights, 8 November 2011).

Other historical cases also illustrate situations of forced sterilisation. *Murray v. McMurchy* (1949) involved a medically necessary intervention, but the woman had not given her consent, and a tubal ligation was performed following a caesarean section (Aggarwal & Gupta, 31 August 2019). *Hundley v. St. Francis Hospital* (1958) concerned an unnecessary hysterectomy resulting from a misdiagnosis (California Court of Appeals, 1958). In both instances, the hospitals were found liable only for the lack of consent and not for the resulting loss of the woman’s ability to procreate.

In Quebec, reports exist of tubal ligations performed without medical necessity and without patient consent, where corrective procedures could have been undertaken instead. In these cases, the women received compensation. Examples include *Quenneville v. Montreal General Hospital*, C.S. Mtl (1980), and *Ramos v. Glickman*, C.S. Mtl (1976), both involving tubal ligations carried out without the consent of the women concerned (Stote, 2012).

Furthermore, in addition to racial or ethnic factors, other circumstances may increase the vulnerability of women targeted by such procedures, including their socio-economic status.

In the case of *Soares de Melo v. Portugal*, analysed by the European Court of Human Rights (ECHR), the applicant — an unemployed Cape Verdean woman with multiple children — was involved in legal proceedings concerning the promotion and protection of her children. She was requested to undergo hospital procedures for sterilisation, to which she agreed during a hearing in the proceedings; however, the procedure was never actually carried out (European Court of Human Rights, 16 February 2016).

The Portuguese State was ordered to pay €15,000 in compensation to the applicant, who was also able to re-establish contact with her children, who had previously been placed in foster care pending adoption. The children's father, who was polygamous, was not required by the national courts to undertake any family planning measures, highlighting gender-based discrimination in this case. This reflects the assumption that women alone bear responsibility for contraception within a couple, a notion Emily Jackson refers to as “woman business” (Jackson, 2003, pp.478–481).

In fact, as Ricardo André Alves Coelho points out:

> "Women *with profound disabilities are up to four times more likely to be victims of sexual abuse than women without disabilities. Person-centred sex education, covering the basic physiology of sexuality as well as information on sexual relations and protection, can help prevent sexual abuse. Involuntary sterilisation has also been employed as a method of contraception. Likewise, the management of menstruation, premenstrual syndrome, and menstrual disorders, combined with sexual disinhibition that is difficult to control or monitor, represents other motivations for such procedures*" (Coelho, 2017, pp.17-19).

On the other hand, reasons commonly invoked to justify the forced sterilisation of women with disabilities include the alleged “best interests of the person,” medical considerations, protection against potential sexual abuse, issues related to contraception or menstruation, and the belief that persons with disabilities are incapable of caring for a child (European Disability Forum, 2017, pp.22–25). It should also be noted that a study conducted by the Observatory on Disability and Human

Rights and the Interdisciplinary Centre for Gender Studies at ISCSP, University of Lisbon, analysing the implementation of the new Law No. 48/2018, found that, in 752 cases between 2019 and 2022, 72% of individuals were deemed unable to exercise parental responsibilities, including parenthood, exercising parental responsibilities, adoption, and reproductive rights (Observatory on Disability and Human Rights, 2023).

Indeed, sterilisation affects women's reproductive capacity, violating their right to reproductive self-determination and, in some cases, doing so irreversibly through hysterectomy. In both forms of sterilisation—tubal ligation and hysterectomy—not only is a woman's right to reproductive self-determination compromised, as she can no longer have children without her consent, but her right to access safe and appropriate medical care is also infringed.

This right is compromised not only by the inadequate implementation of family planning but also by the prescription or performance of surgical procedures that entail avoidable risks and irreversible consequences for women's health, as in the case of hysterectomies, when other effective and safe pharmacological or surgical alternatives for contraception exist (Almeida, Simões, & Soromenho, 2022, pp.256–257).

In 2016, a UN report noted that persons with disabilities, "especially those who have been declared legally incapacitated, continue to be subjected, against their will, to (…) sterilisation" in Portugal (Committee on the Rights of Persons with Disabilities, 2016). The Committee recommended that Portugal take all possible measures to ensure that the right to free, prior, and informed consent to medical treatment is respected, and that assisted decision-making mechanisms are implemented (Committee on the Rights of Persons with Disabilities, 2016).

In addition to constituting an attack on physical integrity, the practice violates the Convention on the Rights of Persons with Disabilities, which states in Article 23(1)(c) that "persons with disabilities, including children, retain their fertility on an equal basis with others."

In January 2021, Catalonia, through Ley 17/2020 of 22 December, which amended Ley 5/2008 on women's right to be free from gender-based violence, classified forced sterilisation as a form of obstetric violence (Autonomous Community of Catalonia, 2021). It should be noted that the term *obstetric violence* first gained prominence in Venezuela in 2007, leading to the enactment of legislation to criminalise the practice. Under Article 15(13) of Venezuelan Law No. 38.668 of 23 April 2007

(Official Gazette of the Bolivarian Republic of Venezuela, 23 April 2007), it is defined as

> *"the appropriation* of women's bodies and reproductive processes by health professionals, expressed through dehumanised treatment and the excessive medicalisation of natural processes, resulting in the loss of women's autonomy and decision-making capacity over their bodies and sexuality, with a negative impact on their quality of life" (Guerreiro & Neves, 2022).

The definition of "obstetric violence and the infringement of sexual and reproductive rights" is provided in Article 4(d) of the aforementioned law, which defines it as violence that:

> *"Consists of* preventing or hindering access to accurate information necessary for autonomous and informed decision-making. It can affect various aspects of physical and mental health, including sexual and reproductive health, and may prevent or impede women from making decisions about their sexual practices and preferences, as well as about their reproduction and the conditions under which it occurs, in accordance with the applicable sectoral legislation. This includes forced sterilisation, forced pregnancy, the denial of abortion in legally permitted cases, and restricted access to contraceptive methods, methods of preventing sexually transmitted infections and HIV, and assisted reproductive technologies, as well as gynaecological and obstetric practices that fail to respect women's decisions, bodies, health, and emotional processes."

As demonstrated, forced and coercive sterilisation constitutes a serious violation of fundamental human rights, including the right to physical integrity, reproductive self-determination, and gender equality. These practices, often justified on social, economic, or eugenic grounds, reflect structural prejudices and historical discrimination against women, particularly those in vulnerable situations. Despite legal and social advances, such as the recognition of forced sterilisation as a form of obstetric violence in Catalonia, reports of such practices continue to emerge, highlighting the need to strengthen the protection of reproductive rights. The elimination of these violations requires not only legislative reform but also cultural and educational transformation to promote informed consent and respect for human dignity.

3.1 FORCED FEMALE STERILISATION FROM THE PERSPECTIVE OF INTERNATIONAL HUMAN RIGHTS LAW

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Human rights conventions prohibit forced sterilisation, as it infringes fundamental rights, including the rights to dignity, physical integrity, privacy, and free and informed consent. According to Article 12 of the Convention on the Rights of Persons with Disabilities,

> *"States Parties* reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law." The provision further states that "States Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life" (United Nations, 30 March 2007).

The Convention on the Rights of Persons with Disabilities enshrines a paradigm shift, recognising that persons with disabilities are entitled to rights on an equal basis with others. It affirms that persons with disabilities are "persons before the law" and possess legal capacity on an equal basis with others (Gomes, Neto, & Vitor, 2020). This approach represents a move away from the model of "substituting the person with a disability in decision-making" towards a "supported decision-making" model, whereby the individual retains authority over decisions concerning themselves.

General Comment No. 1 of the Committee on the Rights of Persons with Disabilities (Committee of the United Nations Convention on the Rights of Persons with Disabilities) states that:

> *"Women* with disabilities are subject to high rates of forced sterilisation and are often denied control over their reproductive health and decision-making, based on the assumption that they are incapable of consenting to sex. Certain jurisdictions also impose substitute decision-makers on women more frequently than on men. It is therefore particularly important to reaffirm that the legal capacity of women with disabilities must be recognised on an equal basis with others" (Committee on the Rights of Persons with Disabilities, 2014, p.9).

The Convention on the Rights of Persons with Disabilities, adopted by the UN, represents a legal and ethical milestone in the promotion and protection of the fundamental rights of persons with disabilities. This international treaty emphasises the importance of ensuring the full enjoyment of legal capacity for all individuals, regardless of any limitations or vulnerabilities. To this end, it advocates a model of supported decision-making, enabling persons with disabilities to exercise their autonomy with the necessary support, while respecting their choices and wishes.

Among the most significant provisions are those addressing discriminatory practices, including forced sterilisation. The Convention promotes fundamental principles such as respect for inherent dignity, freedom to make one's own choices, and equal opportunities. Article 23 emphasises that "persons with disabilities have the right to maintain their fertility on an equal basis with others," condemning practices that violate reproductive freedom and physical integrity.

In this way, the Convention not only provides guidance for the development of inclusive policies but also establishes an ethical foundation for the revision of national legislation. By prioritising self-determination and respect for dignity, it points the way towards the elimination of coercive and discriminatory practices, fostering a more equal and inclusive future for all.

In addition to Article 12, Article 17 of the Convention is also pertinent, as it seeks to protect the integrity of the person, stating that every person with a disability has the right to respect for their physical and mental integrity on an equal basis with others. Article 23 establishes that States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, ensuring that persons with disabilities, including children, maintain their fertility on an equal basis with others. Furthermore, according to Article 25(d) of the Convention, health professionals are obliged to provide persons with disabilities with the same quality of care as others, including fulfilling the duties of providing information and obtaining free and informed consent.

The legal framework established by the Convention on the Rights of Persons with Disabilities demonstrates that an individual's right to make decisions should not be substituted by decisions made by third parties. Persons with disabilities have the right to make choices affecting their own lives, including decisions related to medical treatment, family, and reproductive matters. States Parties are obliged to take appropriate measures to ensure that persons with disabilities have access to the support they may require in exercising their legal capacity.

In 2016, the Committee on the Rights of Persons with Disabilities adopted General Comment No. 3 on Article 6, concerning women and girls with disabilities (Committee on the Rights of Persons with Disabilities, 2016). The Committee identified three main areas of concern regarding the protection of the human rights of women with disabilities: (i) violence; (ii) sexual and reproductive health and rights; and (iii) discrimination. It highlighted the persistence of violence against women and girls with disabilities, including sexual violence and abuse, forced sterilisation, female genital

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mutilation, and sexual and economic exploitation (Committee on the Rights of Persons with Disabilities, 2016).

According to the Committee, certain forms of violence, exploitation, or abuse may constitute cruel, inhuman, or degrading treatment or punishment in violation of international human rights law. These include forced, coerced, or otherwise involuntary pregnancy or sterilisation, as well as any other medical procedure or intervention carried out without the individual's free and informed consent, including those related to contraception and abortion (Committee on the Rights of Persons with Disabilities, 2016).

The Committee on the Elimination of Discrimination against Women (CEDAW Committee) considers forced sterilisation to be a form of violence against women. Indeed, there is a marked gender imbalance among those subjected to sterilisation, with women disproportionately affected (Coelho, 2017, p.10).

CEDAW General Recommendation No. 19 states in paragraph 22 that forced sterilisation or abortion has adverse effects on women's physical and mental health and infringes their right to decide on the number and spacing of their children. Paragraph 24(m) further states that

> "*States Parties* should ensure that measures are taken to prevent situations of coercion in matters of fertility and reproduction, and to ensure that women are not compelled to seek unsafe medical procedures, such as illegal abortion, due to the lack of adequate fertility control services" (Committee on the Elimination of Discrimination against Women, 1992).

Paragraph 22 of General Recommendation No. 24 of the Committee on the Elimination of Discrimination Against Women (CEDAW) emphasises the importance of obtaining women's informed consent when providing medical or related assistance:

> "Services that ensure fully informed consent by women, respect their dignity, guarantee their confidentiality, and are sensitive to their needs and perspectives are considered acceptable. States Parties shall not permit forms of coercion that violate the right to informed consent and the dignity of women, such as sterilisation without consent or compulsory testing for sexually transmitted diseases or pregnancy as a condition of employment" (Committee on the Elimination of Discrimination against Women, 1999).

The Committee on the Rights of the Child has recognised that the forced sterilisation of girls with disabilities under the age of 18 constitutes a form of violence. The Committee has urged States to prohibit the forced sterilisation of children on the

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basis of disability and to provide them with adequate information, guidance, and counselling on relationships, as well as sexual and reproductive health (United Nations, 2012, p.10).

The Committee on Economic, Social and Cultural Rights has also emphasised that the forced sterilisation of women and girls with disabilities violates Article 10 of the International Covenant on Economic, Social and Cultural Rights, which protects the right to family life. According to the Committee, women with disabilities are entitled to protection and support regarding motherhood and pregnancy. Both sterilisation and abortion performed on a disabled woman without her prior and informed consent constitute serious violations of Article 10(2) of the Covenant (United Nations Human Rights, Office of the High Commissioner, 2025).

The Committee against Torture urges States to take immediate measures to investigate all allegations of involuntary sterilisation of women promptly, impartially, thoroughly, and effectively, to prosecute and punish perpetrators, and to provide victims with fair and adequate compensation (Committee Against Torture, n.d.). Paragraph 48 of the 2013 Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment emphasises that:

> "Some women may experience multiple forms of discrimination based on their sex and other status or identity. Targeting ethnic and racial minorities, women from marginalised communities, and women with disabilities for involuntary sterilisation due to discriminatory notions that they are 'unfit' to have children is an increasingly global problem. Forced sterilisation constitutes an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment" (United Nations General Assembly, 1 February 2013).

The Council of Europe Convention on Human Rights and Biomedicine (2005) also contains provisions relevant to forced sterilisation, particularly regarding the provision of information and obtaining informed consent (Council of Europe, 1997).

The Istanbul Convention specifically addresses forced abortions and sterilisation in Article 39 as a form of gender-based violence against women. It further establishes that:

> "The Parties shall take the necessary legislative or other measures to ensure that the following intentional acts are criminalised (…) b) the performance of a surgical operation intended to, or having the effect of, terminating a woman's natural reproductive capacity without her prior and informed consent or without her understanding of the procedure" *(Council of Europe, 2011).*

This structuring role of the Council of Europe in setting normative standards is widely recognised (Rodrigues & Cabete, 2024) and is essential to understanding the international pressure on Portugal to criminalise forced sterilisation. Gender-based violence is also prohibited under the Rome Statute of the International Criminal Court. Article 7 of the Statute includes forced sterilisation among the acts constituting crimes against humanity, "when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack" (International Criminal Court, 1998).

More recently, on 8 June 2023, the forced sterilisation of persons with disabilities in the European Union was addressed in Written Question No. E-001857/2023 to the European Commission under Article 138 of the Rules of Procedure, submitted by MEP José Gusmão (The Left) (European Parliament, 2023).

The request highlights that sterilisation of persons with disabilities is permitted in 14 EU countries, indicating that forced sterilisation remains legally permissible in the majority of Member States. Only nine countries criminalise the practice, despite its violation of both the Istanbul Convention and the Convention on the Rights of Persons with Disabilities. Portugal, Hungary, and the Czech Republic are the only three Member States that allow the sterilisation of minors, including in Portugal, where a legal loophole permits the procedure to be carried out without consent and, in some cases, without formal registration.

The European Union Directive on Combating Violence Against Women and Domestic Violence (2024) does not include the criminalisation of forced sterilisation, as this reference was removed during negotiations on the Directive (European Parliament & Council of the European Union, 2024). In response, twenty Portuguese human rights organisations signed an open letter, promoted by the Portuguese Association Voz do Autista (Voice of the Autistic), calling for the criminalisation of this practice in Portugal (Portuguese Association Voice of the Autistic, n.d.).

3.2 FORCED STERILISATION OF WOMEN WITH DISABILITIES – THE ETHICAL DILEMMA: BETWEEN AUTONOMY, BENEFICENCE AND SOCIAL RESPONSIBILITY

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The ethical dilemma between the principles of autonomy, beneficence, and social responsibility is highly relevant to this issue. Also at stake is decision-making by third parties who have a duty to act in the best interests of the person they represent. Such situations also raise questions concerning the best interests of society and the families of persons with disabilities (Coelho, 2017, p.8). Autonomy is a fundamental bioethical principle and one of the most important rights of users or patients. According to Maria do Céu Patrão Neves and Walter Osswald, the

> “The principle of autonomy affirms a person’s capacity for self-determination and requires truthfulness as a minimum condition for its application, meaning that a person can only make a decision if they have access to all relevant and reliable information. This principle encompasses two aspects: respecting decision-making capacity and promoting the exercise of patient autonomy, going beyond mere non-interference. Disregarding a person’s autonomy implies treating them as a means rather than an end, rendering them susceptible to objectification. Thus, the principle of autonomy entails a negative obligation—that autonomous decisions must not be coerced by others—as well as a positive obligation, requiring respectful treatment (Neves & Osswald, 2007, p.111).

Beauchamp and Childress emphasise that respect for the autonomy of users or patients entails recognising them as autonomous persons, acknowledging their right to hold views, make choices, and act according to their personal values and beliefs (Beauchamp & Childress, 2001, p.63). It involves “respectful action” rather than merely a “respectful attitude,” requiring the removal of obstacles that impede the free development of a person’s autonomy and the provision of information that supports autonomous decision-making. It also entails a negative obligation: the duty to protect individuals from interference by third parties, ensuring that freedom, privacy, confidentiality, truthfulness, and informed consent are properly safeguarded (Beauchamp & Childress, 2001, p.63).

It must be recognised that some persons with disabilities are unable to consent to sexual relations and therefore may have no interest in procreation or the capacity to fully understand pregnancy and child-rearing. Furthermore, social responsibility must be considered in relation to the wishes and needs of the family, given the considerable burdens involved in raising a child within the family of a person with disabilities who may be unable to support the child’s development.

In such cases, a third party may be involved in decision-making, guided by the principles of beneficence and social responsibility, interpreted in the interests of the family, which can influence medical decisions. When assessing a person with a disability's capacity to provide consent, a stratified approach is essential, as a generalised method is not appropriate. For example, intellectual disability can be classified as mild, moderate, or severe/profound. Among people with intellectual disabilities, approximately 87% have mild disability, 11% have moderate disability, and 2% have severe or profound disability (Coelho, 2017, p.14).

Individuals with mild disabilities can, with appropriate support from family and society, live independently and make informed decisions. Those with severe or profound intellectual disabilities require support and supervision throughout their lives, and in most cases, though not all, are unable to provide informed consent for medical decisions or assume parental responsibilities (Coelho, 2017, p.14).

Consequently, an individual assessment of a person's competence to make decisions across various areas of life—such as sexuality, contraceptive use, pregnancy, and parenthood—should be conducted. This assessment is not static, as a person with an intellectual disability may be capable of making informed decisions on some matters but not on others (Coelho, 2017, p.24).

More important than distinguishing between degrees of intellectual disability is the understanding that this condition does not equate to an individual's inability to make decisions. Not all persons with intellectual disabilities are incapable of providing free and informed consent. Therefore, it is essential to conduct an individualised assessment of a person's capacity to give free and informed consent, using appropriate and adapted language (Coelho, 2017, p.15).

Regarding autonomy, we align with Beauchamp and Childress in recognising the autonomy of these women at specific times, advocating for a model of specific and intermittent capacity for certain patient groups. Health professionals should determine on a case-by-case basis whether a woman's autonomy is reduced, rather than assuming ab initio that she lacks the capacity to make decisions about her body and reproductive health. Beauchamp and Childress define "competence" as "the ability to perform a task" and emphasise that competence should be understood as task-specific rather than global, depending both on the person's abilities and on how those abilities relate to the particular decision at hand. They support a model of intermittent and specific competence, whereby healthcare professionals assess decision-making capacity in context (Beauchamp & Childress, 2001, p.70).

Furthermore, various aspects of healthcare must be adapted for women with disabilities, including both access to services and interactions during the provision of specialised care. Routine gynaecological examinations, an integral part of primary care for women of reproductive age, can be traumatic for women with disabilities due to a lack of understanding of the procedures. This lack of comprehension can trigger emotions such as fear, anger, distress, or even self-harm. Sex education for women with disabilities, along with illustrated demonstrations using anatomical models and drawings, aims to explain and facilitate understanding of the purpose and stages of medical procedures, thereby reducing trauma. Challenges also include establishing a successful doctor–patient relationship, insufficient medical training to manage consultations effectively, and difficulties in communication and information sharing on topics such as sexuality, reproduction, marriage, and parenthood (Coelho, 2017, p.16). In conclusion, respect for the autonomy of persons with disabilities, particularly in the context of reproductive health, must be balanced with the principles of beneficence and social responsibility. It is essential to adopt an individualised approach that recognises each person's specific abilities and promotes their informed participation in decision-making. This requires removing barriers, adapting communication practices, and ensuring sensitive doctor–patient interactions. By doing so, the dignity and autonomy of individuals can be preserved, avoiding generalisations and fostering ethical, inclusive healthcare. The role of healthcare professionals—supported by appropriate training and awareness—is pivotal in ensuring that decisions are made with full information, adequate support, and respect for the specific needs of these women.

4 PORTUGUESE LEGISLATION

In Portugal, female sterilisation is regulated by the Health Care Act No. 3/84 of 24 March, which establishes the requirement for the woman's informed and written consent before the procedure may be performed (Assembleia da República, 1984). This requirement is outlined in Article 10 of the Act and further specified in Directorate-General for Health Standard No. 15/2013 (Directorate-General for Health, 2013). The legislation also stipulates that the woman must be at least 25 years of age to undergo sterilisation.

According to the informed consent standard (Directorate-General for Health Standard No. 15/2013):

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> *"In* situations involving persons with hearing or visual impairments, the communication process required for informed, clear, and free consent given in writing must be conducted using means of communication adapted to these populations (such as sign language or Braille) so that they can actively participate in the decision-making process."

According to the Portuguese Association Voz do Autista:

> "*Reasonable accommodations are mentioned only for visual and hearing impairments, although the group most affected by violations of their will and rights in matters of sexuality and reproduction is that of autistic women and women with intellectual or psychosocial disabilities. It is essential to employ a multidisciplinary team to provide support through a range of options, such as easy-to-read guides, social stories, and alternative or augmentative communication, in order to ensure the person's involvement in their own life and respect for their wishes."* (Portuguese Association Voz do Autista, n.d.)

According to the recommendations of the International Federation of Gynaecology and Obstetrics (FIGO), no woman may be sterilised without her prior and informed consent. Women considering sterilisation should receive information about their options in a language they can understand and communicate in (FIGO, 2011).

Directorate-General for Health Standard No. 15/2013 on "informed, clear and free consent given in writing" further provides that:

> "Decisions about the health of a person who lacks the capacity to decide require, regardless of whether their involvement is sought, the authorisation of their legal representative, healthcare proxy, an authority or a person or body designated by law." In the case of minors, the rule states that: " Whenever, under the terms of the law, a minor lacks the capacity to give informed and free consent, a diagnostic or therapeutic act may not be performed without the prior authorisation of their representative, an authority, or a person or body designated by law.." Although minors have the right to decide or dissent, in cases of incapacity only the decision of the legal representative applies. Consequently, despite Portuguese law setting a minimum age of 25 for sterilisation, this exception permits the procedure for "minors or incapacitated persons".

For adults, Law No. 49/2018 of 14 August, on the Legal Regime for Accompanied Adults, applies (Assembly of the Republic, 2018). Article 147 establishes that decisions affecting the body, sexuality, and reproduction are personal and cannot be made by another person.

It is also important to note the Code of Ethics of the Portuguese Medical Association, which in Article 74 on tubal ligation and vasectomy states in paragraph 4:

> *"* Irreversible sterilisation methods should only be performed on minors or incapacitated persons after a duly substantiated request to avoid serious risks to their life or the health of their hypothetical children and, in all cases, subject to the prior opinion of the National Council of Ethics and Deontology of the Portuguese Medical Association.*",* In our view, this provision creates a potential loophole that could permit the practice of forced sterilisation (Medical Association, 2009).

In 2016, the Committee on the Rights of Persons with Disabilities recommended that Portugal take all necessary measures to ensure full, free, and informed consent for medical treatment. The Committee expressed concern that persons with disabilities—particularly those without legal capacity—are subjected to termination of pregnancy and sterilisation against their will, highlighting abusive practices affecting health and sexual and reproductive rights in Portugal (Observatory on Disability and Human Rights, 2016).

In July 2022, the United Nations Committee on the Elimination of Discrimination against Women recommended that Portugal criminalise forced sterilisation, investigate and prosecute such practices, conduct information and awareness campaigns—particularly targeting women with disabilities—and guarantee compensation for victims (Silva, Fernandes, & Romão, 2023, August). In this context, João Vaz Rodrigues argues that if the procedure is carried out without the consent of the person concerned, it may constitute a serious offence against physical integrity under Article 144(b) of the Portuguese Penal Code. Additionally, the crime of arbitrary medical and surgical interventions, provided for and punishable under Article 156 of the Penal Code, may also be applicable.

Despite these recommendations, no official report by the Portuguese State directly addresses this issue, and there is no explicit reference to forced sterilisation in the National Strategy for the Inclusion of Persons with Disabilities 2021–2025 (IRN, 2021). In 2023, Resolution No. 56/2023 of the Assembly of the Republic was approved to conduct a national study on violence against girls and women with disabilities, specifically examining the prevalence of forced sterilisation, in order to regularly collect targeted statistical data. However, no results have been published to date (Assembleia da República, 2023).

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The criminalisation of forced sterilisation, as defined by the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and Article 39 of the Istanbul Convention, together with the establishment of an effective framework for supported decision-making for persons with disabilities, and adherence by healthcare professionals to their duty to provide information and obtain informed consent, are essential to ensure compliance with Portuguese legislation and with the recommendations of international legal bodies (Rodrigues, 2001, p.148).

5 CONCLUSIONS

The practice of forced sterilisation of women with disabilities raises profound ethical, legal, and social questions, challenging the fundamental principles of dignity, autonomy, and equality. Although legally permitted in Portugal under certain conditions, this practice is clearly at odds with the country's international obligations, including the Convention on the Rights of Persons with Disabilities and the Istanbul Convention, which recognise it as a form of gender-based violence and a violation of human rights.

The analysis presented in this article underscores the urgent need for legislative alignment that not only prohibits forced sterilisation but also promotes mechanisms for supported decision-making for persons with disabilities. It is essential to replace the decision-making substitution model with a support model, thereby ensuring that individuals are fully empowered to exercise their rights on an equal basis with others.

Furthermore, the criminalisation of forced sterilisation must be accompanied by concrete awareness-raising and training initiatives targeting healthcare professionals, families, and society at large. Educational campaigns are essential to combat prejudices and stereotypes that perpetuate the notion that women with disabilities are incapable of exercising reproductive autonomy. These efforts should also aim to improve access to sexual and reproductive healthcare for women with disabilities, with adaptations that address their specific needs.

Equally important is the need for the legal system and healthcare professionals to adopt an individualised approach when assessing the capacity of women with disabilities to give consent. Generalised decisions that overlook the uniqueness of each case should be replaced by careful and respectful assessments, employing clear and appropriately adapted communication.

Forced sterilisation is not merely a legal issue but also a manifestation of ableist attitudes entrenched in society. The fight against this practice must therefore be part of a broader strategy to combat all forms of discrimination and exclusion faced by persons with disabilities, particularly women, who often experience double vulnerability (Rodrigues & Rodrigues, 2022).

Finally, Portugal has an opportunity to lead by example by adopting a more rigorous and ethical approach to protecting the rights of women with disabilities. Full recognition of their reproductive autonomy and the guarantee of free and informed consent must be central pillars of any legislative and public policy reform in this area. Only then can a society be built that respects and values diversity, promoting genuine equality of opportunities and rights for all.

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