‘Women With Disabilities & The Human Right to Health: A Policy Paper’

By Carolyn Frohmader for Women With Disabilities Australia (WWDA) © Women With Disabilities Australia (WWDA) May 2010

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced without written permission from Women With Disabilities Australia (WWDA). All possible care has been taken in the preparation of the information contained in this document. WWDA disclaims any liability for the accuracy and sufficiency of the information and under no circumstances shall be liable in negligence or otherwise in or arising out of the preparation or supply of any of the information aforesaid.

Women With Disabilities Australia (WWDA)

Women With Disabilities Australia (WWDA) is the peak organisation for women with all types of disabilities in Australia. WWDA is run by women with disabilities, for women with disabilities. It is the only organisation of its kind in Australia and one of only a very small number internationally. It represents more than 2 million disabled women in Australia and operates as a national disability organisation; a national women’s organisation; and a national human rights organisation. WWDA is inclusive and does not discriminate against any disability. The aim of WWDA is to be a national voice for the needs and rights of women with disabilities and a national force to improve the lives and life chances of women with disabilities. WWDA is committed to promoting and advancing the human rights and fundamental freedoms of women with disabilities.

Our work is grounded in a rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. This rights based approach recognises that equal treatment, equal opportunity, and non-discrimination provide for inclusive opportunities for women and girls with disabilities in society. It also seeks to create greater awareness among governments and other relevant institutions of their obligations to fulfil, respect, protect and promote human rights and to support and empower women with disabilities, both individually and collectively, to claim their rights.
## Contents

List of Abbreviations ........................................................................................................................................... 4

Executive Summary .................................................................................................................................................... 5

Key Strategies ........................................................................................................................................................ 7

The status of women with disabilities in Australia ......................................................................................... 12

Understanding the ‘human right to health’ ..................................................................................................... 13

Women with disabilities right to health – Australia’s obligations ................................................................. 14

The denial of women with disabilities right to health ..................................................................................... 16

The effective realisation of women with disabilities right to health .............................................................. 19

  Accountability .................................................................................................................................................. 20

Legislation ............................................................................................................................................................ 22

National Health Policies & National Disability Policies .................................................................................. 24

National Women’s Health Screening Programs ............................................................................................ 28

National Violence Prevention Policies & Programs ....................................................................................... 29

National Housing Policies & Programs .......................................................................................................... 31

Employment Policies & Programs .................................................................................................................. 33

Service System Issues ..................................................................................................................................... 34

Participation and Inclusion in Health Related Decision-Making ................................................................. 37

Data Collection and Research .......................................................................................................................... 39

Public Health Media Campaigns .................................................................................................................... 41

Training of Health Workers ............................................................................................................................. 42

The Social, Economic and Political Empowerment of Women with Disabilities .......................................... 43

Conclusion ......................................................................................................................................................... 45
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRC</td>
<td>Australian Human Rights Commission</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
</tr>
<tr>
<td>CESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>CRPD</td>
<td>Convention on the Rights of Person’s with Disabilities</td>
</tr>
<tr>
<td>DIG</td>
<td>Disability Investment Group</td>
</tr>
<tr>
<td>FaHCSIA</td>
<td>Department of Families, Housing, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>NAHA</td>
<td>National Affordable Housing Agreement</td>
</tr>
<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
</tr>
<tr>
<td>NDS</td>
<td>National Disability Strategy</td>
</tr>
<tr>
<td>NRAS</td>
<td>National Registration and Accreditation Scheme for the Health Professions</td>
</tr>
<tr>
<td>NWHP</td>
<td>National Women’s Health Program</td>
</tr>
<tr>
<td>WWDA</td>
<td>Women With Disabilities Australia</td>
</tr>
</tbody>
</table>
Executive Summary

The right to the highest attainable standard of health is a fundamental human right recognised in a number of international human rights treaties and instruments to which Australia is a party. However, this international commitment has had little bearing on improving the health of women and girls with disabilities in Australia - who continue to experience violation, denial and infringement of their fundamental right to health. Women with disabilities in Australia not only represent one of the groups with the highest risk of poor health, but experience many of the now recognised markers of social exclusion. They experience major inequalities in health status, and experience significant disadvantage in the social determinants of those inequalities.

The denial and infringement of women with disabilities right to health can be seen in an array of human rights violations: they experience violence at higher rates than their non-disabled sisters, experience less control over what happens to their bodies, have less access to vital health care services, such as cervical and breast cancer screening and, face discrimination, societal prejudice and stigma when it comes to determining their reproductive rights.

Members of Women With Disabilities Australia (WWDA), the national peak organisation for women with all types of disabilities in Australia, have identified the right to the highest attainable standard of health as a priority issue of concern. In keeping with WWDA's systemic advocacy work to create greater awareness among governments and other relevant institutions of their obligations to fulfil, respect, protect and promote the human rights of women with disabilities, this paper examines what is meant by women with disabilities right to health. It places this fundamental human right in the context of Australia's obligations under three of the key human rights conventions it has ratified: the Convention on the Rights of Person's with Disabilities (CRPD), the International Covenant on Economic, Social and Cultural Rights (CESCR) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

The paper highlights the ways in which women and girls with disabilities in Australia are denied the freedoms and entitlements necessary for the realisation of their right to health. It then provides an overview of a range of key policy initiatives required to address the structural, socioeconomic and cultural barriers that currently deny women with disabilities their right to health. The paper includes key strategies for consideration by the Australian Government, in particular the Australian Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the Australian Department of Health & Ageing, and the Attorney-General's Department, which are the Australian Government's principal sources of advice on social policy, health and law and justice respectively.

Recognising that the right to health is dependent on the realisation of other human rights, and extends to the underlying determinants of health, the key strategies identified in this paper address a broad range of themes, including for example government accountability, legislation, national health and disability
policies; national violence prevention programs, women's health screening programs; housing & employment policies and programs, service system issues; participation in health related decision-making; data collection and research; training of health workers; public health media campaigns, and, the social, economic and political empowerment of women with disabilities.

This paper demonstrates that full enjoyment of the right to health still remains a distant goal for women with disabilities. The obligation to respect, protect and fulfil women with disabilities' right to health, clearly requires Australian Governments to do much more than merely abstain from taking measures which might have a negative impact on women with disabilities. The obligation in the case of women with disabilities is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to women with disabilities in order to ensure that they enjoy all human rights – including their right to health. This invariably means that additional resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required.
Key Strategies

Accountability

As a priority, the Australian Government should:

1. Ensure that the National Human Rights Action Plan to be developed as part of the recently announced Human Rights Framework for Australia, includes a clear and frank assessment of the current human rights situation in Australia, including baseline and disaggregated data and an assessment of Australia’s human rights performance by relevant United Nations Human Rights Treaty bodies. The human rights situation of marginalised groups, including women and girls with disabilities, should be a priority within the Plan.

2. Ensure that information on women with disabilities is provided in relevant human rights treaties Periodic Reports as a matter of course. This would include information on the situation of women with disabilities under each right, including their current de-facto and de jure situation, measures taken to enhance their status, progress made and difficulties and obstacles encountered.

3. Act immediately to redress the human rights violations against women and girls with disabilities who have been sterilised without their consent. In the process of reconciliation, financial compensation and an official apology for discrimination should be provided.

4. Address the abuse, neglect, mistreatment, and discrimination of women with disabilities living in institutions. At the very least this should include a National Public Inquiry or Royal Commission into the abuse of people living in institutions, both historically and currently.

5. Address the over-representation of parents with intellectual disabilities in care and protection proceedings. This should include a National Public Inquiry into the removal and/or threat of removal of babies and children from parents with intellectual disabilities; parents with mental health illnesses and parents with psychiatric disabilities.

6. To coincide with the release of the National Disability Strategy (NDS), issue a National Apology to People with Disabilities, in acknowledgment of the damage that has been done to people with disabilities by past policies, practices and strategies of exclusion, incarceration, denial of difference, and barriers which have rendered people with disabilities invisible.

7. Act immediately to make public all data collected through the National Disability Abuse and Neglect Hotline.

Legislation

As a priority, the Australian Government should:

1. Act under its external affairs power to legislate to prohibit non-therapeutic sterilisation of girls with disabilities unless there is a serious threat to health or life.

2. Address discrimination in legislation and protocols that enables the removal of babies and children from parents with intellectual disabilities; parents with mental health illnesses and parents with psychiatric disabilities.

3. Investigate the feasibility of the development of a Model Family Violence Law for Australia. Such legislation should be inclusive of the forms of violence as experienced by women with disabilities and encompass the circumstances and contexts within which women with disabilities experience family violence.
4. Undertake an immediate review of legislation, policies and processes currently in place for procedures occurring to girls and women with disabilities who are deemed ‘incapable of giving informed consent.’ Any review must address (a) who should determine that a person is incapable of giving informed consent; and, (b) what processes and mechanisms should be used to determine that a person is incapable of giving informed consent.

5. Act to ensure that the Migration Act 1958 is amended to remove the potential for any direct or indirect discrimination against refugees and migrants with disabilities.

National Health Policies & National Disability Policies

As a priority, the Australian Government should:

1. Ensure that the principles of gender equity and health equity are applied to all national policies that address the social determinants of health. Where relevant, national policies should make explicit recognition of the impact of multiple discriminations caused by the intersection of gender and disability, and include focused, gender-specific measures to ensure that women with disabilities experience full and effective enjoyment of their right to health.

2. Ensure that the new National Women’s Health Policy (NWHP) gives explicit priority to women with disabilities in recognition of the fact that they experience direct human rights violations that result in ill-health; experience significant disadvantage in the social determinants necessary for health; and remain excluded in the health promotion agenda.

3. Integrate a gender perspective into all aspects of the National Disability Strategy (including monitoring) in recognition that biological, structural, socio-economic and cultural factors play a significant role in influencing women with disabilities’ right to health, and in recognition of the need for targeted measures to enable them to realise their human rights.

4. Ensure that a gender perspective forms an integral dimension of the design, implementation, monitoring and evaluation of the proposed Long-term Care and Support Scheme for people with a disability in Australia, including the proposed National Disability Insurance Scheme.

National Women’s Health Screening Programs

As a priority, the Australian Government should:

1. Act immediately to ensure that the National Breast Cancer and National Cervical Cancer Screening Programs are inclusive of women with disabilities, prioritise women with disabilities as a target group for screening, and collect data on the participation rate of women with disabilities.

2. Act on recommendations from the CEDAW Monitoring Committee, and undertake active measures at all levels of Government to ensure development of the necessary infrastructure to enable women with disabilities to participate in breast and cervical screening programs and initiatives, including measures such as the provision of transport, and requiring government funded group homes to facilitate participation by eligible women residents with disabilities.

National Violence Prevention Policies & Programs

As a priority, the Australian Government should:

1. Ensure that the COAG three year National Plan to Reduce Violence Against Women and their Children gives priority to addressing the needs of marginalised and excluded groups of women (including women with disabilities), and to addressing those forms of violence which have been recognised as under-documented and under-reported. In this context, women with disabilities must form a priority within the National Plan and a percentage of the National Plan Budget should be allocated to the development, implementation, monitoring and evaluation of strategies to
address all forms of violence against women with disabilities. This allocation should be protected, sustained and indexed annually.

2. Act immediately to commission and fund a national research study on the incidence and prevalence of violence against women with disabilities, in recognition of the exclusion of women with disabilities from violence prevention programs and services, along with the paucity of research, data and statistics available.

3. Act to ensure that policies, procedures and protocols are developed to aid in the early identification of violence against women with disabilities including for example screening and assessment tools.

National Housing Policies & Programs

As a priority, the Australian Government should:

1. Act immediately to address the exclusion of women with disabilities from women’s refuges. Inherent in this is the need to undertake a national audit of crisis accommodation services to determine their levels of accessibility and safety for women with disabilities and to determine service/agency needs in meeting relevant anti-discrimination legislation requirements.

2. Legislation, policy frameworks, service standards, accountability frameworks, codes, and guidelines developed under the National Affordable Housing Agreement (NAHA), the National Partnership Agreement on Social Housing, and the National Partnership Agreement on Homelessness should include in a measurable way, implementation of relevant human rights treaties, including the CRPD, CESC and CEDAW. Targets developed to reduce homelessness and to address the right to adequate housing must be established for people with disabilities as a population group and include gender specific targets.

Employment Policies & Programs

As a priority, the Australian Government should:

1. Act immediately to implement Recommendation 56 of the Parliamentary Inquiry Report Making it Fair which recommends that the Government as a matter of priority collect relevant information on workforce participation of women with disabilities to provide a basis for pay equity analysis and inform future policy direction.

2. Act to address the disparity in the proportion of men and women with disabilities who are being assisted by Commonwealth Government funded employment services.


4. Act to de-link disability-related supports and services from income support programs in order to make the supports required by women with disabilities available to those who could not afford to enter the paid labour market otherwise.

Service System Issues

As a priority, the Australian Government should:

1. Act on recommendations from the CEDAW Monitoring Committee, and undertake active measures at all levels of Government to ensure development of the necessary infrastructure to enable women with disabilities to have access to all health services.
2. Ensure that the new national Women’s Health Policy (NWHP) and the national program established to implement the Policy, are based on principles of equity and freedom from discrimination, in recognition of the fact that these principles are critical components of the right to health, and are core obligations of the Australian Governments under the CESCR, CEDAW and the CRPD.

3. Establish and recurrently fund a National Resource Centre for Parents with Disabilities, focusing on pregnancy & birthing, adoption, custody, assisted reproduction, adaptive baby-care equipment, as well as general parenting issues. The National Resource Centre should also be resourced to establish and house a National Reproductive Rights Network for Women with Disabilities.

**Participation and Inclusion in Health Related Decision-Making**

As a priority, the Australian Government should:

1. Ensure that women with disabilities are represented on the national advisory structures established to oversee implementation of the National Women’s Health Policy.

2. Develop the institutional mechanisms to ensure that the participation of women with disabilities takes place in health policy and planning, including the planning, management, delivery and evaluation of health and related services.

**Data Collection and Research**

As a priority, the Australian Government should:

1. Act to ensure that health and socio-economic data is disaggregated by gender and disability, in order to identify and address discrimination and inequities in health.

2. Fund a national research project on the issues which impact on access and uptake of breast, cervical and bone-density screening services for women with disabilities.

3. Fund a full time Project Officer position for Women With Disabilities Australia (WWDA) for a period of three years to develop and implement a national research project on the parenting experiences of women with disabilities.

4. Fund a national project on women with disabilities’ right to reproductive freedom which:
   - addresses the incidence and long term effects of forced sterilisation for all women with disabilities, including those with psychiatric, cognitive, sensory and physical disabilities;
   - researches the practice of menstrual suppression of girls and women with disabilities, including those in group homes and other forms of institutional care. Research into menstrual suppression practices must include:
     - an investigation into the use of Depo-Provera and other injectable contraceptives, the contraceptive pill, and other forms of contraception;
     - an investigation into the use of contraception as a form of social control of girls and women with disabilities;
     - an investigation into the long term physical and mental health and social effects of menstrual suppression practices.

5. Support and fund national research into the recognised markers of social exclusion for women with disabilities, including: 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.
Public Health Media Campaigns

As a priority, the Australian Government should:

1. Act to ensure that women with disabilities are represented, on an equal basis with others, in the development, implementation and evaluation of public health and health promotion campaigns at national, state and territory levels.

Training of Health Workers

As a priority, the Australian Government should:

1. Commission the development of national guidelines for health and related service providers that describe expectations for compliance with the CESCR, CEDAW and CRPD.

2. Through the National Registration and Accreditation Scheme for the Health Professions (NRAS), act to ensure that accreditation of the training of health professionals covered under the Health Practitioner Regulation National Law Act 2009, is contingent on disability and human rights specific curriculum components.

3. Develop national protocols for health education curriculum (beginning at primary school level) which incorporate models of diversity that portray positive images of women with disabilities as sexual beings, including as parents.

4. Act to ensure that relevant training authorities (such as TAFE) develop curriculum content which requires demonstration of competencies in knowledge of human rights of women with disabilities.

The Social, Economic and Political Empowerment of Women with Disabilities

As a priority, the Australian Government should:

1. Recognise, support and strengthen the role of women with disabilities organisations, groups and networks in efforts to fulfil, respect, protect and promote their human rights, and to support and empower women with disabilities, both individually and collectively, to claim their rights. This includes the need to create an environment conducive to the effective functioning of such organisations, groups and networks, including adequate and sustained resourcing. Inherent in this, is the need for financial and political support to enable the establishment and recurrent funding of women with disabilities organisations, groups and networks in each State and Territory.

2. Urgently review the adequacy of income support arrangements for those with a disability across all household types, in recognition of the fact that the non-optional costs of disability are a significant barrier to the social inclusion of women with disabilities, and that the setting of income support payment rates for people with disabilities has failed to take account of these non-optional, extra costs.
1. The status of women with disabilities in Australia

There are more than two million women with disabilities living in Australia, making up 20.1% of the population of Australian women. They come from a diverse range of backgrounds, lifestyles and beliefs including from Aboriginal and Torres Straight Islander backgrounds and from culturally and linguistically diverse communities. Some of them are in heterosexual relationships; some in lesbian relationships and some are single. They experience a range of impairments that impact on their lives in different ways. These may include medical conditions, and/or sensory, physical, cognitive and psychiatric impairments, singly or in combination.¹

Women with disabilities 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.²

Although there has been only limited research in Australia on the many issues facing women with disabilities (including health), it is clear that they experience multiple discriminations, major inequalities in health status, and significant disadvantage in the social determinants of those inequalities. Compared to other women, women with disabilities³:

- are less likely to be in paid work;
- are in the lowest income earning bracket;
- spend a greater proportion of their income on medical care and health related expenses;
- are less likely to receive appropriate health services;
- are substantially over represented in public housing and more likely to be institutionalised;
- are often forced to live in situations in which they experience, or are at risk of experiencing, violence, abuse and neglect;
- are more likely to be unlawfully sterilised;
- are more likely to face medical interventions to control their fertility;
- are more likely to be assaulted, raped and abused;
- are at particular risk of severe forms of intimate partner violence;
- are more likely to experience marriage breakdown and divorce;
- are less likely to have children; and,
- are more likely to be single parents.

The many issues facing women with disabilities in Australia are represented through the national peak organisation Women With Disabilities Australia (WWDA). WWDA’s work is grounded in a rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. Members of WWDA have identified the right to the highest attainable standard of health as a priority issue of concern. This is reflected in the **WWDA Strategic Plan 2010-2015**, which identifies, amongst other things, the need to develop this paper and to identify and act on strategic opportunities for systemic advocacy on access to health and related services for women with disabilities.4

### 2. Understanding the ‘human right to health’

In international human rights law, health is understood as the ‘state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity.’5 Health is also understood and recognised as ‘the fundamental right of every human being’6 and ‘indispensable for the exercise of other human rights.’7 It is important to point out that the ‘right to health’ does not mean the right to be ‘healthy’. Clearly, Governments cannot fully ensure good health, as it is influenced by some factors which may be outside a government’s control (such as individual susceptibility to illness).8 The right to health recognises that whilst all members of society have responsibilities regarding the realisation of the right to health, it is Governments which have the ultimate duty to create and provide the social and environmental conditions to enable people to undertake such responsibilities.9

The ‘right to health’ is therefore, a fundamental right that encompasses both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom; the right to participate in decisions about one’s health; and the right to be free from interference, such as non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. Such entitlements encompass for example, the right to emergency medical services and to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information, including on sexual and reproductive health.10

---


6 Ibid.


10 UN Committee on Economic, Social and Cultural Rights (CESCR), Op Cit [as at 7].
In May 2000, the Committee on Economic, Social and Cultural Rights, which monitors the CESCR, adopted a General Comment\(^1\) on the right to health\(^2\), which sought to clarify the nature and content of individual rights and States Parties’ obligations. The General Comment recognised that the right to health is closely related to and dependent upon the realisation of other human rights, including for example the right to food, housing, work, education, participation, the enjoyment of the benefits of scientific progress and its applications, life, human dignity, non-discrimination, equality, the prohibition against torture, privacy, access to information and the freedoms of association, assembly and movement. Further, the Committee interpreted the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

As with all human rights, the right to health therefore, is interlinked and related to both civil and political rights and other economic, social and cultural rights. As equal human beings, the right to health belongs to every individual. The chances of enjoying good health therefore must not be unfairly diminished because of disadvantaging factors such as disability, gender, race, ethnicity, sexual orientation, age, marital status, or other civil, political, social, economic or cultural attributes such as refugee status.\(^3\)

### 3. Women with disabilities right to health – Australia’s obligations

The right to the highest attainable standard of health is a human right recognised in a number of international human rights treaties and instruments to which Australia is a party, including the International Covenant on Economic, Social and Cultural Rights (CESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of Persons with Disabilities (CRPD). The most authoritative interpretation of the right to health is outlined in Article 12 of the CESCR, which was ratified by Australia in 1975. In ratifying the CESCR the Australian Government acknowledged its responsibility to achieve better health for its citizens by respecting, protecting, and fulfilling rights. This meant that the Australian Government would not violate the rights of its citizens, would prevent human rights violations, and would create policies, structures and resources that promote and enforce rights.

\(^{11}\) Each of the UN human rights treaty-monitoring Committees periodically publish documents known as General Comments which provide guidelines for States Parties on the interpretation of specific aspects of the human rights treaty of concern to the particular committee. General Comments clarify the content of Covenant rights in more detail, may outline potential violations of those rights and offer advice to states parties on how best to comply with their obligations under the treaties.

\(^{12}\) UN Committee on Economic, Social and Cultural Rights (CESCR), \(\text{[as at 7]}\).

\(^{13}\) World Health Organisation (WHO) (2002) \text{Op Cit [as at 5]}.


In meeting its obligations under the CESCR, respecting the right of women with disabilities to health essentially requires the Australian Government to refrain from undertaking actions that inhibit or interfere with the ability of women with disabilities to enjoy the right to health, such as by introducing actions, programs, policies or laws that are likely to result in bodily harm, unnecessary morbidity, and preventable mortality. It also obliges the Australian Government to refrain from denying or limiting equal access for women with disabilities to health services.

Protecting the right to health obliges the Australian Government to prevent third parties from jeopardising the health of women with disabilities. This includes ensuring, even when the private sector and other non-government actors provide health-related services, that there is no discrimination in access to health facilities, goods and services, or health technologies, and that they provide reliable and safe information about health.16 17

Fulfilling the right to health applies to positive measures that the Australian Government is required to take, such as by providing appropriate services, to enable women with disabilities to enjoy the right to health in practice. It requires the Government to undertake actions that foster, maintain and restore the health of women with disabilities. It also requires that special measures be taken to prioritise the health needs of women with disabilities.18 19

Access to health care is a basic right under CEDAW, ratified by the Australian Government in 1983. General Recommendation 18 of CEDAW makes explicit the need for Governments to take special measures to address the needs of women with disabilities. In meeting its obligations to women with disabilities’ right to health under CEDAW, the Australian Government has a responsibility to implement interventions aimed at both the prevention and treatment of diseases and conditions affecting women with disabilities; respond to violence against women with disabilities; and ensure access for women with disabilities to a full range of high-quality and affordable health care, including sexual and reproductive health services.

The CRPD – which aims to ensure that persons with disabilities enjoy human rights on an equal basis with others, is the most recent international human rights treaty ratified by the Australian Government, entering into force in Australia in 2008. The CRPD clearly articulates Australia’s obligations to women with disabilities right to health. It specifically acknowledges the impact of multiple discriminations caused by the intersection of gender and disability. It prioritises women with disabilities as a group warranting specific attention, and calls on Governments to take positive actions and measures to ensure that women and girls with disabilities enjoy all human rights and fundamental freedoms.20

---

The right to health is addressed specifically in Article 25 of the CRPD. It requires Governments to: recognise that women with disabilities have the right to the highest attainable standard of health; ensure that women with disabilities have access to the full range of generic health care services and programs (including gender-sensitive services), as well as to any necessary specialised health services; and, prohibit discrimination on the ground of disability in the provision of health and life insurance. The right to health is also interlinked to a number of civil, political economic, social and cultural rights articulated in the CRPD.

4. The denial of women with disabilities right to health

Despite Australia's ratification of international human rights treaties that recognise women with disabilities right to health, women and girls with disabilities continue to experience violation, denial and infringement of this fundamental right. Successive Australian governments have to date, failed consistently in their obligations to respect, protect, and fulfil the rights of women with disabilities. In doing so, the governments have denied disabled women the freedoms and the entitlements for health. Women with disabilities experience direct human rights violations that result in ill-health; experience significant disadvantage in the social determinants necessary for health; and are largely absent in the health promotion agenda.

Regrettably, examples of the infringements of the health rights of women with disabilities abound.

Women with disabilities are denied their right to bodily integrity, to control their own bodies and to be free from interventions – evidenced by the practices of forced sterilisation, menstrual suppression, forced contraception and coerced abortion. Their right to reproductive freedom is denied in a myriad of other ways, including pressure to undergo tubal ligations and hysterectomies, systematic denial 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, birth and post natal care.21

“It [sterilisation] has resulted in loss of my identity as a woman, as a sexual being.”

“I have been denied the same joys and aspirations as other women.”

“Because I have had important parts of my body taken away it is hard to find out what is really going on in my body.”

“We have the right to control what happens to our own bodies.”

“Women with intellectual disabilities and mental health issues have not been given a role in making decisions and/or having choices around their own issues and concerns.”

“I was devastated when my doctor advised me that the previous surgeon had done more than tie my tubes. He had actually removed parts of my reproductive system that could never be replaced......I was shocked and furious.”

Women with disabilities are denied their right to freedom from exploitation, violence and abuse – they experience alarmingly high rates of all forms of violence and abuse from a range of perpetrators yet remain excluded from violence prevention legislation, policies, services and supports. They experience psychiatric assault through practices such as forced medication, chemical restraint, deprivation of liberty, the use of seclusion and restraints, and compulsory administration of psychoactive drugs and procedures such as electroconvulsive therapy.

“Women with disabilities are not seen as sexual beings, therefore it doesn’t even occur to people that women with disabilities experience domestic violence.”

“Women’s refuges won’t take us because we have disabilities.”

“I have had some counselling with a Rape Crisis Centre......but I feel I need someone that is specialised in working with women with disabilities who have been through sexual assault.”

“I didn't know that emotional and verbal abuse were recognised as domestic violence.”

“I'd rather commit suicide than go back to the psych hospital.”

“I'd never had anything to do with psychiatrists before...early on, I thought the sexual abuse was part of the treatment....”

“I was physically and emotionally abused and I cannot find affordable counselling services.”

“He used to pull my hair, push my head into the wall, kick me on the head, hit me with fists on the head... That is what he used to do continuously when he was fighting me. I don't think the blindness was caused by one incident... I think slowly I was getting damaged.”

“Women with disabilities are at increased risk of violence and yet don’t have equal protection under the law. We are often not seen as credible witnesses in criminal cases and conviction rates for crimes against us are generally much lower.”

Women with disabilities are denied the right to experience their sexuality, to have sexual relationships and to found and maintain a family. They experience discriminatory attitudes and widely held prejudicial assumptions which question their ability and indeed, their right to experience parenthood. They remain invisible and ignored in maternity, obstetric, parenting and related health care policies, programs and services, and face overt discrimination and inequitable access to assisted reproductive technologies. They have their babies and children removed by child welfare authorities without evidence of abuse, neglect and/or parental incapacity, and lose their children in custody disputes simply because they are women with disabilities. They battle against political agendas and social commentaries which cast their children as ‘young carers’ at risk of parentification and themselves as burdens of care.

---


“It is high time that people controlling institutions realise that disabled people are no longer willing to sit back and have their morals dictated to them. In fact, sexuality within institutional accommodation should not even be an issue. Privacy and freedom are not privileges to be granted or taken away. They are our basic human rights. Just as people who run the institutions would not appreciate their own sex life to be regulated by a stranger, nor do we. What we do in our own rooms, and who we do it with, is not the business of staff, administration, the milkman, or anyone else.”

“For women with disabilities, pregnancy and parenting is seen as controversial: “If you can’t look after yourself, having a baby is irresponsible!”

“There is no coordination point for disabled pregnant women. Maternity services don’t know anything about disability and disability services don’t know anything about pregnancy. We just fall through the gaps.”

“My child has been teased at school because his mother is disabled.”

“We need more information about sex and sexuality.”

Women with disabilities have a significantly high level of unmet need for services and support to enable them to live independently and with dignity in the community, and to maintain optimal levels of health. They remain largely ignored in Australian health related research, legislation, policies, and services.25 Women with disabilities have less access to community health programs, such as breast and cervical screening services than any other group of women.26

“There’s a perception that because you have a disability you do not require a pap smear or a breast examination.”

“Lack of services impinge constantly on my well-being.”

“My doctors treated me as if I was feeble minded or neurotic.”

“My GP is not set up to do these tests for someone in a wheelchair.”

“I require help with bathing, cooking and my housework but it’s impossible to get attendant care and home help support.”

“I really need help but my disability falls into a grey area so I don’t qualify.”

“Try having a pap smear test sitting in a wheelchair – quite an acrobatic act.”

“Women with disabilities are often not given the chance to be involved in decision-making about their own health.”

Women with disabilities bear a disproportionate burden of poverty, experience significant un/underemployment, and are in the lowest income earning bracket, yet have more than three times the average yearly health care expenditures of other women.27 They are less likely than their male counterparts to receive adequate vocational rehabilitation or gain entry to labour market programs, and are more likely to be in low paid, part time, short term casual jobs28.

26 Ibid.
“Some people can’t conceive of what is like to have the policies of politicians - who have little concept of living with a disability - continually threatening to erode your already meagre standard of living.”

“If employers ask me anything about myself and I mention the slowness but that I can still get my work done on time, they only hear the word ‘slow’ and they think I’m intellectually disabled. So I haven’t had much of a go in the employment field and that’s affected me a fair bit.”

“I am employable and I am a valuable person - the same as anyone else. I find it hard to convince people to employ me.”

“There are many employment agencies that say that they will help you, but I think that they are all the same - you have to get your own job. They don’t help really.”

“There is an ignorance of the research surrounding women with disabilities and poverty. Like, how it impacts on nutritional choices which then impacts on health. Women with disabilities are forced to use more processed food because they can’t always afford, or prepare fresh food.”

Women with disabilities experience serious violations of the right to an adequate standard of living, including adequate housing. They experience social isolation and segregation, multiple forms of discrimination, inaccessible public environments, poor access to services, and are marginalised, excluded or ignored in decision-making processes which affect their lives.29

“I experience isolation probably due to my self-image.”

“My disabled aunt uses candles because she can’t get anyone to help her change the light bulbs.”

“Women with disabilities are being forced to live in situations that don’t suit us with people we don’t know and housing we don’t choose, just so we can get our support needs met.”

“Temporary emergency housing is by and large completely inaccessible to women with disabilities.”

“If women with disabilities do not have access to transport, accommodation, work, education and information we will continue to be dependent on community services and government payments. We will continue to experience ourselves as living on the edge of our society, as being of less worth than other human beings - and our society will continue to have that perception of us.”

“It is essential that women with disabilities are afforded the opportunity to learn leadership skills so they can represent the views of women with disabilities and also pass on those skills to other women.”

“Society generally doesn’t view women with disabilities as being valuable members of the community. We are seen as dependent and as burdens. It’s somehow assumed that because we’re disabled we can’t contribute. It’s assumed we have no skills and nothing to offer.”

5. The effective realisation of women with disabilities right to health

The full enjoyment of the right to health still remains a distant goal for women with disabilities. Strategies to improve women with disabilities’ right to health must take full account of the underlying determinants of health – particularly gender inequality and discrimination– and must address the specific structural, socioeconomic and cultural barriers that hamper women with disabilities in protecting and improving their health. These strategies must be placed in the broader context of government and broader society

recognising, acknowledging and safeguarding the inherent dignity and equal worth of women with disabilities, as a fundamental pre-requisite to women with disabilities realising their right to health.

The obligation to respect, protect and fulfil women with disabilities’ right to health, clearly requires Australian Governments to do much more than merely abstain from taking measures which might have a negative impact on women with disabilities. The obligation in the case of women with disabilities is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to women with disabilities in order to achieve the broader objectives of full participation and equality within society for all persons with disabilities, and the specific objectives of ensuring that women with disabilities enjoy all human rights and fundamental freedoms. This invariably means that additional resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required. These obligations cannot remain words on paper. They must be reflected in all relevant legislation, national policies and programs, and operationalised at the service system level.

Women with disabilities will only effectively realise their right to health when the structural, socioeconomic and cultural barriers that currently deny them this right, are genuinely and fully addressed. The following section of this paper therefore looks at key areas of policy where the Australian Government should take positive action and specific measures to respect, protect and fulfil women with disabilities’ right to health. Recognising that the right to health is dependent on the realisation of other human rights, and extends to the underlying determinants of health, the key strategies identified address a broad range of policy areas and themes, including for example government accountability, legislation, national health and disability policies; national violence prevention programs, women's health screening programs; housing & employment policies and programs, service system issues; participation in health related decision-making; data collection and research; training of health workers; public health media campaigns, and, the social, economic and political empowerment of women with disabilities.

5.1. Accountability

As rights-holders, women with disabilities are entitled to effective remedies, without which there has been, and continues to be, failure on the part of the Australian Government to fully comply with its obligations under the international human rights treaties to which it is a party, including the CESCR, CEDAW and the CRPD. Such remedies can include, for example: judicial (e.g.: judicial review of executive acts; public interest litigation); quasi-judicial (e.g.: international human rights treaty bodies; human rights public inquiries); administrative (i.e.: human rights impact assessments); political (i.e.: parliamentary committee inquiries); and social (i.e.: public hearings, social audits) actions.

---


As duty-bearers, there must be a commitment and willingness by Australian Governments to examine and redress the violations of human rights experienced by women with disabilities, both historically and currently. It is not possible to truly move forward without an understanding of the depth and seriousness of past and current abuse and discrimination of women and girls with disabilities in Australia, including for example:

- forced sterilisation;
- violence (including abuse and violence against women with disabilities in institutions);
- denial of sexuality, reproductive and parenting rights;
- segregation and incarceration in asylums and institutions;
- financial hardship and poverty;
- removal of children from mothers with disabilities;
- selective abortion;
- pre-natal screening and diagnostic technologies to eliminate disability;
- denial of education and employment.

Such policies and practices have left legacies of personal pain and distress that continue to reverberate in the disability community today.

**Key strategies to consider in accountability:**

In keeping with its obligations under the human rights treaties it has ratified, along with its accountability responsibilities to women with disabilities as rights-holders, the Australian Government should, as a priority:

5.1.1. Ensure that the National Human Rights Action Plan\(^{32}\) to be developed as part of the recently announced Human Rights Framework for Australia\(^{33}\) includes a clear and frank assessment of the current human rights situation in Australia, including baseline and disaggregated data and an assessment of Australia’s human rights performance by relevant United Nations Human Rights Treaty bodies. The human rights situation of marginalised groups, including women and girls with disabilities, should be a priority within the Plan.

5.1.2. Ensure that information on women with disabilities is provided in relevant human rights treaties Periodic Reports as a matter of course. This would include information on the situation of women with disabilities under each right, including their current de-facto and de jure situation, measures taken to enhance their status, progress made and difficulties and obstacles encountered.

---


5.1.3. Act immediately to redress the human rights violations against women and girls with disabilities who have been sterilised without their consent. In the process of reconciliation, financial compensation and an official apology for discrimination should be provided.

5.1.4. Address the abuse, neglect, mistreatment, and discrimination of women with disabilities living in institutions. At the very least this should include a National Public Inquiry or Royal Commission into the abuse of people living in institutions, both historically and currently.

5.1.5. Address the over-representation of parents with intellectual disabilities in care and protection proceedings. This should include a National Public Inquiry into the removal and/or threat of removal of babies and children from parents with intellectual disabilities; parents with mental health illnesses and parents with psychiatric disabilities.

5.1.6. To coincide with the release of the National Disability Strategy (NDS), issue a National Apology to People with Disabilities, in acknowledgment of the damage that has been done to people with disabilities by past policies, practices and strategies of exclusion, incarceration, denial of difference, and barriers which have rendered people with disabilities invisible.

5.1.7. Act immediately to make public all data collected through the National Disability Abuse and Neglect Hotline.34

5.2. Legislation

The critical importance of legislative review, development and implementation to enable the effective realisation of the right to health is clearly articulated in CESCR General Comment 14, particularly in relation to Government's obligations to respect, protect and fulfil the right to health.35 The need for Governments to enact legislation to ensure the full development and advancement of women, including to eliminate and prohibit discrimination against women, is identified in CEDAW.36 The CRPD identifies legislation as a key measure in addressing regulations, customs and practices that constitute discrimination against persons with disabilities, particularly in the areas of violence and abuse, employment and issues relating to guardianship.37

Violations of, or lack of attention to human rights can clearly have serious and lifelong health consequences for women with disabilities. Without appropriate and inclusive legislation, there are limited legal means for women with disabilities and their advocates to fight violations of human rights. Governments are responsible for failures to implement laws, and for gaps in the laws so that certain types of human rights violations are not prohibited, or certain categories of victims are not afforded proper

34 See: http://www.disabilityhotline.org/
35 See CESCR General Comment 14 at paras 34, 35, 36; Available at: http://www.unhcr.org/refworld/docid/453883d0.html [accessed March 2010].
36 See for example CEDAW Article 2 (a)(b)(f); Articles 3, 6, 11(3). Available at http://www.wwda.org.au/hrcore1.htm
37 See for example: CRPD Article 4.1(a)(b); Articles 4.3; 15.2; 16.1; 23.2; 27.1. Available at http://www.wwda.org.au/hrcore1.htm
protection. For example, there is a clear need for the Australian Government to develop national uniform legislation which prohibits the sterilisation of girls with disabilities in the absence of a threat to life or health.\textsuperscript{38} The need for this legislation was identified by the United Nations more than four years ago,\textsuperscript{39} yet successive Australian Governments have failed to act on this recommendation.

Domestic and family violence legislation is another example of current legislation that warrants revision in order to be inclusive of women with disabilities. Definitions that specifically encompass the range of settings in which women with disabilities may live, and which take into account the context in which violence against women with disabilities occurs, is critical. Expansion of existing domestic violence legislation may go some way to ensuring that protection and restraining orders in the cases of violence against women with disabilities, can be issued against carers (paid or unpaid) who are perpetrators of violence.\textsuperscript{40}

Legislation governing access to assisted reproductive technologies (ART) is a further example where review and revision is required. Such legislation should include disability in any non-discrimination clause. The current Victorian legislation, for example, omits disability from its non-discrimination clause, with the Victorian Government electing not to include impairment or disability as one of the grounds on which discrimination in relation to access to ART should be prohibited, on the grounds that ‘\textit{in some cases there is a nexus between disability and risk of harm to a child}’.\textsuperscript{41}

Migration and social security legislation as it relates to refugees and migrants with disabilities is another area which has been identified as warranting reform.\textsuperscript{42} The \textit{Migration Act 1958} is exempted from the \textit{Disability Discrimination Act 1992} (as per section 52 of the DDA), and thus refugees and migrants with disabilities are not offered the same protections from discrimination that apply to other areas of Australian law.\textsuperscript{43} Migration law and processes treat people with disabilities solely as a cost, and devalue the important economic and social contributions that migrants and refugees with disability and their families might make to Australia.\textsuperscript{44}

\textbf{Key strategies to consider in legislation:}

In keeping with Australia’s obligations under the human rights treaties it has ratified, the Australian Government has a responsibility to review, evaluate and revise legislation, policies and procedures that

\begin{footnotesize}
\begin{itemize}
\item See for example: WWDA (March 2010) \textit{Submission to the Australian Attorney-General on the issue of Sterilisation of Minors}. Available online at: http://www.wwda.org.au/subs2006.htm\textsuperscript{38}
\item UN Committee on the Rights of the Child (CRC), \textit{UN Committee on the Rights of the Child: Concluding Observations, Australia}, 20 October 2005, CRC/C/15/Add.268, at para. [46(e)]. Available at: http://www.unhcr.org/refworld/docid/45377eac0.html [accessed June 2009].\textsuperscript{39}
\item WWDA (2007b) ‘\textit{Forgotten Sisters - A global review of violence against women with disabilities}’. WWDA Resource Manual on Violence Against Women With Disabilities, Published by WWDA, Tasmania, Australia.\textsuperscript{40}
\item Victorian Law Reform Commission (VLRC) (2007) \textit{Assisted Reproductive Technology & Adoption: Final Report}. Victorian Law Reform Commission, Melbourne, Victoria.\textsuperscript{41}
\end{itemize}
\end{footnotesize}
enable the violations of women with disabilities human rights and where necessary, create legislation to protect women and girls with disabilities against human rights violations. As a priority, the Australian Government should:

5.2.1. Act under its external affairs power to legislate to prohibit non-therapeutic sterilisation of girls with disabilities unless there is a serious threat to health or life.

5.2.2. Address discrimination in legislation and protocols that enables the removal of babies and children from parents with intellectual disabilities; parents with mental health illnesses and parents with psychiatric disabilities.

5.2.3. Investigate the feasibility of the development of a Model Family Violence Law for Australia. Such legislation should be inclusive of the forms of violence as experienced by women with disabilities and encompass the circumstances and contexts within which women with disabilities experience family violence.

5.2.4. Undertake an immediate review of legislation, policies and processes currently in place for procedures occurring to girls and women with disabilities who are deemed ‘incapable of giving informed consent.’ Any review must address (a) who should determine that a person is incapable of giving informed consent; and, (b) what processes and mechanisms should be used to determine that a person is incapable of giving informed consent.

5.2.5. Act to ensure that the Migration Act 1958 is amended to remove the potential for any direct or indirect discrimination against refugees and migrants with disabilities.

5.3. National Health Policies & National Disability Policies

The Australian Government has a responsibility to develop national health policies and national disability policies that conform to its human rights obligations as set out in the CESCR, CRPD, CEDAW (and the other international human rights treaties it has ratified), along with the various international declarations and consensus documents to which it is a party.

For example, the Australian Government is currently in the process of developing a new National Women’s Health Policy (NWHP)\(^45\) in order to: ‘improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health; encourage the health system to be more responsive to the needs of women; actively promote the participation of women in health decision making and management; and to promote health equity among women.’\(^46\) Australia’s last National Women’s Health

---

\(^{45}\) The new National Women’s Health Policy (NWHP) is due to be released in late 2010. More information on the NWHP is available online at: [http://www.health.gov.au/womenshealthpolicy](http://www.health.gov.au/womenshealthpolicy)

Policy was developed some twenty years ago under the Hawke Labor Government as part of the [then] Government’s National Agenda for Women. Although the Policy was developed within a social health framework which explicitly recognised the link between health status and broader cultural and socioeconomic factors, along with the need to focus on health inequalities, it did not prioritise women with disabilities, nor did it include them as a group experiencing inequalities in health status and in access to health services. Nevertheless, this past policy identified seven priority health issues for women: reproductive health and sexuality; health of ageing women; women’s emotional and mental health; violence against women; occupational health and safety; health needs of women as carers; and, health effects of sex-role stereotyping. In addition it contained five key action areas in the health system to improve women’s health - the need for accessible services; accessible health information; research and data; women’s participation in decision-making; and training of health care providers. The recommendations of the Policy were implemented through the National Women’s Health Program with clear implementation strategies and special purpose funding. Although the structure of the Hawke Government’s National Women’s Health Policy specifically included accessibility, there were no priority programs for women with disabilities. As a result, women with disabilities gained little from the National Women’s Health Policy and Program, and remained largely marginalised and excluded from women’s health and related services and programs.

In the context of the new National Women’s Health Policy (NWHP) therefore, there are a number of substantive elements which should apply and which are critical for women with disabilities. These include the need for the NWHP to:

- prioritise marginalised and/or excluded population groups;
- give priority to addressing thematic issues of major concern;
- ensure the health system is made accessible to all, particularly marginalised groups;
- ensure equality and freedom from discrimination;
- ensure adequately supported, meaningful and effective consumer/community participation;
- disaggregate health data for marginalised and/or excluded population groups;
- promote and protect the right to seek, receive and impart health information;
- ensure information is made accessible and available to all marginalised groups;
- identify benchmarks and indicators to ensure monitoring of the progressive realisation of rights in the field of health.

---

47 In November 1985, the then Prime Minister Bob Hawke announced his Government’s commitment to develop an overall Strategic Plan for Women to the Year 2000, through a National Agenda for Women. This fulfilled international obligations following the Nairobi Conference which marked the end of the United Nations Decade for Women.


49 The first phase of the National Women’s Health Program was launched in 1989 with approximately $34 million in funding, contributed by both States/Territories and the Commonwealth on a dollar for dollar basis for a period of four years, to end on 30 June 1993. Total funding for the second phase of the Program (1993-97) was approximately $60 million. Following the election of a new Federal Government in 1996, provision was made in the 1997/98 budget for the continuation of the National Women’s Health Program for a further two years. In December 1997, the Public Health Funding Outcomes Agreement (PHFOA) was signed between the Commonwealth and States/Territories. The Agreement pools funds from eight Commonwealth program areas that were formerly the subject of individual arrangements between the Commonwealth and State/Territory Governments, including the National Women’s Health Program.

WWDA has strongly advocated for the new NWHP to be developed in a framework of human rights, giving priority to those women whose right to health is compromised by social exclusion and discriminatory practices (including women with disabilities), and prioritising thematic issues of concern in recognition of the conditions and contexts that deny vulnerable and marginalised groups of women their right to health.

Just as national women's health policies must be inclusive of and prioritise disability, national disability policies must be gendered and prioritise women. For example, although women with disabilities occasionally rate a mention in the preambles of national policy documents, they are more often than not almost entirely ignored when it comes to developing and funding appropriate programs and actions. Certainly, disability policies in Australia have consistently failed to apply a gender lens. Most have proceeded as though there are a common set of issues and that men and women experience disability in the same way.

The Australian Government is currently developing its National Disability Strategy (NDS), which is due to be released in late 2010, and is intended to guide government activity and future policy initiatives in creating a more socially inclusive Australia for people with disabilities. Although WWDA has strongly advocated for the NDS to be gendered, it remains unclear as to whether and how the NDS will realise the Australian Government's commitment to take positive action and extra measures to ensure that women and girls with disabilities enjoy all human rights and fundamental freedoms.

As part of the NDS, the Australian Government recently announced a National Inquiry into a Long-term Care and Support Scheme for people with severe and profound disability in Australia, including the establishment of a National Disability Insurance Scheme (NDIS). The need for this National Inquiry was the principal recommendation of the Disability Investment Group (DIG), a group established by the Rudd Labor Government to 'explore innovative funding ideas from the private sector that will help people with disability and their families access greater support and plan for the future'. The DIG’s final report, released in December 2009, proposes a new disability policy framework for Australia, with the central platform being the introduction of an NDIS. The Report, which examines the experience of disability in Australia, the need for change, establishing an NDIS, unmet need, housing and employment issues - makes no mention of women with disabilities nor does it include any gender dimension in either its proposed

---

51 These groups of women include: women with disabilities, Indigenous women, culturally and linguistically diverse (CALD) women, refugees and asylum seekers, institutionalised women (including women in prisons), and, homeless women. See for example: WWDA (2009) Submission to Inform the Development of the Framework for the National Women’s Health Policy. WWDA, Tasmania. Available online at: http://www.wwda.org.au/subs2006.htm

52 The thematic issues identified include: violence, reproductive and sexual health, mental health, available, accessible, affordable and quality services, and, economic health and well-being. See for example: WWDA (2009) [as at 51].


54 More information about the NDS is available online at: http://www.fahcsia.gov.au/sa/disability/proserv/govtinit/Pages/nds.aspx


57 The Inquiry is being undertaken by the Productivity Commission. More information is available online at: http://www.pc.gov.au/projects/inquiry/disability-support

58 More information about the NDIS, including background, is available online at: http://www.ndis.org.au/


60 Commonwealth of Australia (2009) [as at 59].
model for an NDIS or its proposed Terms of Reference for the National Inquiry. Hence, the recently announced Terms of Reference for the National Inquiry, which closely mirror those proposed by the DIG, do not include a gender perspective, make no mention of specific needs for any group and are presented as though the experiences of men and women with disabilities are the same.

Given that the Terms of Reference set the scope of the Inquiry, there remain real concerns that the particular needs of women and girls with disabilities will be ignored, and any resulting new policy framework (including an NDIS) will remain un-gendered. Gender analysis is a crucial component of all public policies and is critical in efforts to achieve gender equality.61

**Key strategies to consider in national health policies & national disability policies:**

In keeping with the Australian Government’s obligations under the human rights treaties it has ratified, and in the context of its specific commitments to take positive action and extra measures to respect, protect and fulfil the human rights of women and girls with disabilities, the Australian Government should:

5.3.1. Ensure that the principles of gender equity and health equity are applied to all national policies that address the social determinants of health.62 Where relevant, national policies should make explicit recognition of the impact of multiple discriminations caused by the intersection of gender and disability, and include focused, gender-specific measures to ensure that women with disabilities experience full and effective enjoyment of their right to health.

5.3.2. Ensure that the new National Women's Health Policy (NWHP) gives explicit priority to women with disabilities in recognition of the fact that they experience direct human rights violations that result in ill-health; experience significant disadvantage in the social determinants necessary for health; and remain excluded in the health promotion agenda.

5.3.3. Integrate a gender perspective into all aspects of the National Disability Strategy (including monitoring) in recognition that biological, structural, socio-economic and cultural factors play a significant role in influencing women with disabilities’ right to health, and in recognition of the need for targeted measures to enable them to realise their human rights.

61 Gender mainstreaming was defined by the United Nations Economic and Social Council in 1997 as follows: “Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women’s as well as men’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate aim is to achieve gender equality.”

5.3.4. Ensure that a gender perspective forms an integral dimension of the design, implementation, monitoring and evaluation of the proposed Long-term Care and Support Scheme for people with a disability in Australia, including the proposed National Disability Insurance Scheme.

5.4. National Women’s Health Screening Programs

Members of WWDA have identified access to breast and cervical screening as a priority issue of concern, in response to their experiences of exclusion from these health promotion initiatives. In many areas of Australia, breast and cervical cancer screening services are simply not available to women with disabilities. Even where screening services are available, many women with disabilities cannot receive these services because of economic, social, psychological and cultural barriers that impede or preclude their access to breast health and cervical screening services. Research has demonstrated that a disproportionate number of deaths from breast and cervical cancer occur among women of minority groups, including women with disabilities.

Screening has the potential to prevent the development of disease, prevent premature death and disability and to improve quality of life through the early detection of disease or its precursors. An implicit assumption underlying the concept of screening is that early detection, before the development of symptoms, will lead to a more favourable prognosis, and that if treatment is started before the disease becomes clinically manifest, it will be more effective than treatment provided at a later date.

Currently, neither the National Breast Cancer Screening Program nor the National Cervical Cancer Screening Program identify women with disabilities as a target group, nor do they collect data on the participation rate of women with disabilities in the screening programs.

The Australian Government's current Evaluation Report of the National Breast Screening Program identifies women with disabilities as a group experiencing barriers to the Program. However, the report suggests that these barriers are 'perceived' by women with disabilities, who may not participate in screening because they 'assume they would be physically unable to undergo a mammogram'. The Report further suggests that 'some of the availability and access barriers reported apply to women who have never been screened and may not accurately reflect the availability of the Program.' The Report acknowledges

---

71 Ibid.
72 Ibid, pp. 68, 76.
that Program participation data is ‘not available’ for women with disabilities. The Report makes a series of key recommendations for the future of the Program, including a major recommendation on increasing the participation of specific groups of women, identifying Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds, women living in very remote areas and women living in major cities. As a group, women with disabilities have been actively excluded from national breast and cervical cancer screening data collection and research. This exclusion is clearly inconsistent with the need for targeted measures to enable women with disabilities to realise their right to health – as articulated in the CESCR, CRPD and CEDAW.

**Key strategies to consider in national women’s health screening programs:**

In keeping with the Australian Government’s commitment to women with disabilities under CESCR, CEDAW, and the CRPD, the Australian Government should:

5.4.1. Act immediately to ensure that the National Breast Cancer and National Cervical Cancer Screening Programs are inclusive of women with disabilities, prioritise women with disabilities as a target group for screening, and collect data on the participation rate of women with disabilities.

5.4.2. Act on recommendations from the CEDAW Monitoring Committee,73 and undertake active measures at all levels of Government to ensure development of the necessary infrastructure to enable women with disabilities to participate in breast and cervical screening programs and initiatives, including measures such as the provision of transport, and requiring government funded group homes to facilitate participation by eligible women residents with disabilities.

5.5. National Violence Prevention Policies & Programs

A human rights approach to health recognises that gender-based violence74 is a priority public health issue and, more specifically, a form of discrimination against women. The CESCR stipulates that a state’s failure to protect women against violence is a violation of its obligation to protect the right to health.75 The obligation of Government to address violence against women is clearly articulated in CEDAW, and the specific responsibilities of Governments in this area are clarified further in CEDAW General Recommendation 19.76 The responsibility of Governments to address violence against women and girls with disabilities is also explicitly delineated in the CRPD, which acknowledges that ‘women and girls with

---


74 Gender-based violence is defined as ‘violence that is directed against a woman because she is a woman or that affects women disproportionately’. See for example: Ateneo Human Rights Center (2008) Violence Against Women: A Form of Discrimination, In CEDAW Interactive Benchbook. Ateneo Human Rights Center, Philippines. Accessed online March 2010 at: [http://www.cedawbenchbook.org](http://www.cedawbenchbook.org)

75 CESCR General Comment 14 at para.51.

disabilities are often at greater risk, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation’.77

The Council of Australian Governments (COAG)78 is currently developing a National Plan to Reduce Violence against Women and their Children. COAG will consider the National Plan, including an initial three-year action plan, during 2010.79 In contributing to the consultations to inform the development of the National Plan, WWDA has highlighted that compared to non-disabled women, women with disabilities experience violence at significantly higher rates, more frequently, for longer, in more ways, and by more perpetrators, yet programs and services for this group either do not exist or are extremely limited. In fact, responses to violence against women with disabilities are characterised by limited recognition by governments and the service sector of the nature and extent of the problem; inadequate research; incomplete or partial response structures, and scarce resources to support advocacy in the area.80

Experience of violence prevents women with disabilities from enjoying their human rights and fundamental freedoms, such as the rights to life and security of the person, to freedom from exploitation, violence and abuse, to the highest attainable standard of physical and mental health, to education, work and housing and to participation in public life. Clearly, violence against women with disabilities is not only a serious form of discrimination but also a widespread cause of ill-health among disabled women and a violation of their right to health.

Key strategies to consider in national violence prevention policies & programs:

In keeping with the Australian Government’s obligations under the human rights treaties it has ratified to address violence against women and in the context of its specific commitments to address violence against women and girls with disabilities, Australian Governments should:

5.5.1. Ensure that the COAG three year National Plan to Reduce Violence Against Women and their Children gives priority to addressing the needs of marginalised and excluded groups of women (including women with disabilities), and to addressing those forms of violence which have been recognised as under-documented and under-reported.81 In this context, women with disabilities must form a priority within the National Plan and a percentage of the National Plan Budget should be allocated to the development, implementation, monitoring and evaluation of strategies to address all forms of violence against women with disabilities. This allocation should be protected, sustained and indexed annually.

77 See CRPD Preamble at para [q]. See also CRPD Article 16: Freedom from exploitation, violence and abuse.
78 The Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia. COAG comprises the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA). The role of COAG is to initiate, develop and monitor the implementation of policy reforms that are of national significance and which require cooperative action by Australian governments.
81 See for example the 2006 Report of the UN Secretary-General In-depth study on all forms of violence against women (page 66). A/61/122/Add.1. Available online at: www.wwda.org.au/unhrt.htm
5.5.2. Act immediately to commission and fund a national research study on the incidence and prevalence of violence against women with disabilities, in recognition of the exclusion of women with disabilities from violence prevention programs and services, along with the paucity of research, data and statistics available.

5.5.3. Act to ensure that policies, procedures and protocols are developed to aid in the early identification of violence against women with disabilities including for example screening and assessment tools.

5.6. National Housing Policies & Programs

The right to adequate housing[82] is identified as a core obligation under the CESCR,[83] and includes the right to accessible housing for women with disabilities.[84] The right of women with disabilities to enjoy adequate living conditions, particularly in relation to housing, is enshrined in CEDAW,[85] and the right to an adequate standard of housing is also clearly articulated in the CRPD.[86] Having access to adequate, safe and secure housing substantially strengthens the likelihood of women with disabilities being able to realise their right to health.

Adequate housing is universally viewed as one of the most basic human needs, and is a critical component of the right to health. Like all members of the community, women with disabilities have a fundamental right to a range of housing options. Yet women with disabilities in Australia continue to experience serious violations of their right to adequate housing, as well as failures to promote and fulfil this most basic human right. Clearly the denial of the right to housing has direct and indirect consequences for health. Issues for women with disabilities include:

- lack of affordable, safe, and secure housing;
- lack of low cost housing;
- lack of income, or low security of income, to purchase a house;
- severe lack of appropriately modified housing;
- lack of availability of housing which adheres to universal design principles;
- escalation in the cost of private rental;
- forced to live further away from services as a result of low income and high urban rental costs;
- discrimination in both the public and private rental markets;
- lack of supports available in the community;
- additional costs of disability, which compound lack of options in the housing market;

---

83 CESCR General Comment 14 at para.15.
84 CESCR General Comment 5 at para.33.
86 See: CRPD Articles 19 & 28.
higher risk of homelessness as a result of violence;

ignored in homelessness and violence policy responses;

lack of access to women’s refuges and other crisis and post-crisis accommodation services.

In Australia, women with disabilities are over-represented in factors that contribute to homelessness, which include unemployment, underemployment, poverty, low income, violence, lack of access to essential services and supports, and lack of access to affordable, safe, secure housing.\textsuperscript{87} Despite this, women with disabilities remain largely excluded from policy and program responses designed to address homelessness in Australia.\textsuperscript{88} It is well documented that domestic and family violence is one of the major factors in homelessness in Australia,\textsuperscript{89} and women with disabilities are twice to three times more likely to be victims of physical and sexual violence than other women.\textsuperscript{90} However, the lack of available services and programs for women with disabilities experiencing violence, coupled with the almost universal exclusion of women with disabilities from women’s refuges and other crisis and post-crisis accommodation services in Australia is a critical issue impacting on the health of women with disabilities, yet remains largely ignored in violence prevention, homelessness prevention and health promotion responses at all levels.\textsuperscript{91}

**Key strategies to consider in national housing policies & programs:**

In keeping with the human rights treaties it has ratified, acknowledging that adequate housing is a critical component of the right to health, and in recognition of the exclusion of women with disabilities from policy and program responses designed to address homelessness, the Australian Government should:

5.6.1. Act immediately to address the exclusion of women with disabilities from women’s refuges. Inherent in this is the need to undertake a national audit of crisis accommodation services\textsuperscript{92} to determine their levels of accessibility and safety for women with disabilities and to determine service/agency needs in meeting relevant anti-discrimination legislation requirements.

5.6.2. Legislation, policy frameworks, service standards, accountability frameworks, codes, and guidelines developed under the National Affordable Housing Agreement (NAHA),\textsuperscript{93} the National


\textsuperscript{91} See WWDA (2008) Op Cit. [as at 88].

\textsuperscript{92} See Priority Action 3.2.2 [p.166] of ’Time for Action’: The National Council’s Plan for Australia to Reduce Violence against Women and their Children, 2009-2021. Prepared by the National Council to Reduce Violence against Women and their Children (March 2009), Published by Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.

\textsuperscript{93} The NAHA is an agreement by the Council of Australian Governments that commenced on 1 January 2009, initiating a whole-of-government approach in tackling the problem of housing affordability. See: http://www.fahcsia.gov.au/sa/housing/progserv/affordability/affordablehousing/Pages/default.aspx
Partnership Agreement on Social Housing, and the National Partnership Agreement on Homelessness should include in a measurable way, implementation of relevant human rights treaties, including the CRPD, CESCRI and CEDAW. Targets developed to reduce homelessness and to address the right to adequate housing must be established for people with disabilities as a population group and include gender specific targets.

5.7. Employment Policies & Programs

The CESCRI identifies the right to work as a one of the key underlying determinants of health and therefore a critical component of the right to health. The obligation of Governments to take all appropriate measures to eliminate discrimination against women in the field of employment is also clearly stated in CEDAW. The right of women with disabilities to work in freely chosen or accepted employment is also clearly articulated in the CRPD.

Employment and working conditions have powerful effects on health equity. It is widely recognised that being in paid employment is a key marker of social inclusion and that unemployment and under-employment are associated with poorer health status. Paid employment is a critical component in enabling women with disabilities to support themselves financially, provide financial security, social status, personal development, social relations and self-esteem, and achieve social recognition – all necessary for realising the right to health. Yet in Australia, women with disabilities are less likely to be in paid work (or looking for work) than other women, men with disabilities or the population as a whole.

For example, in 1998, the labour force participation rate of women with disabilities was 45.5%, compared to 60.3% for men with disabilities. In 2003, the rate increased marginally for women with disabilities to 46.9%, and decreased slightly for men with disabilities to 59.3%. However, a stark contrast can be seen in the unemployment rates for the same period. In 1998, 8.6% of women with disabilities were unemployed, compared to 13.5% of men with disabilities. In 2003, the unemployment rate for disabled men dropped significantly to 8.8%, whilst the unemployment rate for disabled women remained virtually the same at 8.3%. The picture becomes even clearer when we consider the unemployment rates for non-disabled men and women over the same period. In 1998, the unemployment rate of non-disabled women was 8.0% compared to 7.7% for non-disabled men. In 2003, the rate dropped significantly for both non-disabled
women (5.3%) and men (4.8%).\textsuperscript{101} \textsuperscript{102} \textsuperscript{103} In any type of employment women with disabilities are more likely to be in low paid, part time, short term casual jobs.\textsuperscript{104}

**Key strategies to consider in employment policies & programs:**

Consistent with the human rights treaties it has ratified, acknowledging that paid employment is a prerequisite for health, and in recognition of the discrimination facing women with disabilities in employment, the Australian Government should, as a priority:

5.7.1. Act immediately to implement Recommendation 56 of the Parliamentary Inquiry Report *Making it Fair*\textsuperscript{105} which recommends that the Government as a matter of priority collect relevant information on workforce participation of women with disabilities to provide a basis for pay equity analysis and inform future policy direction.

5.7.2. Act to address the disparity in the proportion of men and women with disabilities who are being assisted by Commonwealth Government funded employment services.

5.7.3. Implement the recommendations from the [then] Human Rights and Equal Opportunity Commission (HREOC) 2005 National Inquiry into Employment and Disability.

5.7.4. Act to de-link disability-related supports and services from income support programs in order to make the supports required by women with disabilities available to those who could not afford to enter the paid labour market otherwise.

5.8. **Service System Issues**

The socioeconomic and gender-based inequalities that women with disabilities face are played out in their access to and use of health-care and related services. Addressing discrimination, inequalities and inequity in access to services and systems is a critical element of a human rights based approach to health and fundamental to improving women with disabilities right to health.

In Australia, women with disabilities experience significant difficulty accessing health information, care, support and services for the realisation of the right to health. For many women with disabilities, the services and programs they require to realise their right to health are simply not *available* to them. Even where services and programs are available, many women with disabilities remain excluded due to economic, social, psychological and cultural barriers that impede or preclude their access. For example,


support for choices and services in menstrual management, contraception, abortion, sexual health management, pregnancy, birth, parenting and menopause remain inappropriate, absent or inaccessible.\textsuperscript{106} \textsuperscript{107} As highlighted earlier in this paper, breast and cervical cancer screening services are often not available to women with disabilities. Services and programs for women with disabilities experiencing violence is a further area where women with disabilities experience exclusion.

Just some of the examples of barriers and discriminations women with disabilities face in accessing health and related facilities, services and programs include:

- non-inclusive service policies and programs;
- inaccessible buildings and venues;
- lack of, inaccessible and unaffordable transport;
- inaccessible examination tables; lack of appropriate equipment;
- myths, stereotypes and assumptions that women with disabilities are asexual and do not need health promoting measures relating to sexuality, relationships, parenting, violence, etc;
- lack of/reliance on attendant care support;
- inflexible service procedures;
- attitudes & skills of workers - lack of knowledge, inadequate training, negative attitudes, tendency to focus on the disability not the woman;
- lack of respect, trust, privacy and confidentiality within services;
- social isolation and segregation.

The right to health includes a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.\textsuperscript{108} Health services and systems at all levels must therefore encompass the following inter-related and essential elements if they are to serve women with disabilities adequately:

- \textit{Available}: health and related facilities, goods, services, and programs must be available in sufficient quantity to women with disabilities. Available facilities not only relates to buildings such as hospitals and community health centres, but also to preventive public health strategies and health promotion, and access to well trained health workers. The adequate resourcing of services that can cater to women with all types of disabilities is critical.

- \textit{Accessible}: health and related facilities, goods, services, and programs must be accessible to women with disabilities without discrimination. In the broadest sense accessible services encompass physical, intellectual, psychiatric, sensory and other disabilities. Accessibility includes

\begin{footnotesize}


\end{footnotesize}
the right to seek, receive and impart information and ideas concerning health and health-related services, programs and issues in an accessible format. This includes both content that reflects the experiences of women with disabilities and format of information available, such as Braille, audio, Easy English and the use of telephone access relay services and sign interpreters. A further dimension of access includes being able to understand and meaningfully participate in the services and programs available, including information and education resources. Accessibility of information should not impair women with disabilities right to have personal health data treated with confidentiality and respect. Affordability is a further element of access. Payment for healthcare and related services should be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for women with disabilities.

- **Acceptable:** health and related services and programs that combine sensitivity to both disability issues and to issues of gender are necessary for women with disabilities to realise their right to health. Such services and programs should also be culturally appropriate, sensitive to women with disabilities life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of women with disabilities.

- **Quality:** The provision of responsive and suitable health and related services requires skills and training to enable service providers to recognise and respond appropriately to the needs and issues of women with disabilities.

**Key strategies to consider in service systems:**

In keeping with the Australian Government's obligations to respect, protect and fulfil women with disabilities right to health, the Australian Government should, as a priority:

5.8.1. Act on recommendations from the CEDAW Monitoring Committee, and undertake active measures at all levels of Government to ensure development of the necessary infrastructure to enable women with disabilities to have access to all health services.

5.8.2. Ensure that the new national Women's Health Policy (NWHP) and the national program established to implement the Policy, are based on principles of equity and freedom from discrimination, in recognition of the fact that these principles are critical components of the right to health, and are core obligations of the Australian Governments under the CESCR, CEDAW and the CRPD.

---


108. Ibid.

5.8.3. Establish and recurrently fund a National Resource Centre for Parents with Disabilities, focusing on pregnancy & birthing, adoption, custody, assisted reproduction, adaptive baby-care equipment, as well as general parenting issues. The National Resource Centre should also be resourced to establish and house a National Reproductive Rights Network for Women with Disabilities.

5.9. Participation and Inclusion in Health Related Decision-Making

Participation is a central feature of the right to health. Many international human rights treaties recognise participation as a human right, and several (including the CESCR, CEDAW, and CRPD) contain specific articles concerned with ensuring the participation of marginalised groups in the conduct of public affairs and policy development.

In the context of women with disabilities right to health, ‘participation’ is a process by which they are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing, delivering and evaluating services and in taking action to achieve change.\(^{112}\) The right to participate in decision-making processes that affect their health and development is clearly critical for women with disabilities, however, more often than not, they are excluded and ignored in health and related policy, service and program development, including information and education resources. Inherent in this right, and enshrined in the General Obligations\(^{113}\) of the CRPD, is the need for, and the right to capacity building through programs conducted by their representative organisations, community organisations and governments, so that women with disabilities have the skills, expertise and networks to adequately participate.

For example, in the lead up to the development of the new National Women's Health Policy (NWHP), the Australian Government identified the critical importance of the participation of socially excluded groups of women in health decision-making as a 'key way of making the health system more responsive to the needs of women, improving the health and wellbeing of all women in Australia, especially those with the highest risk of poor health, and promoting health equity among women'.\(^{114}\) Yet women with disabilities were excluded from the initial national consultation forum of ‘key stakeholders’ established by the Government to begin the development of the new NWHP. At this national forum, the Australian Government publicly launched the NWHP Consultation Discussion Paper and invited ‘key stakeholder organisations and other interested parties’ to provide written Submissions which would then be used to inform the development of the Framework for the NWHP. The Consultation Paper was not provided in accessible formats, and repeated requests to the Government for an accessible version of the Paper were initially refused. It took almost three months of lobbying by WWDA, supported by the Australian Human


Rights Commission (AHRC), before an accessible version was provided. WWDA’s capacity to contribute to the consultation process was therefore significantly hampered due to the shortened timeframe to develop a response.

In 2008, the newly elected Rudd Labor Government announced its intention to establish a *National Council to Reduce Violence Against Women and their Children*, as part of its broader framework of social inclusion initiatives. The Council’s role was to draft a national plan to reduce violence against women and their children. WWDA had long articulated the importance of representation of women with disabilities on such a vital advisory structure, and in early 2008, wrote to the Minister for the Status of Women to request that women with disabilities be included in the Council’s membership. However, when the National Council was established, its membership excluded women with disabilities.

Women with disabilities are not only denied the opportunity to participate in national health and related policy initiatives such as those described above. Many women with disabilities are excluded from participating in decisions that affect their lives on a daily basis, including as active partners in their own health care. They are often stereotyped as passive, asexual, dependent, compliant, sick, child-like, incompetent and helpless or powerless or insecure. Alternatively, women with developmental disabilities in particular may be regarded as overly sexual, creating a fear of profligacy and the reproduction of disabled babies, often a justification for their sterilisation. These perceptions, although very different, can result in women with disabilities being denied the right to participate in decision-making processes that affect their health.

**Key strategies to consider in participation and inclusion in health related decision-making:**

In keeping with the Australian Government’s obligations to respect, protect and fulfil women with disabilities right to health, acknowledging the critical role of participation in health, and in recognition of the exclusion of women with disabilities from decision-making processes that affect their health, the Australian Government should, as a priority:

5.9.1. Ensure that women with disabilities are represented on the national advisory structures established to oversee implementation of the National Women’s Health Policy.

---

120 WWDA (2007b) [as at 109].
5.9.2. Develop the institutional mechanisms to ensure that the participation of women with disabilities takes place in health policy and planning, including the planning, management, delivery and evaluation of health and related services.

5.10. Data Collection and Research

In the context of women with disabilities realising their right to health, the importance of data collection and research is clearly articulated within the CRPD, which stresses the importance of disaggregation of statistical and research data in order to identify and address the barriers faced by women with disabilities in exercising their rights.121 The CESCR identifies research and data collection, including disaggregation on the prohibited grounds of discrimination, as an obligation of Governments in fulfilling the right to health.122

The acute lack of available gender and disability specific data, information and research in Australia, at all levels of Government and for any issue, has been identified by WWDA for more than a decade. This neglect has seen Australia criticised by the CEDAW monitoring Committee, for failing to provide information on the situation of women with disabilities in its CEDAW implementation reports.123 In its concluding comments in 2006 regarding the Australian Government’s fourth and fifth reports to CEDAW, the Committee expressed its regret at the absence of research, data and information on women with disabilities, and requested that the Government’s next report address this neglect, so as to ‘provide a full picture of the implementation of all the provisions of the Convention’. However, the Australian Government’s subsequent combined sixth and seventh report124 to CEDAW failed to provide data and information on the situation of women with disabilities as specifically requested by the CEDAW Committee in 2006. It is also essential that data is made publicly available so that the Third Sector125 can fulfil its function under the Australian Government’s 2010 National Compact126 which aims for collaboration which will ‘improve community health and wellbeing and a more inclusive Australia’.

Data, research and information about women with disabilities and their right to health is necessary to guide and inform policy, direct funding, and inform service development.127 128 It also enables the monitoring of equality of opportunity and progress towards the achievement of economic, social, political and cultural rights for women with disabilities. The lack of data, research and information about women

---

121 CRPD, at Article 31.
122 CESCR General Comment 14 at paras. 37 & 57.
123 See: UN Committee on the Elimination of Discrimination Against Women (CEDAW) [as at 111].
125 The Third Sector refers to a broad range of organisations that are “formed by people to provide services for themselves or for others, to advance a cause, to share an enthusiasm, to preserve a tradition, to worship a god or gods. Different groups of these organisations are known by different names: non-government organisations (NGOs), charities, unions, cooperatives, clubs, associations, peoples’ organisations, churches, temples, mosques and so on. Collectively, they comprise a third organised sector.” (Prof Mark Lyons 2003): at: http://www.nationalcompact.gov.au/resources/national-compact/foreword/
with disabilities and their right to health results in invisibility and marginalisation in health systems and
services and invariably leads to a critical lack of resources for this group.129

Members of WWDA have identified a number of priority areas warranting urgent data collection and
research, including for example the right to reproductive freedom; the right to found a family, and the
right to the highest attainable standard of health.130

**Key strategies to consider in data collection and research:**

In keeping with the Australian Government's obligations to respect, protect and fulfil women with
disabilities right to health, and in recognition of the paucity of gender and disability data, research and
information, the Australian Government should, as a priority:

5.10.1. Act to ensure that health and socio-economic data is disaggregated by gender and disability, in
order to identify and address discrimination and inequities in health.

5.10.2. Fund a national research project on the issues which impact on access and uptake of breast,
cervical and bone-density screening services for women with disabilities.

5.10.3. Fund a full time Project Officer position for Women With Disabilities Australia (WWDA) for a
period of three years to develop and implement a national research project on the parenting
experiences of women with disabilities.

5.10.4. Fund a national project on women with disabilities’ right to reproductive freedom which:

- addresses the incidence and long term effects of forced sterilisation for *all* women with
disabilities, including those with psychiatric, cognitive, sensory and physical disabilities;
- researches the practice of menstrual suppression of girls and women with disabilities,
including those in group homes and other forms of institutional care. Research into menstrual
suppression practices must include:
  - an investigation into the use of Depo-Provera and other injectable contraceptives,
the contraceptive pill, and other forms of contraception;
  - an investigation into the use of contraception as a form of social control of girls
and women with disabilities;
  - an investigation into the long term physical and mental health and social effects of
menstrual suppression practices.

---

5.10.5. Support and fund national research into the recognised markers of social exclusion for women with disabilities, including: 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.

5.11. Public Health Media Campaigns

The vast majority of information about disability in the mass media is extremely negative. Disabling stereotypes which medicalise, patronise, criminalise and dehumanise women with disabilities abound in books, films, on television, and in the press. They form the bed-rock on which the attitudes towards, assumptions and about and expectations of women with disabilities are based. They are fundamental to the discrimination and exploitation which women with disabilities encounter daily, and contribute significantly to their systematic exclusion from mainstream community life.\(^\text{131}\) They can, and do, have a profound effect on the self image of women with disabilities themselves.\(^\text{132}\)

Despite the fact that women with disabilities experience direct human rights violations that result in ill-health; experience significant disadvantage in the social determinants necessary for health; and remain excluded in the health promotion agenda, they are rarely included or visible in public health media campaigns. For example, Australian Government national mass media campaigns around stopping violence against women have featured images of indigenous women, culturally and linguistically diverse women, young women and older women but none of women with disabilities, despite the high incidence of violence perpetrated against them. It is a similar situation in the national media campaigns around promoting the uptake of breast and cervical cancer screening.

Despite increasing appreciation of the heterogeneity of women and the need to address such factors as race, ethnicity and class in public health campaigns, disability has not been recognised and it is this exclusion which renders the experiences of women with disabilities essentially invisible.\(^\text{133}\)

**Key strategies to consider in public health media campaigns:**

In keeping with the human rights treaties it has ratified, and acknowledging the need to take targeted, positive action to realise women with disabilities’ right to health, the Australian Government should:

5.11.1. Act to ensure that women with disabilities are represented, on an equal basis with others, in the development, implementation and evaluation of public health and health promotion campaigns at national, state and territory levels.

---


5.12. Training of Health Workers

The obligation to fulfil the right to health for women with disabilities requires the Australian Government to undertake actions that create, maintain and restore the health of the population. This includes ensuring that health workers are trained to recognise and respond to the specific needs of vulnerable or marginalised groups, including women with disabilities. The requirement of Governments to provide education and training for health personnel on health and human rights is also identified as a core obligation under the CESCR. The CRPD requires Governments to take all measures to ensure that health care providers are trained in awareness of the human rights, dignity, autonomy and needs of women with disabilities. It further requires health professionals to provide care of the same quality to women with disabilities as to others, including on the basis of free and informed consent.

The lack of education and training of health and related service providers has been identified as a major barrier to women with disabilities accessing health and related services. This lack of education and training is borne out in a myriad of ways. For example, many service providers lack knowledge of disability, hold inaccurate perceptions about women with disabilities, and have a tendency to view women with disabilities solely through the lens of their impairments. Insufficient time to address the full range of needs is a common barrier during encounters with health and related service providers, as is the general lack of sensitivity, responsiveness, courtesy and support shown to women with disabilities. Health and related service providers can have a tendency to treat women with disabilities as objects of treatment rather than rights-holders, and do not always seek their free and informed consent when it comes to interventions.

Health and human rights education, information and training is therefore essential to sensitise health and related service providers to the human rights of women with disabilities, including their right to health.

Key strategies to consider in training of health workers:

In keeping with its core obligations under CESCR and consistent with the need to take positive measures to address the multiple discriminations faced by women and girls with disabilities in realising their right to health, the Australian Government should:

---

134 CESCR General Comment 14 at para. 37.
135 CESCR General Comment 14 at para. 44(e).
136 CRPD at Article 25(d).
140 Ibid.
5.12.1. Commission the development of national guidelines for health and related service providers that describe expectations for compliance with the CESCR, CEDAW and CRPD.

5.12.2. Through the National Registration and Accreditation Scheme for the Health Professions (NRAS),143 act to ensure that accreditation of the training of health professionals covered under the Health Practitioner Regulation National Law Act 2009, is contingent on disability and human rights specific curriculum components.

5.12.3. Develop national protocols for health education curriculum (beginning at primary school level) which incorporate models of diversity that portray positive images of women with disabilities as sexual beings, including as parents.

5.12.4. Act to ensure that relevant training authorities (such as TAFE) develop curriculum content which requires demonstration of competencies in knowledge of human rights of women with disabilities.

5.13. The Social, Economic and Political Empowerment of Women with Disabilities

Women with disabilities bear a disproportionate burden of poverty and are recognised as amongst the poorest of all groups in society. Poverty and lack of economic opportunities are major barriers to them being able to realise their right to health and are major factors contributing to their entrenched social exclusion. Poverty and discrimination diminish freedom by depriving women with disabilities the opportunity to exercise their fundamental human rights. The denial of human rights can lead to a vicious cycle that entraps women with disabilities in a life of highly restricted choices.144 A disabled woman whose right to education is denied, for example, is more likely to face compromises to her right to health.

In order for women with disabilities to realise their right to health, governments at all levels should take measures to empower women with disabilities and strengthen their economic independence. This includes creating the conditions and structures that improve women with disabilities access to the labour market and affording them more adequate levels of income support. Economic independence and political representation are essential markers of gender equality. Women with disabilities access to decision-making and political participation and representation are essential so that laws and policies reflect their interests and they can exercise their full rights as citizens.145

145 Ibid.
Organisations and groups of women with disabilities play an important role in raising awareness of, and working to address the violations, denials and infringements of the right to health. There is recognition that the empowerment of women with disabilities is achieved principally through women with disabilities coming together to share their experiences, gaining strength from one another and providing positive role models.\textsuperscript{146} \textsuperscript{147} Financial and political support is needed for the establishment and maintenance of such groups of women with disabilities at national, regional and local levels.

**Key strategies to consider in the social, economic and political empowerment of women with disabilities:**

In keeping with the Australian Government’s acknowledgement of the multiple discriminations faced by women and girls with disabilities, and in keeping with its obligations to take positive action and measures to ensure they enjoy all human right and fundamental freedoms, the Australian Government should, as a priority:

**5.13.1.** Recognise, support and strengthen the role of women with disabilities organisations, groups and networks in efforts to fulfil, respect, protect and promote their human rights, and to support and empower women with disabilities, both individually and collectively, to claim their rights. This includes the need to create an environment conducive to the effective functioning of such organisations, groups and networks, including adequate and sustained resourcing. Inherent in this, is the need for financial and political support to enable the establishment and recurrent funding of women with disabilities organisations, groups and networks in each State and Territory.

**5.13.2.** Urgently review the adequacy of income support arrangements for those with a disability across all household types, in recognition of the fact that the non-optional costs of disability are a significant barrier to the social inclusion of women with disabilities, and that the setting of income support payment rates for people with disabilities has failed to take account of these non-optional, extra costs.


Conclusion

This paper has sought to demonstrate that despite Australia’s international commitment to achieve better health for its citizens, particularly marginalised groups, the full enjoyment of the right to health still remains a distant goal for women with disabilities.

Women with disabilities in Australia not only represent one of the groups with the highest risk of poor health, but experience many of the now recognised markers of social exclusion. They experience major inequalities in health status, and experience significant disadvantage in the social determinants of those inequalities. The denial and infringement of women with disabilities right to health can be seen in an array of human rights violations: they experience violence at higher rates than their non-disabled sisters, experience less control over what happens to their bodies, have less access to vital health care services, such as cervical and breast cancer screening and, face discrimination, societal prejudice and stigma when it comes to determining their reproductive rights.

The obligation to respect, protect and fulfil women with disabilities’ right to health, clearly requires Australian Governments to do much more than merely abstain from taking measures which might have a negative impact on women with disabilities. The obligation in the case of women with disabilities is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to women with disabilities in order to ensure that they enjoy all human rights – including their right to health. This invariably means that additional resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required.