1. Introduction

We are very aware of the inequalities between men and women. Men own most wealth, most institutions are run by men. Women are given less respect and their skills are less recognised than those of men. Even where women have made inroads into education and professional employment there remain many barriers. But in the 20th Century struggles by women, especially in rich countries in the global North, have led to reforms and improvements such as the right to vote, the right to own property and services such as refuges for victims of domestic violence, women's health centres, equal employment programs and educational initiatives.

Disabled women, on the other hand, have not achieved the same level of social, economic and political equality. In this paper we will argue that a precondition of disabled women achieving these equalities is recognition and respect by wider society. The lives and experiences of disabled women have been hidden from history and we are only just emerging as political actors in the struggle for human rights.

In the 21st century increasing numbers of disabled women's groups are fighting for their rights in their own localities and national organisations, but also networking at international forums and via the Internet. Disabled women are active not just in the privileged countries of the global North such as in Europe and the USA, but also in the poorer countries of Africa, Asia and India. Disabled women made a strong input into the writing of the United Nations Disability Convention, which was adopted on 13 December 2006, by the General Assembly. Pressure by women’s groups succeeded in getting a separate clause in the text of the Convention as well as several references to girls, women, and gender issues.

2. How do we think about disability and gender?

Disability and gender come together in a particular form of social relations in which individuals and groups act. Both disability and gender involve relationships with bodies. But it is not simply a matter of biology. Sometimes our bodies are objects of social practice; sometimes we are agents in social practice [1].
Social practices construct our understanding of disability and gender. Social embodiment is the process by which disabled women live in the world as agents and objects [2]. Some writers have argued that a 'double handicap' [3] still exists as gender and disability contribute to disabled women's unequal status. This concept is limited in describing the multi-dimensional experience of disabled women. Gender and disability are not like layers of a cloak that can be taken off or put on at will depending on the circumstances.

Improving the lives of disabled women is an immensely complicated affair. There are no easy solutions. Sometimes disability can be acknowledged and embraced with pride (deaf women are a good example); sometimes it is merely tolerated as part of life's experience and some disabled women are desperate to seek a cure for their condition.

Societies may impose the disabled identity against the subject's will for the purposes of containment in institutions. Disability is also a reason for violence and brutality. The presence of disability legitimises abuses such as forced sterilisation. On the other hand disabled women who need special services may not be recognised – such as when they have mobility impairments and require appropriately sized examination tables in hospitals.

When we talk of disabled women we have to pay attention to the historical and contextual dimensions. Disabled women who live in cities have different experiences from their rural counterparts and women who live in the global South experience more hardship than those in the mainly rich nations of the global North. Even the concept of disability is not agreed upon. Many traditional and indigenous communities do not use the concept. This is the case for Australian Aborigines. But we share one thing in common – there are very few disabled women with power, position and influence in the world. We also share the need for equal recognition of our lived experiences and equal respect for our differing impairments, which may be physical, sensory, cognitive or mental. Whilst acknowledging the great difference that exists between disabled women, the picture at a global level shows that the situation for women in developing and poorer countries is most acute.

3. Disabled Women & Girls: An Overview

It is generally estimated that over 650 million people, or approximately ten percent of the world's population, are disabled [4,5]. Around one in five are born with a disability, while most acquire their disability after age 16, mainly during their working lives [6]. The vast majority (80%) live in developing countries [7], two-thirds in the Asia-Pacific region [8]. There are now more than 325 million disabled women and girls in the world, most of whom live in rural areas of developing or resource-poor countries [9]. However, a detailed global picture on how gender and disability intersect is not yet possible as data collection and research has been extremely limited and often clouded by factors that resist quantification, such as the feminisation of poverty, cultural concepts of gender roles and sexual and reproductive rights, violence, abuse and other types of exploitation, such as child labor [10]. Regardless of country, the employment rates of disabled women are significantly lower than those of their male peers, and the activity gap between them is greater than that between disabled and non-disabled persons [11]. Worldwide, less than 25% of disabled women are in the workforce [12]. Disabled women earn less than their male counterparts. In developing countries, many disabled women have no income at all and are
totally dependent on others for their very existence. In developed countries, the wage gap between disabled men and disabled women is as high as 39% [13] and while unionisation helps bridge the gap between disabled people and non-disabled people, it is not as effective in helping disabled women obtain a higher level of wages compared to their male peers [14]. The literacy rate for disabled women worldwide is estimated at one per cent. Statistics from individual countries and regions, while often higher, nonetheless confirm the gender inequalities [15,16]. In developing countries disabled boys attend school more frequently than do disabled girls [17].

Neglect, lack of medical care and less access to food or related resources have resulted in a higher mortality rate for disabled girls [18]. In the face of limited resources, disabled girls are more likely than their male counterparts to be deprived of basic necessities such as food and medicine [19]. For example, a UNICEF study in Nepal found that the survival rate for boy children several years after they have had polio is twice that for girl children, despite the fact that polio itself affects equal numbers of males and females [20].

Women and girls are at an increased risk of becoming disabled during their lives due to neglect in healthcare, poor workforce conditions, gender-based violence and harmful traditional practices [21]. Disabled women’s access to reproductive health care is minimal and as a result they suffer greater vulnerability to reproductive health problems [22]. For example, twenty million women a year are disabled as a consequence of pregnancy and childbirth. In the developing world, where cultural practices and poverty lead to forced and/or early marriages and early pregnancies, at least two million girls are disabled by the consequences of obstetric fistula [23].

Worldwide, an estimated 130 million women have experienced the disabling consequences of female genital mutilation (FGM) and an additional two million girls and women are being subjected to it each year [24]. The physical and psychological consequences of these practices range from mobility difficulties, impaired sexual function and infertility because of infection, to an increased risk of HIV infection [25]. Approximately half of the 40 million people living with HIV are women, and are now being infected at a higher rate than men. Seventy-seven per cent of all HIV-positive women in the world are African [26].

Eighty per cent of all people trafficked worldwide are women and girls [27]. Victims are tricked or coerced into various exploitative situations, including prostitution, other forms of sexual exploitation, forced labour, begging, and slavery. Women and girls may be targeted by traffickers because of their ethnicity,
race, disability or poverty [28]. Human trafficking studies have found that the proportion of child prostitutes who have mild developmental disabilities is six times greater than what might be expected from the incidence in the general population [29].

4. Disabled women in Australia

Two million disabled women live in Australia, making up 20.1% of the population of Australian women. Disabled women continue to be one of the most excluded, neglected and isolated groups in Australian society, experiencing widespread and serious violations of their human rights. As a group, they experience many of the recognised markers of social exclusion - socioeconomic disadvantage, social isolation, multiple forms of discrimination, poor access to services, poor housing, inadequate health care, and denial of opportunities to contribute to and participate actively in society [30].

Despite the work of Women with Disabilities Australia (WWDA), disabled women in Australia still remain largely invisible and voiceless, often ignored by national policies and laws. Their issues and needs are often overlooked within broader government services and programs. We have documented the exclusion of disabled women from support services, social and economic opportunities and participation in community life [31]. Recognition of their personhood and human rights is long overdue. Lack of recognition of their needs and experience constitutes a serious form of disrespect which compounds lack of self esteem and self worth. From our experience in WWDA, women who are able to participate effectively in their communities, find gainful employment, improve their confidence and self esteem.

In Australia, disabled women are less likely to be in paid work than other women, disabled men or the population as a whole. They are less likely than their male counterparts to receive adequate vocational rehabilitation or gain entry to labour market programs. Disabled women earn less than disabled men, are in the lowest income earning bracket, yet pay the highest level of their gross income on housing, and spend a greater proportion of their income on medical care and health related expenses [32]. Disabled women have difficulty in finding accessible housing, are more likely to be institutionalised than their male counterparts and are often forced to live in situations in which they experience, or are at risk of experiencing, violence, abuse and neglect [33].

They continue to be assaulted, raped and abused at a rate of at least two times greater than other women, and are at greater risk of severe forms of intimate partner violence. Compared to other women, disabled women are less likely to receive appropriate health services and are significantly more likely to face medical interventions to control their fertility. Disabled girls and women are more likely to be
unlawfully sterilised than their male counterparts. They are less likely to have children, more likely to experience marriage breakdown and divorce, and more likely to be single parents [34].

WWDA is hopeful that there may be scope to change attitudes towards violence against disabled women following the appointment of a WWDA representative to the Australian Government’s National Violence Advisory Council. The Council was established by the Prime Minister in 2008 but did not include representation of disabled women. WWDA undertook a sustained national campaign demanding that the Government address this exclusion, and in mid 2009 the Government appointed a disabled woman (WWDA’s President) to the Council. Critical to WWDA’s success with this campaign was harnessing widespread support and endorsement from WWDA supporters and allies.

5. Some key issues for disabled women globally

Despite the fact that many countries have embraced and ratified a number of international human rights treaties and instruments affirming their commitment to protect and promote the human rights of women and girls (including disabled women and girls), in practice, they have had little bearing on improving their human rights. These rights include for example:

- the right to freedom from exploitation, violence and abuse
- the right to bodily integrity, and
- the right to found a family and to reproductive freedom

Disabled women continue to experience serious violations of their human rights and these experiences cannot be understood solely on a local level but require analysis on a global scale. While we need to be culturally sensitive, significant similarities exist.

The following section of this paper examines these human rights violations in the context of violence, sterilisation and, motherhood and parenting.

5.1. Violence

Disabled women are twice to three times more likely to be victims of physical and sexual violence than other women. They tend to be subjected to violence for significantly longer periods of time; violence takes many forms and there is a wider range of perpetrators. Fewer pathways to safety exist and they are therefore less likely to report experiences of violence [35]. Violence kills and disables as many women between the ages of 15 and 44 as cancer [36]. Its toll on women’s health surpasses that of traffic accidents and malaria combined [37]. Systematic rape, used as a weapon of war, has left millions of women and girls traumatised, forcibly impregnated, or infected with HIV [38].

Violation of disabled women comes with legal, social, cultural, economic and psychological dimensions and costs. Despite increasing recognition of, and attention to, gender based violence as the ‘most widespread human rights abuse in the world’ [39], worldwide, violence continues in a culture of silence, denial and apathy [40,41]. The lack of international research and data collection on violence against disabled women remains one of the reasons for the lack of community intervention and specific programs and services. Worldwide, disabled women and girls are greatly at risk of violence due to many factors, in
particular their entrenched social exclusion. Poverty can also make them more vulnerable to violence [42], as well as their impairment (such as inability to communicate using conventional means), dependence on others, fear of disclosure, and lack knowledge of their rights and services and support. They may also experience low self-esteem and lack assertiveness [43]. Violence against disabled women and girls can occur in the home, the community, and institutional settings and in the workplace.

Although the forms of violence for disabled women are similar to those for women generally, disabled women often experience different dimensions to physical, psychological, and sexual violence – such as those that are derived from their sexuality, including for example, control of reproduction and menstruation. Disabled women who rely on personal care assistance may be subject to frequent violence and abuse, ranging from neglect, poor care and rough treatment through to verbal, physical and sexual abuse [44]. They remain at greater risk of institutional abuse, chemical restraint, drug use, forced/coerced sterilisation, medical exploitation, humiliation, and harassment.

Disabled women and girls can experience violence from birth. In some societies, the practice of ‘infanticide’ (also known as ‘mercy killing’) still occurs, where disabled children may be killed either immediately at birth or at some point after birth; and sometimes years after birth. Disabled girl infants and girl children are much more likely to die through ‘mercy killings’ than are boy children of the same age with comparable disabling conditions [45].

In a number of countries, disabled girls are regularly used to generate income through begging. Some are placed on the streets to beg by their own families, some are sold by their families to others who keep stables of disabled children in organised rings of beggars [46,47]. In some cases, disabled girls used as beggars are deliberately mutilated in order to make them appear more pathetic and worthy of charity [48,49]. In many parts of the world, disabled girls are sold into prostitution by poor families to raise money to meet basic needs or to simply rid them of the burden of caring for a disabled girl child [50,51]. Disabled girls may also be considered ‘good catches’ by prostitution rings as their disabilities can prevent them from escaping [52].

Across the world, state authorities attempt to respond to violence through the legal and judicial systems on the one hand and through service systems which provide protection, support, treatment and education on the other hand [53]. Disabled women are not only marginalised and ignored in many of these responses, but paradoxically, experience violence within and by the very systems and settings which should be affording them, care, sanctuary and protection [54].

The lack of inclusive services and programs for disabled women experiencing or at risk of experiencing violence is well documented [55]. There are limited support options for those who do escape violence.
Recovering from the trauma of victimisation, and rebuilding their lives as independent, active, valued members of society is a difficult challenge [56]. Where services do exist (such as refuges, shelters, crisis services, emergency housing, legal services, health and medical services, and other violence prevention services) a number of specific issues have been identified which make access for disabled women particularly problematic:

- whilst violence is a significant presence in the lives of large numbers of disabled women, many do not recognise it as a crime, are unaware of the services and options available to them and/or lack the confidence to seek help and support.

- experience in community support services suggests that accessible information and communication is very limited in terms of both content and format of information available.

- the physical means of fleeing a violent situation, (such as accessible transportation), are often unavailable. Crisis services do not necessarily have accessible transport nor are they able to assist a woman to physically leave the violent situation.

- the unlikelihood of being referred to a refuge because it is assumed that such agencies do not or are unable to cater for their needs.

Although many countries today have some type of legislation concerning violence against women, it is often outdated [57] and is limited in recognising the range of forms of violence against women. This is critical for disabled women, who experience forms of violence that are not traditionally included in existing legislation. Both general provisions and specific laws also frequently fail to take into account the context in which violence occurs, a major factor for disabled women experiencing violence [58]. For example, in Australia, legislation, policy and services that focus on the broader issue of violence against women, has demonstrated a lack of awareness about the complexity of issues facing disabled women. Many of the current laws do not contain definitions that specifically encompass the range of settings in which disabled women may live, such as group or nursing homes. Because these experiences may not fit either traditional, or contemporary definitions, violence against disabled women often goes unidentified or unaddressed.

### 5.2. Sterilisation

Forced sterilisation has been acknowledged as a critical human rights issue facing disabled women and girls in a variety of international contexts including the United Nations and within international disability and women’s right’s forums. ‘Forced sterilisation’ refers to the performance of a procedure which results in sterilisation in the absence of the consent of the individual who undergoes the procedure. This is considered to have occurred if the procedure is carried out in circumstances other than where there is a serious threat to health or life. This approach to naming sterilisation is underpinned by a human rights perspective which holds that all individuals have the right to bodily integrity and the right to reproductive choice.
There is a historical precedent in several countries including for example the USA (until the 1950s), in Canada and Sweden (until the 1970s) and Japan (until 1996) indicating that abuse of disabled women by sterilisation occurred on a collective scale – that is, mass forced sterilisation. This policy was rationalised by a pseudo-scientific theory called eugenics – the aim being the eradication of a wide range of social problems by preventing those with ‘physical, mental or social problems’ from reproducing. Although eugenic policies have now been erased from legal statutes in most countries, vestiges still remain within the attitudes of some sectors of the community, and in some areas of the legal and medical establishments [59]. In the 21st century throughout the world, there are numbers of disabled women and girls who have been and continue to be, denied their right to bodily integrity through the ongoing practice of forced sterilisation.

Sterilisation is a procedure that is notorious for having been performed on young disabled women for various purposes ranging from eugenics, through menstrual management and personal care, to the prevention of pregnancy, including pregnancy as a result of sexual abuse. In Australia, for example, the overwhelming majority of sterilisations and certainly all the cases heard by relevant Australian courts and tribunals involve girls with intellectual impairments [60]. In the Australian context, gender and disability are not mutually exclusive when sterilisation in family law is examined [61].

Disabled women activists have continued to maintain that ‘non-therapeutic’ [62] sterilisation is a question for adulthood not childhood, and constitutes an irreversible medical procedure with profound physical and psychological effects [63]. WWDA for example, has insisted that the Australian Government take all necessary steps to stop the forced sterilisation of disabled women and girls. This work [64] has included calls for the Australian Governments to:

- develop universal legislation which prohibits sterilisation of any child unless there is a serious threat to health or life;
- address the cultural, social and economic factors which drive the sterilisation agenda;
- commit resources to assist disabled women and girls and their families and carers to access appropriate reproductive health care; and,
- create the social context in which all women and girls are valued and respected.
Despite strong condemnation of forced sterilisation from many sources including women's organisations, disability rights organisations and international and national human rights bodies [65], disabled women and girls in Australia still experience, and face a serious threat of forced sterilisation. The United Nations Committee on the Rights of the Child has criticised the Australian Government for its regulation of the practice of sterilisation in light of its status as a breach of children’s human rights [66]. Despite this, Australian legislation still fails to prohibit non-therapeutic sterilisation of minors.

Following WWDA’s lead and with WWDA’s support, other disabled women’s groups around the world are starting to demand action from their governments on the ongoing practice of forced sterilisation of disabled women and girls. Most recently, for example, the European Disability Forum (EDF) released its ‘Declaration Against Forced Sterilisation of Girls and Women with Disabilities’. This Declaration, released on International Day for the Elimination of Violence against Women, recognises that forced sterilisation is a form of violence that violates the rights of disabled women and girls to form a family, decide on the number of children they wish to have, gain access to information on family planning and reproduction, and retain their fertility on an equal basis with others. The Declaration calls on Governments to act immediately to revise the legal framework to prohibit the forced sterilisation of disabled women and girls; undertake research and data collection; and, provide appropriate supports for disabled women and girls.

In this section we have shown that reproductive choices for disabled women far from remaining in the realm of the personal and private are intensely political and ideological. Significantly state authorities, the medical profession as well as families and carers are involved in these unjust practices. Sterilisation effectively ‘de-genders’ disabled women. If disabled women are to retain their gender identity we need to work collectively across national borders.

### 5.3. Motherhood and Parenting

For many disabled women around the world, the right to parent remains unrealisable. Disabled women have traditionally been discouraged from, or denied the opportunity of, bearing and raising children. They are perceived as being asexual/overly sexual, dependent, recipients of care rather than care-givers, and generally incapable of looking after children [67]. The denial of the right to found and maintain a family is a critical issue for disabled women, yet in many countries, it remains largely ignored in legislation, policy, research and services.

In addition to sterilisation, the denial of the right to become a parent takes many forms for disabled women, including coerced abortions, lack of appropriate reproductive health care and sexual health screening, limited contraceptive choices, a focus on menstrual control, denial of access to assisted reproductive technologies, and poorly managed pregnancy and birth [68]. Disabled women also face economic, social and environmental barriers to their parenting role. Policies that fail to serve families adequately, along with the widely held belief that disabled women are ‘naturally’ unsuited to parenthood, all comprise an ableist culture for disabled women who are parents, or seeking to become parents [69].
Although there has been little research on any aspect of parenting and disabled women, anecdotal evidence suggests discriminatory attitudes and widely held prejudicial assumptions question the women’s ability and indeed, their right to experience parenthood [70]. They experience significant difficulty in accessing appropriate parenting information, services and support in a host of areas – including preconception, pregnancy, birth, postpartum, and the varying stages of child rearing (eg: infancy; early childhood; adolescence), as well as in areas such as adoption, assisted reproduction, and broader sexuality and reproductive health issues and care.

The lack of financial support, coupled with the higher cost of parenting with a disability is a substantial barrier. In countries where there are income support systems, the extra costs incurred by disabled parents are not recognised. The lack of appropriate, adapted equipment to help disabled women in their parenting, especially of babies and young children is another significant obstacle. For many, parenthood is not a viable option when social and financial supports are not available and some women have reported undergoing termination of much wanted pregnancies solely on the grounds of lack of such supports [71].

In some countries, families discourage their sons from marrying a disabled woman. A lack of awareness means they believe that a disabled woman either will not be able to have children or that any child born will inherit her disability. If a disabled woman becomes pregnant, she is likely to be abandoned – facing the added stigma of being an unmarried mother [72].

In many countries, including Australia, the denial of disabled women’s right to found and maintain a family, finds clear expression in the ongoing practice of the removal of babies/children from women with intellectual impairments. More than six decades of research has demonstrated that intellectual impairment per se is an unreliable predictor of parenting performance [73]. Notwithstanding this, such parents (particularly mothers) are more likely than any other group of parents to have their children permanently removed [74]. In many cases, child removal is ordered without evidence of abuse, neglect and/or parental incapacity, and occurs at the time, or within days of a child’s birth.

The removal or threat of removal of babies/children is also an issue for other disabled women, most notably women with mental health issues and women with psychiatric impairments. Another dimension to this issue is in Family Court decisions where women with mental health issues and women with psychiatric impairments can be denied contact with, or lose custody of the child/ren solely on the basis of the mother’s disability.

6. Women with Disabilities Australia (WWDA)

6.1. History, evolution and current structure
In 1981, the International Year of the Disabled Person, Disabled People's International (DPI) held its first World Assembly in Singapore. Thirteen Australians participated and returned to Australia to set up an Australian branch of DPI. Two years later, DPI Australia (DPIA) was established, and from the outset, was dominated by disabled men. Only 3 of the 11 members of its governance structure were women, and there was no mention of women or gender in DPIA goals and objectives.

Key women members of DPIA were frustrated and disappointed at their unequal participation within DPIA. So in 1985 they decided to establish their own women’s network within DPIA, known as the National Women's Network (DPIA). In the same year, DPI held its second World Assembly in the Bahamas. Australian women with disabilities representing DPIA were required to pay their own way to the Assembly, whilst male representatives of DPIA were funded to attend the Assembly. The Australian women joined forces with their international colleagues and demanded that women be given the right to participate equally in all national organisations of people with disabilities. They threatened to withdraw from the national delegations. The DPI World Council was forced to hold an emergency meeting at which they agreed to establish a Standing Committee on the Affairs of Women with Disabilities.

Returning to Australia, the members of the National Women's Network (DPIA) developed an Affirmative Action Plan which was ratified by DPIA and formally published in DPIA Policy Statements. However, DPIA, still dominated by men, did not implement the Action Plan, discouraged leadership by disabled women, and refused to provide any funding or resourcing to the National Women's Network (DPIA). DPIA, the broader disability sector, and the women’s sector would not recognise, acknowledge nor address the needs and concerns of disabled women such as sexuality, reproductive rights, violence and abuse, parenting, education and employment.

In seeking a vehicle to effectively advocate on their own behalf, the Network passed a motion in 1991 resolving to develop their own organisation along feminist principles, get independent funding, and leave DPIA. It took a further three years to secure a small seeding grant from the Australian Government but in 1994 the Network changed its name to Women With Disabilities Australia (WWDA) and established an interim governance structure. On March 3rd, 1995 WWDA was incorporated as an independent organisation run by disabled women for disabled women.

In its embryonic state, WWDA was considered by its founders as “an opportunity to work together as women with disabilities to build confidence, self esteem and positive expectations about life’s goals.” Within a year of incorporating, WWDA had a membership of over 600 individuals and organisations. For the first few years, WWDA was required by Government to re-apply for its funding every 6 months. This uncertainty of its future was a major challenge for WWDA, however the organisation refused to become insular and reactive, and instead forged ahead with it’s strategies to improve the status of disabled women in Australia. In 1998 after much negotiation, the Australian Government agreed to provide
WWDA’s operational funding on an annual basis. For almost the next decade, WWDA’s funding remained at the same amount, with no guarantee of ongoing funding from one year to the next.

The organisation was initially governed by a Management Committee of 12 disabled women, representing the 6 Australian States and 2 Territories. The WWDA Constitution required that each State and Territory be represented on the Committee and that the women representing these geographic locations be drawn from existing ‘groups or networks’ of disabled women. In practice, this model did not work well, because where they existed, the ‘groups’ were unfunded, operated on a voluntary basis, and relied on the goodwill of individual disabled women to drive them. Consequently, many of the women involved became burnt out and with no support, several of the groups floundered.

In 2000, WWDA undertook a major review of its governance structure and re-wrote its Constitution to better reflect the role and function of a national peak NGO for disabled women. This was a difficult task for WWDA because it meant conceding that, with only one and a half paid staff members, the organisation could no longer take responsibility for trying to establish and support State and Territory groups of disabled women. The re-written Constitution saw the removal of the clause requiring State and Territory representation on the WWDA Management Committee. Instead, the Committee was to be made up of disabled women who were full members of the organisation, regardless of their geographic location. It was considered more important that potential Committee members possessed the knowledge and skills required to manage a community based NGO. The revamped Constitution also enabled WWDA to co-opt additional members onto the Management Committee if required. This model has worked well in practice and has given WWDA much more flexibility in being able to draw on the expertise of individual women to help the organisation meet its objectives.

WWDA has a simple Membership structure. Membership of the organisation is open to individual disabled women (Full Membership) and individuals and organisations who are supportive of the aim and objectives of WWDA (Associate membership). Only full members have voting rights. Membership fees are deliberately kept low so that disabled women are not excluded from membership on the grounds of affordability. Free memberships are available to disabled women who are unable to pay and this is at the discretion of the CEO. WWDA has clear aims and objectives and every 5 years produces a detailed Strategic Plan which sets out its vision, goals, policy priorities, and objectives and strategies to achieve its goals. The Strategic Plan is developed in consultation with WWDA members and reflects key issues of concern to disabled women in Australia.

WWDA has, in its short life, developed a critical mass of expertise on the needs of disabled women. It has concentrated and utilised the energies of disabled women as activists, researchers and service providers and engaged other organisations and individuals keen to advance the needs of disabled women.

The organisation has grown and matured considerably in the past decade. It has moved from being a small group of disabled women concerned primarily with building individual confidence and self-esteem, to an international human rights organisation enabling and representing the collective interests of disabled women and committed to promoting and advancing their human rights. WWDA now has a strong and growing international presence and is seen as a leading voice in international disability, women’s and human rights debates. WWDA’s innovative programs have been critically acclaimed at national and
international levels, and the organisation has been rewarded with a number of prestigious awards, including national and state violence prevention and human rights awards.

6.2. Challenges and Successes

6.2.1. Dealing with authorities

A major challenge for WWDA has been relationships with governments. Can we have meaningful relationships with governments when we are challenging their authority? States do not always act in a democratic way or in the interests of the people. Disabled women must understand the nature of power, both within and outside government. As the majority of our funding comes from government, tension exists when we challenge the government policy. At what point do we accept limited success on one issue and move onto another one? There are both ethical and strategic questions at stake here.

In Australia, under the government of Prime Minister John Howard, WWDA had to sign a funding contract whereby we agreed not to speak to the media unless we had cleared our statements with the Minister of Family and Community Services. On the occasions we decided to speak out without permission the Minister reprimanded us, but no further actions were taken against the organisation. Speaking out was a difficult decision and the management board, made up of members, was fearful of losing funding. But we considered it important to disseminate our message to as wide as possible a constituency – in other words gaining support of disabled women and their allies in Australia. Whatever the substantive issue we are concerned with, gaining public recognition of the rights of disabled women is always high on the agenda. Of course not only governments hold power. The medical profession has much power over disabled women, which is not always visible, and its members remain inaccessible. One strategy we use for dealing with governments is adapting our rhetoric so that change in the interests of disabled women can benefit society as a whole.

6.2.2. Negotiating the local, the national and the global

Before WWDA was established as an NGO we were a minority group within the Australian disability movement. The birth of WWDA was a result of marginalisation within the movement and the domination of positions of power by disabled men. The initial group of women saw themselves as being disaffected from the women’s movement and from the disability movement. In order to inform the broader community of the needs of disabled women we had to reach out at a national level. Initially with only one part time worker the task was immense. There were times when the key players in the organisation felt powerless to sustain connections with women at the local level in such a large country. Australia is the sixth largest in the world, 50 per cent larger than Europe, with the lowest population density in the world - only two people per square kilometre. An even greater challenge as social movements have gone global is to keep a balance between working at the local level, the national and the international. This entails maintaining a balance between being part of a broader national and international disability movement and remaining true to our mission as an NGO for disabled women in Australia. An NGO is fundamentally different from an activist group. As an NGO we are a formalised organisation with a membership and governance structure. As part of both a feminist and a disability social movement/s we are dealing with a much more fluid and changing phenomena where there is no particular person or organisation with whom to make alliances.
Advances in communication technologies have accelerated our international engagement and we have both sought support for our own causes and campaigns and also lent support to other groups of disabled women worldwide.

### 6.2.3. Using the new communication technologies

New communication technologies have been a vital part of WWDA’s success as well as an essential part of maintaining contact with disabled women around Australia. As a national body with very few resources it is unlikely we would have been able to continue without the advent and widespread use of the Internet. The globalisation of communication has thrown up both the means to contest, resist and oppose stigmatising and demeaning representations of disabled women. We act at multiple levels of the local, national and international in our political practice. Our website is a major source of information for women in Australia and around the globe (see [www.wwda.org.au](http://www.wwda.org.au)). Through using new media we have been able to network with disabled women from all over the world and engage in mutual learning.

Disabled women who do not see themselves as political actors have been able to participate in online mobilisation for change. Yet at the same time these new technologies are expensive and not available in remote and rural areas. It is clear that the rapid dissemination of blogs, online videos and artwork can be helpful for disabled women but the challenge for small organisations such as WWDA is to keep abreast of new developments and also to ensure that disabled women have access to new forms of interactivity. We also need to instil in women the confidence to speak out, even on the Internet. The Internet as a technology does not automatically engender confidence in marginalised groups. Many disabled women do not have access to the Internet. There are issues of affordability, capacity and ‘gatekeepers’ to technology. So we still have to use ‘old’ ways such as hard copy and slow post, which may be more costly and resource intensive.

### 6.2.4. Forming strategic alliances

Access to new communication technologies has brought us into more possibilities for forming coalitions and alliances than ever before. Yet we need to be careful not to compromise out values and ideals. WWDA has successfully made alliances with the women’s health movement in Australia so that at the 5 yearly conference there is always a prominent disabled woman keynote speaker. We also need to form alliances with workers, usually women, within the existing power structures of the bureaucracy, as while government change, the bureaucrats often remain the same. There are inevitably dangers in this type of pragmatic opportunity, but within a liberal democracy some gains can be made for disabled women.

### 7. Conclusions: Moving forward with disabled women at an international level
Despite the adoption of the United Nations Disability Convention, which many countries have still not ratified, our goals remain substantially the same. The only difference is that we are now recognised in an international human rights convention. Our goals are to make visible our needs and demand an end to exclusion, inequality and violence. We need to be able to participate in education, employment and political, civil, social and cultural organisations. We need to have our safety guaranteed whether we live in the community or in institutions. Recognition and respect by governments and by broader society are fundamental to achieving our goals.

Broader gender politics needs to recognise the harm done to us as disabled women but also the value of our political work. Disabled women have and are contributing much to the world. Our creativity and many talents need also to be recognised. There are now many groups of disabled women organising locally, nationally and internationally on the many issues that affect their lives. We are campaigning and lobbying for our rights as women and as disabled persons. We are also learning to be comfortable with our differing embodiments. The global nature of conferences, such as this one, suggest that disabled women have much to learn from each other and much to offer in making the world a more democratic and caring place. The global nature of gendered disability means we also have to work at an international level with feminist movements and human rights groups, including groups of men supporting gender equality.

References

[6] Ibid, p. 44.
[10] Ibid.
[14] Ibid.
[17] Ibid.
[21] Ibid.
[28] Ibid.
[29] United States Agency for International Development (USAID), Op Cit.
[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Ibid.
[55] Ibid.
[62] "Non-therapeutic sterilisation" is sterilisation for a purpose other than to 'treat some malfunction or disease': Secretary, Department of Health and Community Services v JWB and SMB, 1992, 175 CLR 218; 106 ALR 385.
[64] For an overview of WWDA's work on Sterilisation, see: Sterilisation of Women and Girls with Disabilities at www.wwda.org.au/sterilise.htm
In considering Australia’s report under Article 44 of the CRC (Fortieth Session), the Committee on the Rights of the Child encouraged Australia to: ‘prohibit the sterilisation of children, with or without disabilities’; United Nations Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, Concluding Observations: Australia, CRC/C/15/Add.268, 20 October 2005, paras 45, 46(e).


Email correspondence to WWDA from members regarding parenting support for women with disabilities in Australia [unpublished].

