Women With Disabilities Australia (WWDA)

Submission to Inform the Development of the Framework for the National Women's Health Policy

August 2009
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States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.

Article 6, Convention on the Rights of Persons with Disabilities (CRPD)
Ratified by the Australian Government, July 2008

“It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for”

UN Secretary-General, Kofi Annan, 2002

“The right to health...requires governments to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time”

Mary Robinson, former UN High Commissioner for Human Rights 2002
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## Abbreviations

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<tr>
<td>AHRC</td>
<td>Australian Human Rights Commission</td>
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<td>AWHN</td>
<td>Australian Women’s Health Network</td>
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<td>CAT</td>
<td>Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</td>
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<td>CRPD</td>
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<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<td>CESCER</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>NWHP</td>
<td>National Women’s Health Policy</td>
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<td>UN</td>
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1. Introduction

Women With Disabilities Australia (WWDA) is the peak organisation for women with all types of disabilities in Australia. WWDA is an organisation 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. WWDA’s rights based approach also demonstrates, in a practical way, our organisation’s commitment to the implementation of the core international human rights treaties ratified by the Australia Government.

This Submission is WWDA’s response to the Australian Government’s National Women’s Health Policy (NWHP) Consultation Discussion Paper 2009. WWDA’s capacity to respond to the Discussion Paper was initially hampered by the Australian Department of Health and Ageing’s exclusion of WWDA from the early consultation process – evidenced by the Department’s failure to include women with disabilities in its National Women’s Health Policy Roundtable Consultation, and its initial refusal to provide consultation materials in accessible formats in order for WWDA to undertake electronic consultation with constituents who are blind. This experience of barriers to participation is characteristic of the issues that women with disabilities face in their lives on a daily basis - excluded, ignored, marginalised, perceived as ‘difficult’ and ‘outside the norm’.

This Submission examines these and other issues in the context of women with disabilities and health. It clearly demonstrates that many women with disabilities in Australia are currently denied the freedoms and entitlements necessary for health:

- we are denied our right to bodily integrity through endorsed practices such as forced sterilisation, forced contraception and menstrual suppression;
- we are denied our right to reproductive freedom in a myriad of other ways – coerced abortion, pressure to undergo tubal ligations and hysterectomies, systematic denial of appropriate reproductive health care;
- we are denied our right to found and maintain a family through a host of violations, such as the removal of our babies and children by child welfare authorities;
- we are denied our right to live free from violence, abuse and exploitation;

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1 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 in that it operates as a national disability organisation; a national women's organisation; and a national human rights organisation. WWDA represents more than 2 million disabled women in Australia. 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 addresses disability within a social model, which identifies the barriers and restrictions facing women with disabilities as the focus for reform. More information about WWDA can be found at the organisation's extensive website at: www.wwda.org.au
• we are denied our right to sexual freedom and to experience sexual relationships;

• we are denied our right to accessible information and training in all of the above areas;

• we are denied our fundamental right to participate in decision making processes which affect our lives;

• we are denied many of the other conditions and pre-requisites for health, such as the right to work, to an adequate standard of living, to education, to information, and to adequate housing;

This Submission is therefore not about the ‘needs’ of women with disabilities in relation to our health, but rather it is about our *rights* to health and all that it entails. Indeed, human rights concern the relation between the State and the individual; they lead to state obligations and individual entitlements\(^2\).

This Submission does not, therefore, reduce our views to a few pages of dry issues, but instead, places our issues clearly in a framework of human rights – rights that for far too long have been violated, denied, ignored and trivialised by those in positions to make a difference.

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\(^2\) See for example: [www.ops.org.bo/medicamentos/essential_medicines/2-access/human_rights.ppt](http://www.ops.org.bo/medicamentos/essential_medicines/2-access/human_rights.ppt)
2. Background

In the lead up to the Federal election in late 2007, the Australian Labor Party (ALP) articulated its intention to ‘develop a national policy on women’s health that will encourage specific health services for women and will actively promote participation of women in health decision making and management’ (ALP National Platform and Constitution 2007). Australia’s last national women’s health policy had been developed some twenty years previously under the Hawke Labor Government in 1989, as part of the then Government’s National Agenda for Women. In early 2009, the Rudd Labor Government commenced the task of developing its new National Women’s Health Policy (NWHP). It convened a National Roundtable Consultation which was attended by 14 ‘invited only’ key stakeholder organisations. Women with disabilities were neither invited to, nor represented at this National Roundtable Consultation, despite the Australian Government identifying women with disabilities as a group experiencing major inequalities in health status, and further identifying the critical importance of the participation of socially excluded groups of women in health as a ‘key way of making the health system more responsive to their needs’ (Commonwealth of Australia 2009).

At the National Roundtable Consultation on March 12, the Australian Government publicly launched the NWHP Consultation Discussion Paper, which stated that the purpose of the NWHP will be 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 (Roxon 2009).

Key stakeholder organisations and other interested parties were invited to provide written Submissions to the Consultation Paper, which would 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. This action clearly contravened CRPD (Article 9) which articulates the need for States to ensure that information is accessible to all people with disabilities on an equal basis with others. 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.

As a result of these difficulties, WWDA was able to successfully negotiate for a small funding grant from the Australian Department of Health and Ageing to assist with the preparation of WWDA’s Submission to the NWHP Consultation Discussion Paper.

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3 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.

4 The National Roundtable Consultation was held at Parliament House, Canberra, on 12 March 2009 and attended by invited stakeholders: Australian Women’s Coalition, Womenspeak, Security4Women, National Rural Women’s Coalition, Rural Doctors Association, Natural Family Planning, Australian Longitudinal Study, Australian Reproductive Health Alliance, Public Health Association, National Foundation of Australian Women, Multicultural Centre for Women’s Health, Royal Australian College of General Practitioners, Jean Hailes Foundation, Country Women's Association and AWHN. Congress Alukura was invited but was unable to attend.

This Submission is based and draws on, the lived experiences of women with disabilities in relation to their health, and is supported by international and national literature (both published and unpublished) relevant to the field.

WWDA’s members have informed the development of this Submission by providing their views, their experiences and in many cases, their candid personal stories. The small amount of funding secured by WWDA to assist in the preparation of this Submission, enabled us to host a Women with Disabilities and Health Forum in Queensland. This Forum was conducted in partnership with the Queenslanders with Disabilities Network (QDN), and facilitated on behalf of WWDA by WWDA member Karin Swift.

WWDA takes this opportunity to acknowledge the contributions of its members, past and present, in contributing material to inform the development of this Submission.
3. **Structure of this Submission**

This Submission focuses predominantly on the Framework for the new National Women’s Health Policy, in the context of human rights and women with disabilities. It examines what is meant by the ‘right to health’ and looks at women with disabilities’ right to health under the relevant international human rights treaties to which Australia is a party.

In the context of women with disabilities and the right to health, this Submission focuses on the *International Covenant on Economic, Social and Cultural Rights* (CESCR), which was ratified by Australia in 1975 and provides arguably the most authoritative interpretation of the right to health. This Submission also examines women with disabilities right to health under the *Convention on the Elimination of All forms of Discrimination Against Women* (CEDAW) and the *Convention on the Rights of Persons with Disabilities* (CRPD).

Giving consideration to Australia’s obligation to women with disabilities under these three core human rights treaties, the denial of women with disabilities right to health is highlighted, demonstrating that successive Governments have failed in their obligation to respect, protect and fulfil the rights of women with disabilities.

The Principles to underpin the new National Women’s Health Policy are addressed and the inequities experienced by women with disabilities in claiming their right to health are examined. Examples are given to illustrate these inequities in the areas of: the right to freedom from exploitation, violence and abuse; the right to bodily integrity; the right to found a family and to reproductive freedom; the right to health facilities, goods and services; the right to work; and, the right to an adequate standard of living, including adequate housing.

The final section of this Submission looks at priorities for the new National Women’s Health Policy and identifies (and provides rationale for) both priority groups and priority thematic issues that should be included in the new National Women’s Health Policy.
4. Recommendations

Giving consideration to Australia’s core obligations under the relevant international human rights treaties to which it is a party, and in recognition of the denial of the freedoms, entitlements, conditions and contexts for women with disabilities to realise their right to health, WWDA makes the following recommendations in relation to the Framework for the new National Women’s Health Policy:

4.1. The NWHP adopt the definition of health recognised in international human rights law and the relevant human rights treaties, declarations and consensus documents to which Australia is a party. In this context, the NWHP should define health in the following way, consistent with the definition in the constitution of the World Health Organisation (1946):

*Health is the state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is the fundamental right of every human being without distinction of race, religion, political belief, economic or social condition and indispensable for the exercise of other human rights.*

4.2. The NWHP be developed in a human rights framework consistent with Article 12 and General Comment 14 (the right to the highest attainable standard of health) of the *International Covenant on Economic, Social and Cultural Rights* (CESCR), ratified by Australia in 1975.

4.3. The NWHP make explicit linkages to the relevant international human rights treaties, norms and standards ratified by Australia which recognise women and girls right to health, in particular:

- *International Covenant on Economic, Social and Cultural Rights* (CESCR)
- *Convention on the Rights of Persons with Disabilities* (CRPD)
- *Convention on the Elimination of All forms of Discrimination Against Women* (CEDAW)
- *Convention on the Rights of the Child* (CRC)

4.4. ‘Freedom from discrimination’ be included as a principle underpinning the NWHP, in recognition that freedom from discrimination:

- is the key principle in international human rights law;
- is a critical component of the right to health;
- is central in the design, implementation, monitoring, and evaluation of health-related policies and programs; and,
- is essential for protecting the health status of women with disabilities and other marginalised and socially excluded groups.

4.5. ‘Participation in health-related decision-making’ be included as a principle underpinning the NWHP, in recognition that the right to participate in decision-making:

- is a guiding principle of all human rights and a critical component of the right to health;

6 See: [www.who.int/governance/eb/who_constitution_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf)

• should be an integral component of any national health policy, program or strategy;
• is essential for women with disabilities who are more often than not, excluded and ignored in policy, service and program development.

4.6. The NWHP give explicit priority to women with disabilities in recognition of the multiple discriminations they experience, the denial of the freedoms and entitlements necessary for their health, and in keeping with the Australian Government’s commitment and obligations under the CRPD to take positive action and extra measures to respect, protect, fulfil their rights.

4.7. Consistent with a human rights framework, and in keeping with Australia’s international human rights obligations, the NWHP should give priority to vulnerable and marginalised groups of women whose right to health is compromised by social exclusion and discriminatory practices. The priority groups should include:
   i. Women with disabilities;
   ii. Indigenous women;
   iii. Culturally and linguistically diverse (CALD) women;
   iv. Refugees and asylum seekers;
   v. Institutionalised women (including women in prisons);
   vi. Homeless women.

4.8. Consistent with a human rights framework, in keeping with Australia’s international human rights obligations, and in recognition of the conditions and contexts that deny vulnerable and marginalised groups of women their right to health, the NWHP should prioritise the following thematic issues:
   i. Violence;
   ii. Reproductive and sexual health;
   iii. Mental health;
   iv. Available, accessible, affordable and quality services;
   v. Economic health and well-being.

4.9. The realisation of the National Women’s Health Policy be facilitated through an adequately funded and resourced National Women’s Health Program, which includes a national research agenda focusing on the NWHP priorities.

4.10. In recognition of the right of women with disabilities to participate in health-related decision making, and acknowledging that women with disabilities have traditionally been excluded from national policy advisory structures, the Australian Government ensure that women with disabilities are represented on any national advisory structures to oversee implementation of the National Women’s Health Policy.
5. Women With Disabilities & the Right to Health

There are now more than 2 million women with disabilities in Australia, making up 20.1% of the population of Australian women. Women with disabilities in Australia represent one of the groups with the highest risk of poor health, and experience many of the now recognised social determinants of health. These include the markers of social exclusion\(^8\) - socioeconomic disadvantage, social isolation, multiple forms of discrimination, poor access to services, poor housing, limited access to and inadequate health care, and denial of opportunities to contribute to and participate actively in society.

Although there has been limited research in Australia on issues facing women with disabilities (including health), we know that women with disabilities experience multiple discriminations, major inequalities in health status, and significant disadvantage in the social determinants of those inequalities. Compared to non-disabled women, women with disabilities:

- 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;
- are more likely to be single parents.


5.1. Women with disabilities right to health under the CESCR

Women with disabilities have a fundamental right to health. This right is enshrined in a number of international human rights treaties to which Australia is a signatory. 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’ (WHO 2002). Health is also understood and recognised as ‘the fundamental right of every human being’ (WHO 2002) and ‘indispensable for the exercise of other human rights’ (UN 2000).

The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including

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\(^8\) Social exclusion is a process that deprives individuals and families, groups and neighbourhoods of the resources required for participation in the social, economic and political activity of society as a whole. This process is primarily a consequence of poverty and low income, but other factors such as discrimination, low educational attainment and depleted living environments also underpin it. Through this process people are cut off for a significant period in their lives from institutions and services, social networks and developmental opportunities that the great majority of a society enjoys (Vinson 2009)
sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection (including a variety of facilities and conditions) which provides equality of opportunity for people to enjoy the highest attainable level of health (UN 2000, Asher 2004).

The most authoritative interpretation of the right to health is outlined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (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. Unfortunately, Australia has not, to date, enacted any legislation to enshrine these rights.

Respecting the right of women with disabilities to health essentially requires the Australian Government to refrain from undertaking actions that directly or indirectly 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.

Protecting the right to health applies mainly to obligations of the Australian Government to make efforts to minimise risks to health and to take all necessary measures to safeguard women with disabilities from infringements of the right to health by third parties. In practice, this means that the Government is responsible for regulating the conduct of individuals and groups who are working in the non-governmental sector and for protecting the right of women with disabilities to health through legislative and other measures. 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 (Asher 2004, OHCHR 2008).

Fulfilling the right to health applies to positive measures that the Australian Government is required to take, such as by providing relevant services, to enable women with disabilities to enjoy the right to health in practice. It requires that all necessary steps be taken to ensure that the benefits covered by the right to health are provided and that appropriate legislative, administrative, budgetary, judicial, promotional and other relevant measures are adopted to ensure its full realisation. It also requires that special measures be taken to prioritise the health needs of women with disabilities (who are considered a vulnerable and/or disadvantaged group in society) (Asher 2004, OHCHR 2008).

The obligation to fulfil the right to health is commonly divided into the associated obligations to facilitate, provide and promote the right to health. This reflects the different types of responsibility that the Australian Government incurs to take positive measures to implement the right to health.

- **Facilitating** the right to health requires the Government to take positive measures that enable and assist women with disabilities to enjoy the right to health.
- **Providing** the right to health requires the Government to intervene when women with disabilities are unable, for reasons beyond their control, to realise the right to health themselves through the means at their disposal.
Promoting the right to health requires the Government to undertake actions that create, maintain and restore the health of women with disabilities. Health promotion is an important component of the measures necessary to fulfil the right to health. In order to enjoy the right to health, women with disabilities must have adequate and appropriate health-related information.

In May 2000, the Committee on Economic, Social and Cultural Rights, which monitors the CESCR, adopted a General Comment on the right to health, 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, 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. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels (WHO 2002, Gruskin et al 2007).

CESCR General Comment 14 (the right to the highest attainable standard of health) sets out four criteria by which to evaluate the right to health:

3.1. **Availability:** Functioning public health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity. This should include the underlying determinants of health, such as safe and potable drinking-water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel, and essential drugs.

3.2. **Accessibility:** Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

   (a) **Non-discrimination** - Health facilities, goods and services must be accessible to all, in law and in fact, without discrimination on any of the prohibited grounds.

   (b) **Physical accessibility** - Health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as persons with disabilities, ethnic minorities and indigenous populations, women, children, adolescents, older persons, and persons with HIV/AIDS, including in rural areas.

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(c) **Economic accessibility (affordability)** - Health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all.

(d) **Information accessibility** – Accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

3.3. **Acceptability:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

3.4. **Quality:** Health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

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**“The right to health”**

**Underlying determinants**
- water, sanitation, food, nutrition, housing, healthy occupational and environmental conditions, education, information, etc.

**Health-care**

**AAAQ**
- Availability, Accessibility, Acceptability, Quality

(General Comment No. 14 of the Committee on Economic, Social and Cultural Rights)
5.2. Women with disabilities right to health under the CRPD

The social exclusion and discrimination faced by people with disabilities has increasingly been recognised as a human rights issue. A paradigm shift, from a medical and charity based welfare model of disability, to today's rights based model, acknowledges the movement to link disability issues to a full range of civil, political, economic, social and cultural rights (ILO 2007). The human rights framework recognises people with disabilities as having the same rights as people without disabilities. A rights based approach also recognises that equal treatment, equal opportunity, and non-discrimination provide for inclusive opportunities for women and men with disabilities in mainstream society (WWDA 2008). This rights based approach is most clearly articulated in the UN Convention on the Rights of Persons with Disabilities (CRPD) – which aims to ensure that persons with disabilities enjoy human rights on an equal basis with others. The CRPD was adopted by the United Nations General Assembly in December 2006 and opened for signature in March 2007. It was ratified by the Australian Government on July 2008, and entered into force in Australia on August 2008.

The CRPD is a complement to existing international human rights treaties. It does not recognise any new human rights of people with disabilities, but rather clarifies the obligations and legal duties of States to respect and ensure the equal enjoyment of all human rights by all people with disabilities. The Convention identifies areas where adaptations have to be made so that people with disabilities can exercise their rights and areas where the protection of their rights must be reinforced because those rights have been routinely violated. It also establishes universal minimum standards that should apply to everyone and that provide the basis for a coherent framework for action (UN 2007, ARHC 2007).

The CRPD 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 States Parties to take positive action and measures to ensure that women and girls with disabilities enjoy all human rights and fundamental freedoms (Article 6).

The right to health is addressed specifically in the CRPD (Article 25). It requires States to: recognise that people with disabilities have the right to the highest attainable standard of health; ensure that people 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.

5.3. Women with disabilities right to health under CEDAW

Access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), ratified by the Australian Government in 1983. Article 12 requires states to eliminate discrimination in access to health services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement, and the post-natal period. In 1999, the Committee on the Elimination of Discrimination against Women elaborated a general recommendation on Article 12 of the Convention. Key points include:
States parties should implement a comprehensive national strategy to promote women’s health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services.

States parties should allocate adequate budgetary, human and administrative resources to ensure that women’s health receives a share of the overall health budget comparable with that for men’s health, taking into account their different health needs.

States parties to the Convention are urged, in particular, to:

- Place a gender perspective at the centre of all policies and programs affecting women’s health and involve women in planning, implementing and monitoring the provision of health services to women;
- Remove all barriers to women’s access to health services, education and information, including in the area of sexual and reproductive health, and allocate resources for programs to prevent and treat sexually transmitted diseases including HIV/AIDS among adolescents;
- Prioritise the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion;
- Monitor the provision of health services to women by public, non-governmental and private organisations, to ensure equal access and quality of care;
- Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;
- Ensure that the training curricula of health workers includes comprehensive, mandatory, gender-sensitive courses on women’s health and human rights, in particular gender-based violence.


5.4. The denial of women with disabilities right to health

It is clear from the internationally endorsed position of what constitutes the right to health (including the criteria used to measure realisation of the right to health) that Australian Governments have, to date, failed consistently in their obligations to respect, protect, and fulfil the rights of women with disabilities, and in doing so, have denied disabled women the freedoms and the entitlements for health. This denial of rights finds clear expression through the many fundamental human rights infringements of women with disabilities still prevalent in Australia today. In this era of human rights, and in a country where the current Federal Government has expressly stated its commitment to ‘promote human rights and the fundamental equality of all people’ (McClelland 2008), women with disabilities:

- are denied their right to bodily integrity through a failure to legislate to prohibit the practice of forced sterilisation except in circumstances of threat to life;
• are denied their right to control their own bodies and to be free from interventions – evidenced by the widespread practices of menstrual suppression, forced contraception and coerced abortion;

• are denied the right to experience their sexuality, and to have sexual relationships;

• are denied their right to reproductive freedom in a myriad of other ways - 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, poorly managed pregnancy and birth;

• are denied their right to found and maintain a family, experiencing discriminatory attitudes and widely held prejudicial assumptions which question their ability and indeed, their right to experience parenthood;

• remain invisible and ignored in maternity, obstetric and related health care policies, programs and services;

• face overt discrimination and inequitable access to assisted reproductive technologies;

• have their babies and children removed by child welfare authorities without evidence of abuse, neglect and/or parental incapacity;

• lose their children in custody disputes simply because they are women with disabilities;

• are denied adequate support services for all aspects of pregnancy and parenting;

• battle against political agendas and social commentaries which cast their children as ‘young carers’ at risk of parentification and themselves as burdens of care;

• have less access to breast and cervical screening programs and services than any other group of women yet are ignored in these policies, services and programs;

• remain largely ignored in Australian health related research, legislation, policies, and services;

• experience poverty, un/underemployment, inaccessible or inappropriate housing arrangements and inaccessible public environments, social isolation, multiple forms of discrimination, poor access to services, heightened vulnerability to violence and abuse;

• are denied their right to freedom from exploitation, violence and abuse – experiencing alarmingly high rates of violence and abuse yet excluded from violence prevention legislation, policies, services and supports;

• experience serious violations of the right to an adequate standard of living, including adequate housing;
• are marginalised, excluded or ignored in decision-making processes which affect their lives.

5.5. Women with disabilities right to health & the NWHP

The Australian Government has a responsibility to develop national health policies and legislation 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. In this context, and particularly in light of the Australian Government’s commitment to take positive action and measures to ensure that women and girls with disabilities enjoy all human rights and fundamental freedoms (CRPD Article 6), WWDA strongly recommends that the National Women’s Health Policy be developed in a framework of human rights.

A rights based approach in this context refers to the processes of:

• using human rights as a framework for health development;
• assessing and addressing the human rights implications of any health policy, program or legislation;
• making human rights an integral dimension of the design, implementation, monitoring and evaluation of health-related policies and programs in all spheres, including political, economic and social.
Substantive elements to apply to the National Women’s Health Policy in this framework should include:

- Safeguarding human dignity;
- Making the attainment of the right to the highest attainable standard of health the explicit ultimate aim;
- Prioritising vulnerable, marginalised and/or excluded population groups;
- Ensuring the health system is made accessible to all, particularly marginalised groups;
- Utilising a gender perspective;
- Ensuring equality and freedom from discrimination, advertent or inadvertent, direct or indirect;
- Disaggregating health data for disability (as well as for all marginalised groups as itemised in 4.7);
- Ensuring adequately supported, meaningful and effective consumer/community participation;
- Promoting and protecting the right to education and the right to seek, receive and impart information concerning health issues;
- Respecting the right to privacy in relation to personal health data;
- Making explicit linkages to international human rights norms and standards;
- Articulating the concrete government obligations to respect, protect and fulfil human rights;
- Identifying benchmarks and indicators to ensure monitoring of the progressive realisation of rights in the field of health;
- Increasing transparency in, and accountability for, health as a key consideration at all stages of program development.

(Asher 2004, WHO 2002)
6. Principles to underpin the new NWHP

The NWHP Consultation Discussion Paper identifies five principles as a basis for the development of the new NWHP:

- Gender equity;
- Health equity between women;
- A focus on prevention;
- A strong and emerging evidence base; and
- A lifecourse approach.

In keeping with a human rights approach to health, and reflecting Australia’s core obligations under the international human rights treaties it has ratified, WWDA proposes that the following principles - critical components of the right to health and of great immediacy to women with disabilities - be included as a basis for the development of the new NWHP:

- Freedom from discrimination; and,
- Participation in health-related decision-making.

6.1. Gender Equity

WWDA supports gender equity as a principle underpinning the NWHP. Women experience multiple and compounding forms of health-related discrimination throughout the course of their lives, and this is especially the case for women with disabilities.

Gender equity is an essential component of the right to health, and is consistent with the international human rights treaties ratified by Australia. CESCR General Comment 14 (20) clearly articulates the need for Governments to 'integrate a gender perspective in their health-related policies, planning, programs and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health’.

CESCR General Comment 14 (21) gives clear direction regarding the need to develop a comprehensive national strategy for promoting women's right to health throughout their life span. It recommends that such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, including protecting women from domestic violence. It further stresses that the realisation of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. The importance of preventive, promotive and remedial action to shield women from the impact of practices and norms that deny them their full reproductive rights, is also highlighted.
General Recommendation 24 of the Convention on the Elimination of Discrimination Against Women (CEDAW) also clearly articulates the need for governments to implement a comprehensive national strategy to promote women's health throughout their lifespan, aimed at both the prevention and treatment of ill health, as well as responding to violence against women, and ensuring universal access for all women to a full range of high-quality and affordable health care.

In its concluding comments to 'Women In Australia' (the combined 4th and 5th reports of the Australian Government to the UN on the implementation of CEDAW, the UN CEDAW Committee (2006) noted its concern that:

‘………….the health needs of disabled women are inadequately met due to the lack of special equipment and other infrastructure.……..The Committee recommends that the State Party develop the necessary infrastructure to ensure that disabled women have access to all health services.’

The Convention on the Rights of Persons with Disabilities (CRPD) gives clear direction regarding women with disabilities and health. Specifically Article 6 on women with disabilities states:

States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.

States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

Article 25 of the CRPD (Health) requires states to recognise that people with disabilities have the right to the highest attainable standard of health; requires states to ensure that people with disabilities have access to the full range of generic health care services and programs, as well as to any necessary specialised health services; and requires states to prohibit discrimination on the ground of disability in the provision of health and life insurance.

6.2. Health equity between women

Efforts to promote greater equity in health require political leadership to prioritise the rights of vulnerable and socially excluded groups in policy and in practice. Equity is a fundamental principle of a human rights approach to health. WWDA strongly supports the inclusion of ‘health equity between women’ as a principle to underpin the NWHP.

It is internationally acknowledged that the right to health is dependent upon, and contributes to, the realisation of a range of other human rights, many of which are now recognised as underlying determinants of health. Examples include: rights to work, education, housing, an adequate standard of living, food, participation, information, and more. There are multifaceted links between health and human rights (WHO 2002). For example:

• violations or lack of attention to human rights can have serious health consequences;
• health policies and programs can promote or violate human rights according to the ways they are
designed or implemented;
• vulnerability to, and the impact of poor or ill health can be reduced by taking steps to respect,
protect and fulfil human rights.

Women with disabilities in Australia face many violations (and denials) of their human rights – all of
which clearly impact on their right and capacity to achieve the highest attainable standard of health. The
following examples demonstrate the inequities experienced by women with disabilities in claiming their
right to health.

6.2.1. The right to freedom from exploitation, violence and abuse

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 (UN 2006, UNFPA 2005, UN 2008, WWDA 2008). 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.

The nature of violence against women and girls with disabilities in Australia encompasses a wide range of
injustices and maltreatment. They experience, and are greatly at risk of violence and abuse due to
structural, cultural and contextual issues, including the entrenched social exclusion they experience.
Issues of abuse, neglect, discrimination and omission often provide the conditions and contexts that deny
women with disabilities their human rights and also lead to violence10.

Regrettably, in Australia violence against women and girls with disabilities continues in a culture of
silence, denial and apathy (Raye 1999). Compared to other women, women with disabilities:
• experience violence at higher rates and more frequently;
• are at a significantly higher risk of violence;
• have considerably fewer pathways to safety;
• are at particular risk of severe forms of violence;
• tend to be subjected to violence for significantly longer periods of time;
• experience violence that is more diverse in nature; and,
• experience violence at the hands of a greater number of perpetrators;
• are not believed when they report experiences of violence;
• are less likely to report experiences of violence.


Despite these facts, in Australia, legislation, policy and services for women with disabilities experiencing,
or at risk of experiencing violence, are limited at best and non-existent at worst (WWDA 2007). Current
areas of Australian legislation, policy and services which focus on the broader issue of violence against
women, indicate a prevailing lack of awareness about the complexity of issues facing women with

10 For a detailed analysis of the issue of violence against women with disabilities, go to: www.wwda.org.au/viol.htm
disabilities in relation to violence – a situation which perpetuates and legitimises not only the multiple forms of violence perpetrated against them, but also the failure of governments to recognise and take action on the issue (WWDA 2007).

The duty of Governments to respect, protect, fulfil and promote human rights with regard to violence against women includes the responsibility to prevent, investigate and prosecute all forms of, and protect all women from such violence and to hold perpetrators accountable (UN 2006, emphasis added). Yet, successive Australian Governments have shown little interest in, and taken minimal action to address, any aspect of the ‘epidemic’ that is violence against women with disabilities. For example, the lack of Australian research and data collection on violence against women with disabilities is an issue that has been consistently articulated to Government for over a decade\(^1\), and highlighted by the United Nations Committee on the Elimination of All forms of Discrimination Against Women (CEDAW)\(^2\). Yet in 2009, the situation remains largely unchanged. This neglect was unfortunately perpetuated in 2008 by the Australian Government’s establishment of a National Council to Reduce Violence Against Women and their Children without direct representation of women with disabilities, and demonstrated a lack of understanding of inclusive consultation principles. The assumption that the non-disabled can be delegated to speak on behalf of women with disabilities has been universally discredited.

Violence has a profound effect on the health of women with disabilities. The responsibility of the Australian government to address violence against women and girls with disabilities is explicitly delineated in a number of the human rights treaties it has ratified, particularly the CRPD.

Article 16 of the CRPD (Freedom from exploitation, violence and abuse) requires states to ensure that people with disabilities are not subject to any form of exploitation, violence or abuse; requires states to protect women, children and older people with disabilities from gender and age aggravated exploitation, violence and abuse; requires states to institute measures to ensure the detection, investigation and prosecution of exploitation, abuse and neglect of people with disabilities and to promote the physical and psychological recovery and social reintegration of victims.

It would be a denial of the principles of ‘health equity between women’ and ‘participation in health-related decision making’, if women with disabilities are not directly included in the national consultation process for the further development of either the National Violence Prevention Plan or the NWHP.

### 6.2.2. The right to bodily integrity

International treaties in the human rights field give people the right to bodily integrity without discrimination – and this clearly includes people with disabilities. The right to bodily integrity (including the right to control one’s own body), is a fundamental pre-requisite for health. Despite this, girls and

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\(^1\) The Australian Government has to date, rejected calls for its national Safety Survey/s (conducted to gather information about women’s and men’s experiences of violence) to include an indicator for disability, in order to enable data collection on violence against women with disabilities. Reasons given by the Government for excluding disability include sample size (12,000 in 2005) and survey methodology: ‘as women are most at risk of experiencing violence from someone known to them, we are aware of the sensitivities involved in surveying women with disabilities about their experience(s) of violence in the presence of a carer, who in some circumstances may be the perpetrator of violence’ (Flanagan 2004).

women with disabilities in Australia are denied their right to bodily integrity through the ongoing practice of involuntary or forced sterilisation.\(^\text{13}\)

Sterilisation is a procedure that is notorious for having been performed on young women with disabilities for various purposes ranging from eugenics, through menstrual management and personal care, to the prevention of pregnancy, including pregnancy as a result of sexual abuse. Indeed, the overwhelming majority of sterilisations and certainly all the cases heard by relevant Australian courts and tribunals, involve girls with intellectual disabilities (Brady et al 2001).

Debates about sterilisation are commonly advanced by legislators, medical and legal or disability 'professionals'. In these instances the vocabulary used includes terms such as non/therapeutic, in/voluntary, un/authorised, un/lawful, and non/consensual sterilisation. Each of these terms derive from particular perspectives which take as their starting point the gendered, disablist view that the menstruation, sexuality and reproductive lives of disabled women and girls are the legitimate domain of legal, medical or other experts to determine. The work of WWDA has clearly demonstrated that these terms and the underlying assumptions that drive their use actively undermine the lived experience of women and girls with disabilities and creates the conditions for the infringement of their human rights. This kind of terminology sanitises the nature of a forced or coerced sterilisation which occurs without consent. For the women and girls affected, it obscures the fact that they have undergone a medical procedure, often at a very young age, which removes non-diseased body parts which are essential to their on-going health. It conceals the violation of their rights to bodily integrity and to bear children and renders insignificant the life long physical, social and emotional consequences which result (Dowse 2004).

Despite the many international human rights treaties and instruments ratified by Australia, and despite strong condemnation of forced sterilisation from many sources including women's organisations, disability rights organisations and international and national human rights bodies\(^\text{14}\), women and girls with disabilities in Australia still experience, and face a serious threat of forced sterilisation. For more than a decade, WWDA has called on the Australian Government to take all necessary steps to stop the forced sterilisation of women and girls with disabilities. This work has included calls for the Australian Governments to:

- develop universal legislation which prohibits sterilisation of any child unless there is a serious threat to heath or life;
- address the cultural, social and economic factors which drive the sterilisation agenda;
- commit resources to assist disabled women and girls and their families and carers to access appropriate reproductive health care; and,
- create the social context in which all women and girls are valued and respected (Dowse 2004, WWDA 2007, 2009).

\(^\text{13}\) Forced sterilisation refers to the performance of a procedure which results in sterilisation in the absence of the consent of the individual who undergoes the procedure. This is considered to have occurred if the procedure is carried out in circumstances other than where there is a serious threat to health or life. This approach to naming sterilisation is underpinned by a human rights perspective which holds that all individuals have the right to bodily integrity (Dowse & Frohmader 2001).

WWDA’s position has been endorsed by the UN High Commissioner for Human Rights; UNICEF; and the Child Rights Information Network (CRIN). In 2008, WWDA’s position was endorsed by more than 100 Australian non-government organisations in Australia’s NGO Submission to the UN Committee on Economic, Social and Cultural Rights.

Despite the many international human rights treaties and instruments ratified by Australia, and despite an Australian Government which claims to be committed to ‘work to promote human rights and the fundamental equality of all people’ (McClelland 2008), Australian legislation still fails to prohibit forced sterilisation of girls with disabilities. The Australian Governments have essentially dismissed the issue, deciding there is little worth in protecting the fundamental right of women and girls with disabilities to bodily integrity.

The ongoing practice of forced sterilisation of women and girls with disabilities is in clear breach of a number of human rights treaties to which Australia is a party, including the recently ratified CRPD. Article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment) requires states to ensure that people with disabilities are not subject to torture or to cruel, inhuman or degrading treatment or punishment; and requires states to ensure that people with disabilities are not subject to medical or scientific experimentation without their consent. Article 17 (Protecting the integrity of the person) requires states to ensure respect for the physical and mental integrity of people with disabilities on an equal basis with others. The forced sterilisation of women and girls with disabilities contravenes these and a number of other CRPD Articles.

6.2.3. The right to found a family and to reproductive freedom

Reproductive rights and freedoms rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions regarding reproduction free of discrimination, coercion and violence (ICPD 1994). For women with disabilities, reproductive rights and freedoms include the right to bodily integrity, the right to procreate, the right to sexual pleasure and expression, the right for their bodies to develop in a normal way, the right to sex education, to informed consent regarding birth control, to terminate a pregnancy, to choose to be a parent, and to access reproductive information, resources, medical care, services, and support (WWDA 2009).

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15 See for example: www.wwda.org.au/steriladv07.htm#resp
17 In March 2008, the Standing Committee of Attorney’s General (SCAG) decided that ‘there would be limited benefit in developing model legislation’ and the issue of sterilisation of intellectually disabled minors was removed from the SCAG Agenda. Ministers also agreed to ‘review current arrangements to ensure that all tribunals or bodies with the power to make orders concerning the sterilisation of minors with an intellectual disability are required to be satisfied that all appropriate alternatives to sterilisation have been fully explored and/or tried before such an order is made’. There is no evidence to date that these ‘reviews’ have been carried out.
18 See for example: CESCR Articles 10, 12; ICCPR Articles 7, 17, 23; CEDAW Articles 2, 12, 16; CRC Articles 2, 6, 12, 19, 23, 24, 36, 37; CAT Articles 2, 4, 14, 16
19 See for example: CRPD Articles 4:3, 6, 7, 8b, 12-17, 22, 23, 25, 26, 28.
In international human rights law, the family is recognised as the basic unit of society and as such is entitled to receive comprehensive protection and support. This includes the need for Governments to take effective action to eliminate all forms of coercion and discrimination in policies and practices, and in the case of women with disabilities, ‘provide assistance in the exercise of their family and reproductive rights and responsibilities’ (ICPD 1994).

Although the right to ‘found a family’ and to ‘reproductive freedom’ is clearly articulated in a number of international human rights instruments to which Australia is a signatory, for many women with disabilities in Australia, such fundamental human rights are not realisable. Instead, women with disabilities have traditionally been discouraged or denied the opportunity, to bear and raise children (Prilleltensky 2003). They have been, and continue to be perceived as asexual, dependent, recipients of care rather than care-givers, and generally incapable of looking after children (Collins 1999, Farber 2000, Prilleltensky 2003, McKeever et al 2003, Smeltzer 2007, McKay-Moffat 2007, Radcliffe 2008).

In Australia, the denial of the right to reproductive freedom and the right to found and maintain a family takes many forms for women with disabilities, impacting directly and indirectly on their health status. Examples include:

- coerced abortions, pressure to undergo tubal ligations and hysterectomies, and unlawful sterilisation;
- forced contraception through the use of menstrual suppressant drugs;
- systematic denial of appropriate reproductive health care and sexual health screening;
- limited contraceptive choices, including a focus on menstrual control;
- denial of, discrimination and inequitable access to, assisted reproductive technologies;
- invisibility in maternity, obstetric and related health care policies, programs and services, including poorly managed pregnancy and birth;
- the denial of rights to be a parent based solely on the fact of disability;
- removal of babies/children from women with intellectual disabilities, women with mental health illnesses and women with psychiatric disabilities;
- discriminatory attitudes and widely held prejudicial assumptions which question their ability and indeed, their right to experience parenthood;
- lack of appropriate, adapted equipment to help disabled women in their parenting;
- lack of financial support, coupled with the higher cost of parenting with a disability;
- lack of, and difficulty in accessing, appropriate parenting information, services and support in a host of areas – including preconception, pregnancy, birth, postpartum, and the varying stages of child rearing, as well as in areas such as adoption, assisted reproduction, and broader sexuality and reproductive health issues and care;
- political agendas and social commentaries which cast their children as ‘young carers’ at risk of parentification and themselves as burdens of care.

6.2.4. The right to health facilities, goods and services

The right to health is understood to include 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 (UN 2004). The right to health in all its forms and at all levels contains the following inter-related and essential elements:

• availability;
• accessibility – (encompassing non-discrimination, physical and information accessibility, and affordability);
• acceptability; and
• quality.

In Australia, women with disabilities experience significant difficulty accessing health information, care, support and services for the realisation of the highest attainable standard of health.

For many women with disabilities, the services and programs they require to realise their right to health are simply not available to them. 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 (Dowse and Frohmader 2001, WWDA 2004, Swift 2009). In many areas of Australia, breast and cervical cancer screening services are not available to women with disabilities, despite the fact that breast cancer is one of the most common cancers for females in Australia and one of the leading causes of death from cancer in females. Even where screening services are available, the vast majority of 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. 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 emergency housing in Australia is a critical issue impacting on the health of women with disabilities, yet remains largely ignored in violence prevention and health promotion responses at all levels.

Affordability is a major issue impacting on the ability of women with disabilities to access health facilities, goods and services. Women with disabilities throughout Australia bear a disproportionate burden of poverty and are recognised as amongst the poorest of all groups in society. Women with disabilities are less likely to be in paid work than other women, men with disabilities or the population as a whole. They are less likely than their male counterparts to receive adequate vocational rehabilitation or gain entry to labour market programs. Women with disabilities earn less than men with disabilities, are in the lowest income earning bracket, yet have more than three times the average yearly health care expenditures of other women (Blanchard & Hosek 2003). Even with the current concessions ostensibly afforded through bulk billing and pharmaceutical benefits to holders of Health Care Cards, the health of many women with disabilities is sub-optimal because the total cost of their health care is not affordable.

Accessibility is obviously of critical importance to women with disabilities in relation to their right to health. Policy makers, service providers and the broader community have limited understandings of accessibility, believing it requires only a ramp or an accessible toilet (WWDA 2007b). In fact accessibility
includes being able to receive all policy, service and program information in an accessible format. Experience in Australian health and community support services suggests that this kind of access is extremely limited in terms of both content that reflects the experiences of disabled women and format of information available, such as Braille, audio, Easy English and the use of telephone access relay services and sign interpreters. Another dimension of access includes being able to understand and meaningfully participate in the services and programs available. Again experience suggests that women with disabilities generally have limited input into the development of policies, services and programs, including information and education resources.

In Australia, women with disabilities experience significant difficulty accessing health information, care and services in relation to a wide range of women’s health issues, including: managing menstruation, contraception, exploitative relationships, violence, sexually transmitted diseases, sexual assault, menopause, late onset incontinence, osteoporosis, sexuality, reproductive health, self-management, fatigue, increased dependency, and parenting. In many cases, services and programs catering to the needs of women with disabilities in these areas are either absent or inaccessible.

There remain many, many barriers and impediments to women with disabilities in accessing health and related services, and it is outside the scope of this paper to cover them all. However, just some examples can be given in order to illustrate the multiple discriminations disabled women face in accessing a variety of facilities, goods services and conditions necessary for the realisation of the highest attainable standard of health:

- non-inclusive services 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, 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/issue;
- social isolation and segregation.

6.2.5. The right to work

Employment and working conditions have powerful effects on health equity. It is widely recognised that being in paid employment is a marker of social inclusion (Gillard & Wong 2007, UK Cabinet Office 2001, Gannon & Nolan 2005; 2006, Clarke 2006, Hayes & Gray 2008). 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 important for health. Like all members of the Australian community, women with disabilities have a fundamental right to employment. This right is enshrined in a number of international human rights
conventions to which Australia is a party. 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. In Australia, twenty-one per cent (21%) of men with disabilities are in full time employment compared to nine percent (9%) of women with disabilities. In any type of employment women with disabilities are more likely to be in low paid, part time, short term casual jobs (WWDA 2004).

It is widely acknowledged that unemployment and under-employment are associated with poorer health status. For many women with disabilities in Australia simply ‘wanting’ a job does not equate to ‘finding’ one. In order for women with disabilities to seek and retain employment, they need the elimination of discrimination and negative stereotypes from both a gender and disability perspective which compound their exclusion from support services, social and economic opportunities and participation in community life.

The social isolation which is a side effect of un/underemployment contributes to the high incidence of mental health issues as an additional complicating and debilitating factor in the management of a primary disability.

6.2.6. The right to an adequate standard of living, including adequate housing

The link between low socio-economic status and poor health has been well documented (WWDA 2005, CSDH 2008). Poor people are less healthy than those who are better off, whether the benchmark is mortality, the prevalence of acute or chronic diseases, or mental health. Women with disabilities throughout Australia bear a disproportionate burden of poverty and are recognised as amongst the poorest of all groups in society (WWDA 2006). Poverty is both a cause and a consequence of disability. Correlates of poverty, such as inadequate medical care and unsafe environments, significantly contribute to the incidence and impact of disability, and complicate efforts for prevention and response (UNICEF 2007).

The Disability Support Pension is inadequate to support women with disabilities. The setting of income support payment rates for women with disabilities has failed to take account of the non-optional, extra costs associated with disability. In 2004, the Senate Inquiry into Poverty and Financial Hardship (Commonwealth of Australia 2004) found widespread poverty among people with disabilities, and recommended that a new welfare allowance be introduced to address the extra costs associated with disability, such as the need for professional carers, special education and employment support. The Inquiry Report acknowledged that increased income alone would not overcome the many barriers facing people with a disability, but needs to be accompanied by changes in the areas of employment, health, education, housing and accommodation assistance, transport and information (Saunders 2006).


23 See Australian Labor Party (ALP) National Platform and Constitution 2007: ‘Labor is committed to achieving full employment, meaning that anyone who wants a job can find one within a reasonable time.’ (p11)

Adequate housing is universally viewed as one of the most basic human needs. Like all members of the community, women with disabilities have a fundamental right to a range of housing options. ‘Adequate housing’ comprises security of tenure, availability of services, affordability, habitability, accessibility, location and cultural adequacy (CESCR General Comment 4).

The indivisibility and interdependence of all human rights find clear expression through the right to housing. The full enjoyment of such rights as the right to human dignity, the principle of non-discrimination, the right to an adequate standard of living, the right to freedom to choose one’s residence, the right to freedom of association and expression (such as for tenants and other community-based groups), the right to security of person (in the case of forced or arbitrary evictions or other forms of harassment) and the right not to be subjected to arbitrary interference with one's privacy, family, home or correspondence is indispensable for the right to adequate housing to be realised, possessed and maintained by women with disabilities (OHCHR 2008).

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;
- 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;
- 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.

WWDA commends the current Australian Government initiatives to address the chronic lack of suitable public housing in Australia, but is apprehensive that lack of overarching policies to address the above factors in terms of the needs of women with disabilities will result in perpetuation of a discriminatory situation.

Despite the fact that Australia has affirmed its commitment to the right to adequate housing through ratification of various international human rights conventions, there remains a vast disparity between the standards set in these Conventions and the situation of women with disabilities with regard to their access to safe, available, affordable, habitable, accessible and inclusive housing.
6.3. Freedom from discrimination

WWDA strongly recommends that ‘freedom from discrimination’ be included as a principle underpinning the NWHP.

Freedom from discrimination is the key principle in international human rights law, and a critical component of the right to health. Non-discrimination is a well-established and integral component of nearly all human rights and is essential for protecting the health status of vulnerable and disadvantaged groups who bear a high proportion of health problems in any given society. Poverty is now recognised as a major adverse risk factor for health status worldwide. Discrimination, which can manifest itself in a complex variety of ways, is often directly or indirectly at the root of what makes individuals and groups vulnerable to poverty and ill-health. The principle of freedom from discrimination is central in the design, implementation, monitoring, and evaluation of health-related policies and programs (WHO 2009). The obligation to ensure non-discrimination requires specific health standards to be applied to particular population groups, such as women with disabilities.

CESCR General Comment 14 spells out that all states have an immediate obligation to ensure non-discrimination and that this duty is not subject to progressive realisation. Regardless of their level of development, all states are required to take immediate action to ensure non-discrimination in order to reduce existing health inequities within and between populations. This immediate and universal obligation prohibits:

any discrimination in access to health care and underlying determinants of health, as well as to the means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health (para 18:1).

The impact of discrimination is compounded when an individual experiences double or multiple discrimination, such as discrimination on the basis of sex and disability. As has been demonstrated earlier in this Submission, it is clear that women with disabilities in Australia experience multiple discriminations in the freedoms and the entitlements for health. In ratifying the CRPD and CEDAW, the Australian Government has acknowledged the multiple discriminations faced by women with disabilities, committed to prioritise women with disabilities as a group warranting specific attention, and committed to take positive action and measures to ensure that women and girls with disabilities enjoy all human rights and fundamental freedoms (Article 6). These obligations must be reflected in the NWHP.

6.4. Participation in health-related decision-making

WWDA strongly recommends that ‘participation in health-related decision-making’ be included as a principle underpinning the NWHP.

The right to participate in decision-making is a guiding principle of all human rights and an important component of working within a human rights framework. Individuals and groups have the right to
participate in decision-making processes that might affect their health and development. The *International Covenant on Civil and Political Rights* (ICCPR), ratified by Australia in 1980 states that:

> Every citizen shall have the right and the opportunity, without ... [discrimination] ... and without unreasonable restriction: ... to take part in the conduct of public affairs, directly or through freely chosen representatives (25).

CESCR General Comment 14 (11) interprets the right to health to include ‘the participation of the population in all health related decision making at the community, national and international levels’. It further states:

> The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people’s participation is secured by States (54).

The *Convention on the Rights of Persons with Disabilities* (CRPD) also clearly articulates the responsibility of governments to ‘promote actively an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others...’ (29:b).

A human rights approach to health emphasises that the effective and sustainable provision of health-related services can only be achieved if people participate in the design of policies, programs and strategies that are meant for their protection and benefit. The involvement of communities in setting priorities, and in designing, implementing and evaluating government programs, policies, budgets, legislation and other activities relevant to the right to health is not only a human right, but has been shown to increase the likelihood that the needs of the community will be met more effectively. Community action and involvement is the key to the empowerment that is essential to understanding and claiming human rights, including the right to health. Effective community action also contributes to achieving better health (Asher 2004).

Participation and empowerment go hand in hand. The human rights system identifies individuals and groups as claim-holders and States parties, which are governments, as duty-bearers. In this framework, individuals and groups who might otherwise be marginalised or socially excluded are provided with the tools to:

- adopt a legitimate voice in the public realm;
- participate in decision-making; and
- raise legitimate demands based on claiming their rights.

The right to participate in decision-making processes that might affect their health and development is critical for women with disabilities who are more often than not, excluded and ignored in policy, service
and program development. Such participation must be facilitated through access to adequate, affordable, accessible and quality representational training.

6.5. A strong and emerging evidence base

WWDA supports ‘a strong and emerging evidence base’ as a principle underpinning the NWHP, where such evidence is understood to include research and data collection (qualitative and quantitative) that complies with, and reflects Australia’s obligations to achieve better health for its citizens by respecting, protecting, and fulfilling rights.

In order to reveal information relevant to health and human rights, health research and data must be collected and analysed with adequate specificity to reveal information about, and differences between, population groups, with particular sensitivity to vulnerable groups. Accordingly, data needs to be disaggregated by relevant categories and variables, including disability.

A human rights approach to health places particular focus on, and prioritises, the needs of the most disadvantaged and vulnerable individuals and communities in a society. It is therefore essential that data used for monitoring the right to health be disaggregated so as to enable monitoring the status of, and changes within, these vulnerable groups. Among other things, disaggregated data can highlight the differential treatment of population groups in risk factors, exposures, manifestations, frequency and severity of ill health and disease, as well as government responses to these. Disaggregated health data can help determine which groups require, or are likely to require, additional attention; which groups are suffering from discrimination in access to health-related services or facilities; which practices and behaviours need to be promoted, supported, induced or changed; which service provisions need to be enhanced and in what ways; and what financial mechanisms are needed to ensure that those who need more attention and/or services actually receive more (Asher 2004).

Over the last decade, WWDA has found that one of the greatest difficulties in determining and substantiating the needs and human rights violations of women with disabilities is the acute lack of available gender and disability specific data in Australia - at all levels of Government and for any issue. There is also an alarming lack of Australian research on gender and disability issues, despite the multiple discriminations and human rights violations experienced by women and girls with disabilities in this country. This neglect in research of women with disabilities in Australia has been highlighted by the United Nations Committee on the Elimination of All forms of Discrimination Against Women (CEDAW)(2006).

Where survey design is such that the sample size will not yield a statistically significant population of women with disabilities, additional targeted surveying must be undertaken to supplement the information gathered from broader data collection research.

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 (Morris & Wates 2006, Preston 2009, Olkin et al 2006). 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 with disabilities and their right to health results in
invisibility and marginalisation in society, which invariably leads to a critical lack of resources for this group (Kirshbaum 2000).

Comprehensive research and data collection encompasses both quantitative and qualitative methodologies and in the Australian context, includes national, state/territory, regional, local and service levels. Of paramount importance, is the need for all aspects of research to include women with disabilities. This includes the funding and empowerment of organisations and groups of women with disabilities, to undertake their own research in order to include their own experiences of issues, and their recommended strategies to address these issues (Calderbank 2000, DAA 1997), along with a recognition of the value of both qualitative and quantitative data.

**6.6. A focus on prevention, and a lifecourse approach**

WWDA supports a ‘focus on prevention’ and a ‘lifecourse approach’ as a principle underpinning the NWHP. Both these principles are consistent with CESCR General Comment 14 (21) which states:

> To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women’s right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women’s health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.
7. Priorities of the new NWHP

A human rights approach to health places particular focus on, and prioritises, the needs of the most disadvantaged and vulnerable individuals and communities in a society, as well as thematic issues of major concern (OHCHR 2002). In this context, WWDA is of the view that the following groups and thematic issues warrant inclusion as priorities in the NWHP.

7.1. Priority Groups

7.1.1. Women With Disabilities

There are now more than 2 million women with disabilities in Australia, making up 20.1% of the population of Australian women. Women with disabilities in Australia represent one of the groups with the highest risk of poor health, and experience many of the now recognised and experience many of the now recognised social determinants of health. These include the markers of social exclusion - socioeconomic disadvantage, social isolation, multiple forms of discrimination, poor access to services, poor housing, limited access to and inadequate health care, and denial of opportunities to contribute to and participate actively in society. Women with disabilities experience widespread and serious violations of their human rights, as well as failures to promote and fulfil their rights.

Although there has been limited research in Australia on issues facing women with disabilities (including health), we know that women with disabilities experience multiple discriminations, major inequalities in health status, and significant disadvantage in the social determinants of those inequalities. Compared to non-disabled women, women with disabilities:

- 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;
- are more likely to be single parents.


In ratifying the CRPD and CEDAW, the Australian Government has acknowledged the multiple discriminations faced by women with disabilities, agreed to prioritise women with disabilities as a group warranting specific attention, and committed to take positive action and measures to ensure that women
and girls with disabilities enjoy all human rights and fundamental freedoms (Article 6). These obligations must be reflected in the NWHP.

7.1.2. Indigenous Women

Indigenous women in Australia experience higher rates of disability and long-term health conditions and hospitalisation than do non-indigenous women. In 2006, 4% of indigenous people were identified as needing assistance with core activities (self-care, mobility or communication) some or all of the time. After taking account of age differences between the indigenous and non-indigenous populations, the level of need for assistance among indigenous women overall was estimated as twice as high as that among non-indigenous women (AIHW 2008). This is likely to be a gross underestimate.

The burden of disease experienced by indigenous Australians is estimated to be two-and-a-half times greater than the burden of disease in the total Australian population. Long-term health conditions responsible for much of the ill-health experienced by indigenous people include circulatory diseases, diabetes, respiratory diseases, musculoskeletal conditions, kidney disease, and eye and ear problems. For most of these conditions, indigenous Australians experience an earlier onset of disease than other Australians (AIHW 2008). Life expectancy for indigenous Australians is 59 years for males and 65 years for females, compared with 77 years for all males and 82 years for all females, a difference of around 17 years (AIHW 2008, HREOC, 2008).

Contributing generally to the poor health status of many Indigenous women are: social factors such as cultural disempowerment, dispossession, dislocation and discrimination; disadvantages in education, housing, income and employment; violence and abuse; and physical environmental factors. These social, economic and environmental disadvantages underlie specific health risk factors (such as smoking, obesity, physical inactivity and high blood pressure), and, often contribute to lack of access to good quality health care (Australian Indigenous HealthInfoNet 2008).

7.1.3. Culturally & Linguistically Diverse Women (CALD)

Culturally and linguistically diverse women (CALD) face numerous societal prejudices and barriers in relation to health and social inclusion. The following highlights just some of the issues identified by CALD women in relation to health and wellbeing:

- health professionals lack skills and sensitivity to specific cultural differences particularly knowledge of health practices of some ethnic groups;
- lack of knowledge of existing services and how to access them;
- shortage of counselling services for refugee women;
- access to preventative testing programs, such as pap smear testing that was seen as limited for some groups a many women had never been tested in their country of origin.
- poor dental care due to long waiting lists;
- severe shortage or lack of female bilingual health professionals and paraprofessionals.
- lack of English language skills - can drastically restrict access to services, employment and training opportunities;
- limited availability of interpreting services - improper or lack of usage of interpreter services by service providers; long waiting times for interpreters; wrong interpreters provided; lack of professional interpreters especially when dealing with complex health issues.

Particularly disturbing is the frequency with which new and emerging CALD women relate stories of discrimination and racism against them, their children and families. Central to health and well-being is a sense of belonging and inclusion in society (Messimeri-Kiandis, 2004).

### 7.1.4. Refugees & Asylum Seekers

Long-term detention, by its nature, is widely recognised as having a seriously debilitating effect on the health of detainees. Specific health problems facing refugees can include: psychological disorders such as post traumatic stress disorder, anxiety, depression and psychosomatic disorders; poor oral health; delayed growth of children; or under recognised and under managed hypertension, diabetes. For refugees and humanitarian visa holders, these mental health issues may actually be compounded by experiences of immigration detention and uncertainty over their future in Australia (Balgi et al 2008, Sobhanian et al 2006). Recent Australian research has found that mental health of detainees deteriorates significantly during immigration detention, and numerous instances of self-harming behaviour have occurred, including among children (Balgi et al 2008).

Despite previous recommendations from the Committee against Torture and repeated calls by the Australian Human Rights Commission and other human rights bodies, the Australian Government maintains a policy of indefinite mandatory detention of asylum-seekers (HRLRC 2008).

### 7.1.5. Institutionalised women

The term institutionalisation is used to describe the adverse psychological effects on individuals who have spent long periods living in institutions such as prisons, remand centres, juvenile detention centres, aged care/nursing home facilities, psychiatric units, detoxification/rehabilitation centres, children’s homes and refugee detention centres (WCHM 2009).

According to Wybron & Dicker (2009), there is significant evidence to suggest that institutionalisation has a profoundly negative impact on people’s health and well-being, which continues long after they return to the community. The health status of Australian women with lived prison experience for example, is frighteningly poor, with research showing that they are more likely to have mental health issues, drug and alcohol problems and to have experienced physical, emotional and sexual violence than women in the broader community. The gross over representation of Indigenous women in Australian prisons, is a reflection of the multiple discriminations they face, and becomes a contributory factor to their poor health outcomes both during and post incarceration.

Women with disabilities living in institutions are clearly one of the most vulnerable groups in our society. Women with disabilities in institutions continue to live in appalling conditions and experience ongoing abuse and degradation of their basic human rights. Institutional care for women with disabilities can include an array of living arrangements and related programs, such as group homes, hospitals, foster care, residential schools, day support programs, respite care settings, prisons and a host of other
environments. Extensive and documented research of more than 30 years points to the fact that institutions and institutionalised living are in themselves, causal factors in the presence and perpetration of frequent and sustained forms of violence against persons who are devalued and vulnerable, and create a climate in which violence goes unreported (WWDA 2007b). Institutions have a long history of violence and it is clear that an entrenched culture of violence continues to exist in both public and private institutions today (WWDA 2008).

### 7.1.6. Homeless women

The most widely accepted definition of homelessness in Australia describes three kinds of homelessness:

- **Primary homelessness**, such as sleeping rough or living in an improvised dwelling;
- **Secondary homelessness**, which includes staying with friends or relatives and with no other usual address, and people in specialised homelessness services;
- **Tertiary homelessness** includes people living in boarding houses or caravan parks with no secure lease and no private facilities, both short and long-term (Chamberlain & Mackenzie 1992).

Seeking attention for health care becomes a low priority for women who do not know where they or their children will sleep that night, or where they will find their next meal. Just some of the health and well-being issues for homeless women include:

- poor nutrition, not enough food to eat; lack of healthy foods;
- high prevalence of violence, including sexual violence; high lifetime rates of childhood physical and sexual abuse;
- higher incidence of mental illnesses depression, anxiety and stress; substance abuse;
- high level of unmet need for mental health services;
- experience more physical conditions including hypertension, gastrointestinal problems, neurological disorders, arthritis and other musculoskeletal disorders, chronic obstructive pulmonary disease, and peripheral vascular disease;
- higher risk of pregnancy complications due to lack of prenatal care, poor nutrition, stress, and exposure to violence;
- can become pregnant due to victimisation, economic survival, lack of access to contraceptives, uncertain fertility, and desire for intimacy;
- common illnesses (such as colds or the flu) that are easily treated in the general population often escalate to more severe problems in the homeless population;
- are twelve times more likely than individuals in stable housing to have dental problems;
- poor access to sexual health and cancer screening services.

(Silver & Pañares 2000)

Such close linkages between homelessness and poor health means that cross-referencing between the NWHP and the National Homelessness Strategy must be a priority.

Women with disabilities are over-represented in the factors that contribute to homelessness, and have been identified as one of the most vulnerable groups to homelessness or risk of homelessness in Australia (WWDA 2009). Despite this, women with disabilities remain invisible and ignored in responses to homelessness at all levels.
7.2. Priority Themes

7.2.1. Violence

A human rights approach to health recognises that gender-based violence, or ‘violence that is directed against a woman because she is a woman or that affects women disproportionately’, is a priority public health issue and, more specifically, a form of discrimination against women. Gender-based violence is not only a serious form of discrimination but also a widespread cause of ill-health among women and a violation of women’s right to health. Governments have an obligation to protect women against violence by third parties, including domestic violence and abuse, sexual assault, and sexual harassment in the workplace.

CESCR General Comment 14 stipulates that a state’s failure to protect women against violence by failing to investigate and prosecute those who attack them, including men who commit domestic violence, is a violation of its obligation to protect the right to health. However, although governments are obliged to regulate conduct in the private sector so as to protect the right to health, violence against women continues to be tolerated, disregarded and remains unpunished throughout the world.

As has been highlighted earlier in this paper, 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.

7.2.2. Reproductive and sexual health

Reproductive and sexual health are a critical component in a human rights approach to the right to health, and are issues that affect women at every life stage.

In 1994 the International Conference on Population and Development (ICPD), held in Cairo, approved by consensus a Programme of Action (PoA) to guide governments and international co-operation in the field of population and development over the next twenty years. The PoA was adopted by the 179 UN member states participating in the Conference, including Australia. The Programme of Action sets out the context and content of reproductive rights:

‘Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.’

‘Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of
men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programs should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so.

This definition has since provided authoritative standards for implementing the right to reproductive health at all levels - internationally, regionally, nationally, and locally — and is used as a framework for legislative and policy change worldwide (Asher 2004).

According to Women’s Health Victoria25:

- 16.9% of Australian women have reported that they had been diagnosed with a sexually transmitted infection or blood-borne virus at some stage of their life.
- Chlamydia notifications continue to rise. The implications these have for women’s health, particularly reproductive health and fertility, must be addressed.
- There is no coordinated approach to teaching and promoting young people’s sexual and reproductive health across health and education.
- Predominantly, women bear the primary responsibility for contraception.
- One in five Australian women has been coerced into unwanted sex, and because of this is more likely to experience psychological distress.
- Lack of access to public termination services impedes women’s control over their reproductive health, particularly in rural and regional areas.
- Sexual and reproductive health is interlinked with many other aspects of health - particularly mental health - and contributes to the overall health and wellbeing of the individual.

For women with disabilities, reproductive and sexual health issues and rights are of critical importance. Disabled women and girls in Australia continue to experience gross violations of their reproductive rights, and denial of their freedoms and entitlements to reproductive and sexual health.

7.2.3. Mental health

According to the World Health Organisation (2009), gender specific risk factors for common mental health disorders that disproportionately affect women include gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others. The high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post Traumatic Stress Disorder (PTSD) following such violence, renders women the largest single group of people affected by this disorder (WHO 2009).

WHO (2009) asserts the following focus on women and mental health issues:

- Build evidence on the prevalence and causes of mental health problems in women as well as on the mediating and protective factors.
- Promote the formulation and implementation of health policies that address women’s needs and concerns from childhood to old age.

25 See: www.whv.org.au
• Enhance the competence of primary health care providers to recognise and treat mental health consequences of domestic violence, sexual abuse, and acute and chronic stress in women.

### 7.2.4. Available, accessible, affordable and quality services

Available, accessible, affordable and quality health and community services (including acute health services such as hospitals) are fundamental to women’s right to health and therefore should be a critical priority of the NWHP. As highlighted by the Australian Women’s Health Network (2009) women in Australia face a wide range of obstacles and barriers to available, accessible, affordable and quality services. Examples of these barriers include:

- limited access to bulk-billing practitioners in many parts of Australia;
- shortages of accessible women-specific health services, such as the dearth of sexual and reproductive health services away from major cities;
- shortages of women medical practitioners;
- waiting times, particularly for specialists and allied health practitioners;
- lack of gender and cultural competence;
- lack of sensitivity and understanding about the specific health care needs of certain groups of women, such as same sex attracted women, refugee women, women with disabilities and older women;
- lack of transport options, especially for low income women;
- lack of gender sensitivity in the design of some diagnostic tests and treatments;
- gender bias in medical research and training which preferences the male body.

Clearly, for women with disabilities, availability, acceptability, affordability, accessibility and quality of services are crucial for the realisation of the right to health. As highlighted earlier in this paper, women with disabilities continue to experience widespread discrimination and violations of their human rights in this area.

### 7.2.5. Economic health and wellbeing

Economic security is clearly a critical women’s health issue. The link between socioeconomic disadvantage and poor health has been observed repeatedly (Berkman & Epstein 2008). As highlighted by the Australian Women’s Health Network (2009):

*Socioeconomic status is fundamental to women’s life chances and affects all areas of health and wellbeing, including physical, mental and emotional health. Australian women, in comparison with men, are disproportionately affected by economic disadvantage on almost every indicator of economic health and wellbeing, including experiencing higher rates of poverty and more severe poverty. In turn, economic insecurity compounds the health issues of women in marginalised groups, such as Aboriginal and Torres Strait Islander women, CALD women and women with disabilities.*

Women who are socioeconomically disadvantaged experience inequities in health and health care. In their daily lives they face chronic stressors such as poverty, lack of social support, isolation, racism, violence, language barriers, access to services barriers, discrimination, and low levels of education and
employment. These challenges create a complex burden of psychosocial, functional, and physical health risks which can obstruct their access to material resources and health care, and in turn put them at high risk for poor health outcomes and poor quality of life (Landy et al 2008).

Women with disabilities throughout Australia bear a disproportionate burden of poverty and are recognised as amongst the poorest of all groups in society (WWDA 2006). As discussed earlier in this Submission, women with disabilities are less likely to be in paid work than other women, men with disabilities or the population as a whole. They are less likely than their male counterparts to receive adequate vocational rehabilitation or gain entry to labour market programs. Women with disabilities earn less than disabled men, are in the lowest income earning bracket, yet pay the highest level of their gross income on housing, and spend a greater proportion of their income on medical care and health related expenses.
8. Conclusion

It is now more than 30 years since the Australian Government ratified the *International Covenant on Economic, Social and Cultural Rights* (CESCR), and almost ten years since the Committee on Economic, Social and Cultural Rights, adopted General Comment 14 on the right to health, which clarified the nature and content of individual rights and States Parties’ obligations.

This Submission has examined women with disabilities’ right to health in the context of the CESCR and other core human rights treaties to which Australia is a signatory, specifically the *Convention on the Rights of Persons with Disabilities* (CRPD), and the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW). WWDA’s Submission demonstrates that successive Australian Governments have failed in their obligations to respect, protect and fulfil the rights of women with disabilities, and in doing so, have denied disabled women the freedoms and the entitlements for health.

In focusing on the Framework for the new National Women’s Health Policy, WWDA has argued that the NWHP must be developed in a framework of human rights, consistent with the relevant international human rights treaties to which Australia is a party. WWDA’s Submission has examined the proposed principles to underpin the NWHP and in doing so, highlighted the inequities experienced by women with disabilities in claiming their right to health. WWDA has recommended that the principles of ‘freedom from discrimination’ and ‘participation in health-related decision making’ be included as a basis for the development of the new NWHP.

In keeping with a human rights approach to health which places particular focus on, and prioritises, the needs of the most disadvantaged and vulnerable individuals and communities in a society, as well as thematic issues of major concern, WWDA’s Submission has identified and provided rationale for, priority groups and themes that should be included in the new NWHP.
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