



# Women With Disabilities and the Human Right to Health

**Written by Carolyn Frohmader for Women With Disabilities Australia (WWDA)  
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## ***Abstract***

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

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

This paper examines what is meant by women with disabilities right to health. It places this fundamental human right in the context of Australia's obligations under three of the key human rights conventions it has ratified: the Convention on the Rights of Person's with Disabilities (CRPD), the International Covenant on Economic, Social and Cultural Rights (CESCR) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The paper draws on the work of Women With Disabilities Australia (WWDA) to highlight the ways in which women and girls with disabilities in Australia are denied the freedoms and entitlements necessary for the realisation of their right to health. It then provides an overview of a range of policy initiatives required to address the structural, socioeconomic and cultural barriers that currently deny women with disabilities from realising their right to health.

**Keywords: women with disabilities, health, human rights**

## The status of women with disabilities in Australia

There are more than two million women with disabilities living in Australia, making up 20.1% of the population of Australian women. As a group, they experience many of the recognised markers of social exclusion - socioeconomic disadvantage, social isolation, multiple forms of discrimination, poor access to services, poor housing, inadequate health care, and denial of opportunities to contribute to and participate actively in society.<sup>1</sup> Although there has been only limited research in Australia on the many issues facing women with disabilities (including health), it is clear that they experience multiple discriminations, major inequalities in health status, and significant disadvantage in the social determinants of those inequalities. Compared to other women, women with disabilities<sup>2</sup>:

- are less likely to be in paid work;
- are in the lowest income earning bracket;
- spend a greater proportion of our 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 we 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 our fertility;
- are more likely to be assaulted, raped and abused;
- are at particular risk of severe forms of intimate partner violence;
- are more likely to experience marriage breakdown and divorce;
- are less likely to have children; and,
- are more likely to be single parents.

The many issues facing women with disabilities in Australia are represented through the national peak organisation Women With Disabilities Australia (WWDA). WWDA's work is grounded in a rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. Members of WWDA have identified the right to the highest attainable standard of health as a priority issue of concern.<sup>3</sup>

## Understanding the 'human right to health'

In international human rights law, health is understood as the '*state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity.*'<sup>4</sup> Health is also understood and recognised as '*the fundamental right of every human being*'<sup>5</sup> and '*indispensable for the exercise of other human rights.*'<sup>6</sup> The human right to health encompasses both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, the right to participate in decisions about one's health, the right to be free from interference, such as non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. This includes for example, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information.

As equal human beings, the right to health belongs to every individual. The chances of enjoying good health therefore must not be unfairly diminished because of disadvantaging factors such as disability, gender, race, ethnicity, sexual orientation, age, marital status, or other civil, political, social, economic or cultural attributes such as refugee status.<sup>8</sup> The right to health recognises that whilst all members of society have responsibilities regarding the realisation of the right to health, it is Governments which have the ultimate duty to create and provide the social and environmental conditions to enable people to undertake such responsibilities.<sup>9</sup>

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<sup>1</sup> Women With Disabilities Australia (WWDA) (2009) *Submission to the National Human Rights Consultation*. Available online at:

<http://www.wwda.org.au/subs2006.htm>

<sup>2</sup> See for example: WWDA (2010) *Submission to the Australian NGO Beijing+15 Review*. Available online at: <http://www.wwda.org.au/subs2006.htm>

<sup>3</sup> See Women With Disabilities Australia (WWDA) (2009) *Strategic Plan 2010 – 2015*. Published by Women With Disabilities Australia (WWDA), Hobart, Tasmania. Available online at: <http://www.wwda.org.au/stratplan.htm>

<sup>4</sup> World Health Organisation (WHO) (2002) *25 Questions and Answers on Health and Human Rights*. Health and human rights publication series. WHO, Geneva.

<sup>5</sup> WHO (2002) *Ibid.*

<sup>6</sup> United Nations (2000) Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*. E/C.12/2000/4.

<sup>7</sup> United Nations (2000) *Op Cit.*

<sup>8</sup> International Federation of Health and Human Rights Organisations (IFHHRO) (2008) *Our right to the highest attainable standard of health*. IFHHRO, Utrecht, The Netherlands.

<sup>9</sup> Potts, H. (2009) *The Right to Health*. Accessed online February 2010 at: <http://physiciansforhumanrights.org/right-to-health/conversation-with-helen-potts.html>

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

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

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

The CRPD – which aims to ensure that persons with disabilities enjoy human rights on an equal basis with others, is the most recent international human rights treaty ratified by the Australian Government, entering into force in Australia in 2008. The CRPD clearly articulates Australia’s obligations to women with disabilities right to health.<sup>10</sup> It specifically acknowledges the impact of multiple discriminations caused by the intersection of gender and disability. It prioritises women with disabilities as a group warranting specific attention, and calls on Governments to take positive action and measures to ensure that women and girls with disabilities enjoy all human rights and fundamental freedoms.<sup>11</sup>

## The denial of women with disabilities right to health

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

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

Women with disabilities are denied their right to bodily integrity, to control their own bodies and to be free from interventions – evidenced by the practices of forced sterilisation, menstrual suppression, forced contraception and coerced abortion. Their right to reproductive freedom is denied in a myriad of other ways, including pressure to undergo tubal ligations and hysterectomies, systematic denial of appropriate reproductive health care and sexual health screening, limited contraceptive choices, a focus on menstrual control, denial of access to assisted reproductive technologies, and, poorly managed pregnancy, birth and post natal care.<sup>12</sup>

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

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

Women with disabilities are denied their right to freedom from exploitation, violence and abuse – they experience alarmingly high rates of all forms of violence and abuse from a range of perpetrators yet remain excluded from violence prevention legislation, policies, services and supports.<sup>13</sup> They experience psychiatric assault through practices such as forced medication, chemical restraint, deprivation of liberty, the use of seclusion and restraints, and compulsory administration of psychoactive drugs and procedures such as electroconvulsive therapy.<sup>14</sup>

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<sup>10</sup> CRPD Article 25.

<sup>11</sup> CRPD at Article 6.

<sup>12</sup> WWDA (2009) *Submission to the National Human Rights Consultation*. Available online at: <http://www.wvda.org.au/subs2006.htm>

<sup>13</sup> WWDA (2008) ‘We’re women too!’ - Response to the Australian Government’s Consultation on the National Plan to Reduce Violence against Women and Children. Available online at: <http://www.wvda.org.au/subs2006.htm>

<sup>14</sup> International Network of Women With Disabilities (INWWD) (2010) 15-Year Review of the Beijing Declaration and Platform for Action: Comments from the International Network of Women With Disabilities (INWWD). Unpublished.

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

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

Women with disabilities are denied the right to experience their sexuality, to have sexual relationships and to found and maintain a family. They experience discriminatory attitudes and widely held prejudicial assumptions which question their ability and indeed, their right to experience parenthood. They remain invisible and ignored in maternity, obstetric, parenting and related health care policies, programs and services, and face overt discrimination and inequitable access to assisted reproductive technologies. They have their babies and children removed by child welfare authorities without evidence of abuse, neglect and/or parental incapacity, and lose their children in custody disputes simply because they are women with disabilities. They battle against political agendas and social commentaries which cast their children as ‘young carers’ at risk of parentification and themselves as burdens of care.<sup>15</sup>

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

*“We need more information about sex and sexuality.”*

Women with disabilities have a significantly high level of unmet need for services and support to enable them to live independently and with dignity in the community, and to maintain optimal levels of health. They remain largely ignored in Australian health related research, legislation, policies, and services.<sup>16</sup> Women with disabilities have less access to community health programs, such as breast and cervical screening services than any other group of women.<sup>17</sup>

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

Women with disabilities bear a disproportionate burden of poverty, experience significant un/underemployment, and are in the lowest income earning bracket, yet have more than three times the average yearly health care expenditures of other women.<sup>18</sup> They are less likely than their male counterparts to receive adequate vocational rehabilitation or gain entry to labour market programs, and are more likely to be in low paid, part time, short term casual jobs<sup>19</sup>.

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

Women with disabilities experience serious violations of the right to an adequate standard of living, including adequate housing. They experience social isolation and segregation, multiple forms of discrimination, inaccessible public environments, poor access to services, and are marginalised, excluded or ignored in decision-making processes which affect their lives.<sup>20</sup>

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

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<sup>15</sup> WWDA (2009) *Parenting Issues for Women with Disabilities in Australia: A Policy Paper*. Available online at: <http://www.wwda.org.au/subs2006.htm>

<sup>16</sup> WWDA (2009) *Submission to the National Human Rights Consultation*. Available online at: <http://www.wwda.org.au/subs2006.htm>

<sup>17</sup> Ibid.

<sup>18</sup> Blanchard, J. & Hosek, S. (2003) *Financing Health Care for Women with Disabilities*. A RAND White Paper. Prepared for the FISA Foundation. Accessed online April 2009 at: [www.wwda.org.au/health2001.htm](http://www.wwda.org.au/health2001.htm)

<sup>19</sup> WWDA (2008) *Submission to the Parliamentary Inquiry into pay equity and associated issues related to increasing female participation in the workforce*. Available online at: <http://www.wwda.org.au/subs2006.htm>

<sup>20</sup> WWDA (2009) *Submission to the National Human Rights Consultation*. Available online at: <http://www.wwda.org.au/subs2006.htm>

## The effective realisation of women with disabilities right to health

The full enjoyment of the right to health still remains a distant goal for women with disabilities. Strategies to improve women with disabilities' right to health must take full account of the underlying determinants of health – particularly gender inequality and discrimination– and must address the specific structural, socioeconomic and cultural barriers that hamper women with disabilities in protecting and improving their health. These strategies must be placed in the broader context of government and broader society recognising, acknowledging and safeguarding the inherent dignity and equal worth of women with disabilities, as a fundamental pre-requisite to women with disabilities realising their right to health.

The obligation to respect, protect and fulfil women with disabilities' right to health, clearly requires Australian Governments to do much more than merely abstain from taking measures which might have a negative impact on women with disabilities. The obligation in the case of women with disabilities is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to women with disabilities in order to achieve the broader objectives of full participation and equality within society for all persons with disabilities,<sup>21</sup> and the specific objectives of ensuring that women with disabilities enjoy all human rights and fundamental freedoms. This invariably means that additional resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required. These obligations cannot remain words on paper. They must be reflected in all relevant legislation, national policies and programs, and operationalised at the service system level.

Women with disabilities will only effectively realise their right to health when the structural, socioeconomic and cultural barriers that currently deny them this right, are genuinely and fully addressed. The following section of this paper therefore looks at key areas of policy where the Australian Government should take positive action and specific measures to respect, protect and fulfil women with disabilities' right to health.

### Accountability

As rights-holders, women with disabilities are entitled to effective remedies, without which there has been, and continues to be, failure on the part of the Australian Government to fully comply with its obligations under the international human rights treaties to which it is a party. As duty-bearers, there must therefore be a commitment and willingness by Australian Governments to examine and redress the violations of human rights experienced by women with disabilities, both historically and currently.

As a priority, the Australian Government should therefore:

- Act immediately to redress the human rights violations against women and girls with disabilities who have been sterilised without their consent. This must include a process of reconciliation which incorporates financial compensation and an official apology for discrimination.
- Address the abuse, neglect, mistreatment, and discrimination of women with disabilities living in institutions.
- Address the over-representation of parents with intellectual disabilities in care and protection proceedings.

### Legislation

In keeping with Australia's obligations under CESC, CEDAW and the CRPD, the Australian Government has a responsibility to review, evaluate and revise legislation, policies and procedures that enable the violations of women with disabilities human rights and where necessary, create legislation to protect women and girls with disabilities against human rights violations.<sup>22 23 24</sup>

For example, there is a clear need for the Australian Government to develop national uniform legislation which prohibits the sterilisation of girls with disabilities in the absence of a threat to life or health.<sup>25</sup> The need for this legislation was identified by the United Nations more than four years ago,<sup>26</sup> yet successive Australian Governments have failed to act on this recommendation.

<sup>21</sup> CESC, General Comment 5: Persons with disabilities. Eleventh session, 9/12/1994.

<sup>22</sup> CESC General Comment 14 at paras 34, 35, 36.

<sup>23</sup> See: CEDAW Article 2 (a)(b)(f); Articles 3, 6, 11(3).

<sup>24</sup> See: CRPD Article 4.1(a)(b); Articles 4.3; 15.2; 16.1; 23.2; 27.1.

<sup>25</sup> See: WWDA (2010) Submission to the Australian Attorney-General on the issue of Sterilisation of Minors. Available online at: <http://www.wwda.org.au/subs2006.htm>

<sup>26</sup> Committee on the Rights of the Child, Concluding Observations: Australia, UN Doc CRC/C/15/Add.268 (2005) [46(e)].

Domestic and family violence legislation is another example of current legislation that warrants revision in order to be inclusive of women with disabilities. Definitions that specifically encompass the range of settings in which women with disabilities may live, and which take into account the context in which violence against women with disabilities occurs, is critical.

As a priority, the Australian Government should therefore:

- Act under its external affairs power to legislate to prohibit non-therapeutic sterilisation of girls with disabilities unless there is a serious threat to health or life;
- Address discrimination in legislation and protocols that enables the removal of babies and children from parents with intellectual disabilities; parents with mental health illnesses and parents with psychiatric disabilities;
- Investigate the feasibility of the development of a Model Family Violence Law for Australia. Such legislation should be inclusive of the forms of violence as experienced by women with disabilities and encompass the circumstances and contexts within which women with disabilities experience family violence;
- Undertake an immediate review of legislation, policies and processes currently in place for procedures occurring to girls and women with disabilities who are deemed 'incapable of giving informed consent.'

## National Health Policies

The Australian Government has a responsibility to develop and implement national health policies that conform to its human rights obligations as set out in the CESC, CRPD, CEDAW.

For example, the Australian Government is currently in the process of developing a new National Women's Health Policy (NWHP)<sup>27</sup> in order to: *'improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health; encourage the health system to be more responsive to the needs of women; actively promote the participation of women in health decision making and management; and to promote health equity among women.'*<sup>28</sup> Australia's last National Women's Health Policy was developed some twenty years ago,<sup>29</sup> and, although it was developed within a social health framework which explicitly recognised the link between health status and broader cultural and socioeconomic factors, along with the need to focus on health inequalities, it did not prioritise women with disabilities. As a result, women with disabilities gained little from the National Women's Health Policy and Program, and remained largely marginalised and excluded from women's health and related services and programs.

In the context of the new National Women's Health Policy (NWHP) therefore, WWDA has strongly advocated for the Policy to be developed in a framework of human rights, giving priority to those women whose right to health is compromised by social exclusion and discriminatory practices<sup>30</sup> (including women with disabilities), and prioritising thematic issues of concern in recognition of the conditions and contexts that deny vulnerable and marginalised groups of women their right to health.<sup>31</sup>

As a priority, the Australian Government should therefore:

- Ensure that the principles of gender equity and health equity are applied to all national policies that address the social determinants of health.<sup>32</sup>
- Ensure that the new National Women's Health Policy (NWHP) gives explicit priority to women with disabilities in recognition of the fact that they experience direct human rights violations that result in ill-health; experience significant disadvantage in the social determinants necessary for health; and remain excluded in the health promotion agenda.

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<sup>27</sup> More information on the NWHP is available online at: <http://www.health.gov.au/womenshealthpolicy>

<sup>28</sup> Roxon, N. (2009) cited in Commonwealth of Australia (2009) *Development of a new national women's health policy: Consultation discussion paper*. Australian Government Department of Health & Ageing, Canberra.

<sup>29</sup> 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.

<sup>30</sup> These groups of women include: women with disabilities, Indigenous women, culturally and linguistically diverse (CALD) women, refugees and asylum seekers, institutionalised women (including women in prisons), and, homeless women. See: WWDA (2009) Submission to Inform the Development of the Framework for the National Women's Health Policy. Available online at: <http://www.wwda.org.au/subs2006.htm>

<sup>31</sup> The thematic issues identified include: violence, reproductive and sexual health, mental health, available, accessible, affordable and quality services, and, economic health and well-being. See: WWDA (2009) [at 29 above].

<sup>32</sup> World Health Assembly (WHA) (2009) Reducing health inequities through action on the social determinants of health. Sixty-Second World Health Assembly, Eighth plenary meeting, 22 May 2009, Agenda item 12.5, WHA62.14, A62/VR/8.

## National Women's Health Screening Programs

Members of WWDA have identified access to breast and cervical screening as a priority issue of concern, in response to their experiences of exclusion from these health promotion initiatives.<sup>33</sup> In many areas of Australia, breast and cervical cancer screening services are simply not available to women with disabilities. Even where screening services are available, many women with disabilities cannot receive these services because of economic, social, psychological and cultural barriers that impede or preclude their access to breast health and cervical screening services.<sup>34 35 36</sup>

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

For example, the Australian Government's current *Evaluation Report of the National Breast Screening Program*<sup>37</sup> identifies women with disabilities as a group experiencing barriers to the Program. However, the report suggests that these barriers are 'perceived' by women with disabilities. The Report makes a series of key recommendations for the future of the Program, including a major recommendation on increasing the participation of specific groups of women, identifying Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds, women living in very remote areas and women living in major cities. As a group, women with disabilities have been actively excluded from national breast and cervical cancer screening data collection and research. This exclusion is clearly inconsistent with the need for targeted measures to enable women with disabilities to realise their right to health – as articulated in the CESC, CRPD and CEDAW.

As a priority, the Australian Government should therefore:

- Act immediately to ensure that the National Breast Cancer and National Cervical Cancer Screening Programs are inclusive of women with disabilities, prioritise women with disabilities as a target group for screening, and collect data on the participation rate of women with disabilities.
- Act on recommendations from the CEDAW Monitoring Committee<sup>38</sup>, and undertake active measures at all levels of Government to ensure development of the necessary infrastructure to enable women with disabilities to participate in breast and cervical screening programs and initiatives.

## National Violence Prevention Policies & Programs

A human rights approach to health recognises that gender-based violence is a priority public health issue and, more specifically, a form of discrimination against women.<sup>39</sup> The obligation of Governments to address violence against women with disabilities is clearly articulated in CEDAW<sup>40</sup> and the CRPD.<sup>41</sup> The CESC stipulates that a state's failure to protect women against violence is a violation of its obligation to protect the right to health.<sup>42</sup>

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.<sup>43</sup> 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.

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<sup>33</sup> See WWDA (2009) *Strategic Plan 2010 – 2015*. Available online at: <http://www.wwda.org.au/stratplan.htm>

<sup>34</sup> People With Disabilities (WA) (2010) *Access to Women's Health Services for Women with Disabilities*. Consultation and report conducted by Samantha Jenkinson for People With Disabilities (WA), Perth, WA.

<sup>35</sup> NSW Cervical Screening Program (2004) *Preventative Women's Health Care for Women with Disabilities: Guidelines for General Practitioners: Background and Literature Review*. Available online at: <http://www.wwda.org.au/health2001.htm>

<sup>36</sup> See Johnson, K. et al (2002) *Screened Out! Women With Disabilities and Cervical Screening*. Report prepared for the Cancer Council Victoria.

<sup>37</sup> Commonwealth of Australia (2009) *BreastScreen Australia Evaluation: Evaluation Final Report*. Screening Monograph No.1/2009. Department of Health & Ageing, Canberra.

<sup>38</sup> United Nations Committee on the Elimination of All forms of Discrimination Against Women (CEDAW) (2006) *CEDAW Concluding Comments on the Australian Government's Report 'Women in Australia' (the combined Fourth and Fifth Reports on Implementing the United Nations Convention on the Elimination of All forms of Discrimination Against Women (CEDAW))*. United Nations, New York.

<sup>39</sup> Ateneo Human Rights Center (2008) *Violence Against Women: A Form of Discrimination*, In CEDAW Interactive Benchbook. Ateneo Human Rights Center, Philippines. Accessed online March 2010 at: <http://www.cedawbenchbook.org>

<sup>40</sup> CEDAW General Recommendation 19 & General Recommendation 18

<sup>41</sup> CRPD Article 16 & Article 6.

<sup>42</sup> CESC General Comment 14 at para.51.

<sup>43</sup> WWDA (2008) *'We're women too!' - Response to the Australian Government's Consultation on the National Plan to Reduce Violence against Women and Children*. Available online at: <http://www.wwda.org.au/subs2006.htm>

As a priority, the Australian Government should therefore:

- Ensure that the COAG<sup>44</sup> three year *National Plan to Reduce Violence Against Women and their Children* gives priority to addressing the needs of marginalised and excluded groups of women (including women with disabilities), and to addressing those forms of violence which have been recognised as under-documented and under-reported.<sup>45</sup>
- Act immediately to commission and fund a national research study on the incidence and prevalence of violence against women with disabilities, in recognition of the exclusion of women with disabilities from violence prevention programs and services, along with the paucity of research, data and statistics available.
- Act to ensure that policies, procedures and protocols are developed to aid in the early identification of violence against women with disabilities including for example screening and assessment tools.

## National Housing Policies & Programs

The right to adequate housing<sup>46</sup> is identified as a core obligation under the CESCR,<sup>47</sup> and includes the right to accessible housing for women with disabilities.<sup>48</sup> The right of women with disabilities to enjoy adequate living conditions, particularly in relation to housing, is enshrined in CEDAW,<sup>49</sup> and the right to an adequate standard of housing is also clearly articulated in the CRPD.<sup>50</sup> Having access to adequate, safe and secure housing substantially strengthens the likelihood of women with disabilities being able to realise their right to health.

Yet women with disabilities in Australia continue to experience serious violations of their right to adequate housing,<sup>51</sup> as well as failures to promote and fulfil this most basic human right.

In Australia, women with disabilities are over-represented in factors that contribute to homelessness, which include unemployment, underemployment, poverty, low income, violence, lack of access to essential services and supports, and lack of access to affordable, safe, secure housing.<sup>52</sup> Despite this, women with disabilities remain largely excluded from policy and program responses designed to address homelessness in Australia.<sup>53</sup> It is well documented that domestic and family violence is one of the major factors in homelessness in Australia,<sup>54</sup> and women with disabilities are twice to three times more likely to be victims of physical and sexual violence than other women.<sup>55</sup> However, the lack of available services and programs for women with disabilities experiencing violence, coupled with the almost universal exclusion of women with disabilities from women's refuges and other crisis and post-crisis accommodation services in Australia is a critical issue impacting on the health of women with disabilities, yet remains largely ignored in violence prevention, homelessness prevention and health promotion responses at all levels.<sup>56</sup>

As a priority, the Australian Government should therefore:

- Act immediately to address the exclusion of women with disabilities from women's refuges. Inherent in this is the need to undertake a national audit of crisis accommodation services<sup>57</sup> to determine their levels of

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<sup>44</sup> The Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia. COAG comprises the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA). The role of COAG is to initiate, develop and monitor the implementation of policy reforms that are of national significance and which require cooperative action by Australian governments.

<sup>45</sup> See for example the 2006 Report of the UN Secretary-General In-depth study on all forms of violence against women (page 66). A/61/122/Add.1. Available online at: [www.wvda.org.au/unhrt.htm](http://www.wvda.org.au/unhrt.htm)

<sup>46</sup> The Committee on Economic, Social and Cultural Rights has defined the term "adequate housing" to comprise security of tenure, availability of services, affordability, habitability, accessibility, location and cultural adequacy. See CESCR General Comment 4.

<sup>47</sup> CESCR General Comment 14 at para.15.

<sup>48</sup> CESCR General Comment 5 at para.33.

<sup>49</sup> CEDAW Article 14.2h; and CEDAW General Recommendation 18.

<sup>50</sup> CRPD Articles 19 & 28.

<sup>51</sup> For more information see: <http://www.wvda.org.au/housing.htm>

<sup>52</sup> Chung, D. et al. (2001) *The Impact of Domestic and Family Violence on Women and Homelessness: Findings from a national research project*. In *Out of the Fire: Domestic Violence and Homelessness*. A joint publication of the NSW Women's Refuge Resource Centre, the Domestic Violence and Incest Resource Centre and the Council to Homeless Persons. pp. 21-24.

<sup>53</sup> See WWDA (2008) 'Shut Out, Hung Out, Left Out, Missing Out'. Response to the Australian Government's Green Paper 'Which Way Home? A New Approach to Homelessness'. Available online at: <http://www.wvda.org.au/subs2006.htm>

<sup>54</sup> See for example: Commonwealth of Australia (2008) *Which Way Home? A new approach to homelessness*. A Green Paper on Homelessness prepared by the Commonwealth as a consultation paper. ISBN 9781 921380 976

<sup>55</sup> Frohmader, C. & Meekosha, H. (2010) *Recognition, respect and rights: disabled women in a globalised world*. Paper presented to the 2010 Regional Conference on Women with Disabilities, Guangzhou, China.

<sup>56</sup> See WWDA (2008) 'Shut Out, Hung Out, Left Out, Missing Out'. As at [51].

<sup>57</sup> See Priority Action 3.2.2 [p.166] of '*Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021*'. Prepared by the National Council to Reduce Violence against Women and their Children (March 2009), Published by Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.

accessibility and safety for women with disabilities and to determine service/agency needs in meeting relevant anti-discrimination legislation requirements.

- Ensure that targets developed to reduce homelessness and address the right to adequate housing are established for people with disabilities as a population group and include gender specific targets.

## Employment Policies & Programs

The CESCR identifies the right to work as a one of the key underlying determinants of health and therefore a critical component of the right to health.<sup>58</sup> The obligation of Governments to take all appropriate measures to eliminate discrimination against women in the field of employment is clearly stated in CEDAW.<sup>59</sup> The right of women with disabilities to work in freely chosen or accepted employment is also clearly articulated in the CRPD.<sup>60</sup>

Employment and working conditions have powerful effects on health equity. It is widely recognised that being in paid employment is a key marker of social inclusion<sup>61</sup> and that unemployment and under-employment are associated with poorer health status.<sup>62</sup> Paid employment is a critical component in enabling women with disabilities to support themselves financially, provide financial security, social status, personal development, social relations and self-esteem, and achieve social recognition – all necessary for realising the right to health. Yet in Australia, women with disabilities are less likely to be in paid work (or looking for work) than other women, men with disabilities or the population as a whole.<sup>63</sup> In any type of employment women with disabilities are more likely to be in low paid, part time, short term casual jobs.<sup>64</sup>

As a priority, the Australian Government should therefore:

- Act immediately to collect relevant information on workforce participation of women with disabilities to provide a basis for pay equity analysis and inform future policy direction.
- Act to address the disparity in the proportion of men and women with disabilities who are being assisted by Commonwealth Government funded open employment services.
- Act to de-link disability-related supports and services from income support programs in order to make the supports required by women with disabilities available to those who could not afford to enter the paid labour market otherwise.

## Service System Issues

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

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

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

<sup>58</sup> CESCR General Comment 14 at para [3].

<sup>59</sup> See CEDAW Article 11.

<sup>60</sup> See CRPD Article 27.

<sup>61</sup> See for example: Gillard, J. & Wong, P. (2007) An Australian Social Inclusion agenda. Election 2007. Authorised by T. Gartrell, ALP National Secretary, Canberra. Accessed online February 2008 at: [www.alp.org.au](http://www.alp.org.au). See also: Hayes, A. & Gray, M. (2008) Social inclusion: a policy platform for those who live particularly challenged lives. Family Matters, Vol 78 (Summer), Australian Institute of Family Studies.

<sup>62</sup> Berkman, L. & Epstein, A. (2008) Beyond Health Care: Socioeconomic Status and Health. The New England Journal of Medicine, Vol.358, No.23.

<sup>63</sup> For more information see: WWDA (2008) Submission to the Parliamentary Inquiry into pay equity and associated issues related to increasing female participation in the workforce. Available online at: <http://www.wwda.org.au/subs2006.htm>

<sup>64</sup> Salthouse, S. (2010) Downward Spirals: disability and health costs as contributors to poverty and imagining ways forward. Paper to be presented to the Australian Women's Health Conference, Hobart, May 2010.

- social isolation and segregation.

The right to health includes a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.<sup>65</sup> Health services and systems at all levels must encompass the following inter-related and essential elements if they are to serve women with disabilities adequately:

- **Available:** health and related facilities, goods, services, and programs must be available in sufficient quantity to women with disabilities. Available facilities not only relates to buildings such as hospitals and community health centres, but also to preventive public health strategies and health promotion as well as well trained health workers. The adequate resourcing of services that can cater to women with all types of disabilities is critical.
- **Accessible:** health and related facilities, goods, services, and programs must be accessible to women with disabilities without discrimination. In the broadest sense accessible services encompass physical, intellectual, psychiatric, sensory and other disabilities. Accessibility includes the right to seek, receive and impart information and ideas concerning health and health-related services, programs and issues in an accessible format. This includes both content that reflects the experiences of women with disabilities and format of information available, such as Braille, audio, Easy English and the use of telephone access relay services and sign interpreters.<sup>66</sup> A further dimension of access includes being able to understand and meaningfully participate in the services and programs available, including information and education resources.<sup>67</sup> Accessibility of information should not impair women with disabilities right to have personal health data treated with confidentiality. Affordability is a further element of access. Payment for healthcare and related services should be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for women with disabilities.
- **Acceptable:** health and related services and programs that combine sensitivity to both disability issues and to issues of gender are necessary for women with disabilities to realise their right to health. Such services and programs should also be culturally appropriate, sensitive to women with disabilities life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of women with disabilities.
- **Quality:** The provision of responsive and suitable health and related services requires skills and training to enable service providers to recognise and respond appropriately to the needs and issues of women with disabilities.

As a priority, the Australian Government should therefore:

- Act on recommendations from the CEDAW Monitoring Committee<sup>68</sup>, and undertake active measures at all levels of Government to ensure development of the necessary infrastructure to enable women with disabilities to have access to all health services.
- Ensure that the new national Women's Health Policy (NWHP) and the national program established to implement the Policy, are based on principles of equity and freedom from discrimination, in recognition of the fact that these principles are critical components of the right to health, and are core obligations of the Australian Governments under the CESC, CEDAW and the CRPD.

## Participation and inclusion in health related decision-making

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

In the context of women with disabilities right to health, 'participation' is a process by which they are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing, delivering and

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<sup>65</sup> CESC, General Comment 14.

<sup>66</sup> WWDA (2007b) 'Forgotten Sisters - A global review of violence against women with disabilities'. WWDA Resource Manual on Violence Against Women With Disabilities. Published by WWDA, Tasmania, Australia.

<sup>67</sup> Ibid.

<sup>68</sup> CEDAW as at [41].

evaluating services and in taking action to achieve change.<sup>69</sup> The right to participate in decision-making processes that affect their health and development is clearly critical for women with disabilities, however, more often than not, they are excluded and ignored in health and related policy, service and program development, including information and education resources.

Women with disabilities are not only denied the opportunity to participate in health and related policy initiatives and service and program development. Many women with disabilities are excluded from participating in decisions that affect their lives on a daily basis, including as active partners in their own health care. They are often stereotyped as passive, asexual, dependent,<sup>70</sup> compliant,<sup>71</sup> sick, child-like, incompetent and helpless,<sup>72</sup> powerless<sup>73</sup> or insecure.<sup>74</sup> Alternatively, women with developmental disabilities in particular may be regarded as overly sexual, creating a fear of profligacy and the reproduction of disabled babies, often a justification for their sterilisation.<sup>75</sup> These perceptions, although very different, can result in women with disabilities being denied the right to participate in decision-making processes that affect their health.

As a priority, the Australian Government should therefore:

- Ensure that women with disabilities are represented on the national advisory structures established to oversee implementation of the National Women's Health Policy.
- Develop the institutional mechanisms to ensure that the participation of women with disabilities takes place in health policy and planning, including the planning, management, delivery and evaluation of health and related services.

## Data Collection and research

In the context of women with disabilities realising their right to health, the importance of data collection and research in order to identify and address the barriers faced by women with disabilities in exercising their rights<sup>76</sup> is clearly articulated within the CRPD. The CESCR identifies research and data collection, including disaggregation on the prohibited grounds of discrimination, as an obligation of Governments in fulfilling the right to health.<sup>77</sup>

The acute lack of available gender and disability specific data, information and research in Australia, at all levels of Government and for any issue, has been identified by WWDA for more than a decade. This neglect has seen Australia criticised by the CEDAW monitoring Committee, for failing to provide information on the situation of women with disabilities in its CEDAW implementation reports.<sup>78</sup>

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.<sup>79</sup> <sup>80</sup> 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 health systems and services and invariably leads to a critical lack of resources for this group.<sup>81</sup>

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

As a priority, the Australian Government should therefore:

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<sup>69</sup> World Health Organisation (WHO) (2002) Community participation in local health and sustainable development: approaches and techniques. European Sustainable Development and Health Series: 4. WHO, Geneva.

<sup>70</sup> See: Curry, M. et al (2001) Abuse of women with disabilities: An ecological model and review. *Violence Against Women*, Vol. 7, No. 1, pp. 60-79

<sup>71</sup> See: Carlson, B. (1997) Mental retardation and domestic violence: An ecological approach to intervention. *Social Work*, Vol.42, No.1, pp. 79-89.

<sup>72</sup> See: Crawford, D. & Ostrove, J. (2003) Representations of Disability and the Interpersonal Relationships of Women with Disabilities. *Women & Therapy*, Vol. 26, No.3/4, pp.179-194.

<sup>73</sup> See: Chang, J. et al (2003) Helping Women with Disabilities and Domestic Violence: Strategies, Limitations and Challenges of Domestic Violence Programs and Services. *Journal of Women's Health*, Vol.12, No.7, pp. 699-708.

<sup>74</sup> See: Calderbank, R. (2000) Abuse and Disabled People: vulnerability or social indifference? *Disability & Society*, Vol.15, No.3, pp. 521-534.

<sup>75</sup> WWDA (2007b) [as at 53]

<sup>76</sup> CRPD, at Article 31.

<sup>77</sup> CESCR General Comment 14 at paras [37] and [57].

<sup>78</sup> See: CEDAW as at [41].

<sup>79</sup> Morris, J. & Wates, M. (2006) Supporting disabled parents and parents with additional support needs. *Adults' Services Knowledge Review 11*, Published by Social Care Institute for Excellence, London.

<sup>80</sup> Preston, P. (2009) Parents with Disabilities. National Center for Parents with Disabilities: Through the Looking Glass, Berkeley, California. Accessed online March 2009 at: [www.lookingglass.org](http://www.lookingglass.org)

<sup>81</sup> Kirschbaum, M. (2000) A Disability Culture Perspective on Early Intervention with Parents with Physical or Cognitive Disabilities and their Infants. *Infants and Young Children*, Vol. 13, No.2, pp. 9-20.

- Act to ensure that health and socio-economic data is disaggregated by gender and disability, in order to identify and address discrimination and inequities in health.
- Fund a national research project on the issues which impact on access and uptake of breast, cervical and bone-density screening services for women with disabilities.
- Fund a full time Project Officer position for Women With Disabilities Australia (WWDA) for a period of three years to develop and implement a national research project on the parenting experiences of women with disabilities.
- Fund a national project on women with disabilities' right to reproductive freedom which:
  - addresses the incidence of forced sterilisation for *all* women with disabilities;
  - researches the long-term physical and mental health and social effects of sterilisation;
  - researches the practice of menstrual suppression of girls and women with disabilities, including those in group homes and other forms of institutional care.

## Public Health Media Campaigns

The vast majority of information about disability in the mass media is extremely negative. Disabling stereotypes which medicalise, patronise, criminalise and dehumanise women with disabilities abound in books, films, on television, and in the press. They form the bed-rock on which the attitudes towards, assumptions and about and expectations of women with disabilities are based. They are fundamental to the discrimination and exploitation which women with disabilities encounter daily, and contribute significantly to their systematic exclusion from mainstream community life.<sup>82</sup> They can, and do, have a profound effect on the self image of women with disabilities themselves.<sup>83</sup>

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

Despite increasing appreciation of the heterogeneity of women and the need to address such factors as race, ethnicity and class in public health campaigns, disability has not been recognised and it is this exclusion which renders the experiences of women with disabilities essentially invisible.<sup>84</sup>

As a priority, the Australian Government should therefore:

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

## Training of health workers

The obligation to fulfil the right to health for women with disabilities requires the Australian Government to undertake actions that create, maintain and restore the health of the population. This includes ensuring that health workers are trained to recognise and respond to the specific needs of vulnerable or marginalised groups,<sup>85</sup> including women with disabilities. The requirement of Governments to provide education and training for health personnel on health and human rights is also identified as an obligation under the CESC<sup>86</sup> and the CRPD.<sup>87</sup>

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

<sup>82</sup> Barnes, C. (1992) *Disabling Imagery and the Media: An exploration of the principles for media representations of disabled people*. Published by the British Council of Organisations of Disabled People and Ryburn Publishing, Derby, UK.

<sup>83</sup> See Meekosha, H. & Dowse, L. (1997) *Distorting Images, Invisible Images: Gender, Disability and the Media* Media International Australia, Vol. 84, May; and also: Meekosha, H & Dowse, L (1997) 'Enabling Citizenship: Gender, disability and citizenship' *Feminist Review*, Vol. 57, Autumn.

<sup>84</sup> Garland-Thomson, R. (2001) *Re-shaping, Re-thinking, Re-defining: Feminist Disability Studies*. Centre for Women Policy Studies, Washington DC.

<sup>85</sup> CESC<sup>86</sup> General Comment 14 at para. 37.

<sup>86</sup> CESC<sup>86</sup> General Comment 14 at para. 44(e).

<sup>87</sup> CRPD at Article 25(d).

The lack of education and training of health and related service providers has been identified as a major barrier to women with disabilities accessing health and related services.<sup>88</sup> This lack of education and training is borne out in a myriad of ways. For example, many service providers lack knowledge of disability, hold inaccurate perceptions about women with disabilities, and have a tendency to view women with disabilities solely through the lens of their impairments.<sup>89</sup> Insufficient time to address the full range of needs is a common barrier during encounters with health and related service providers, as is the general lack of sensitivity, responsiveness, courtesy and support shown to women with disabilities.<sup>90</sup> Health and related service providers can have a tendency to treat women with disabilities as objects of treatment rather than rights-holders, and do not always seek their free and informed consent when it comes to interventions.<sup>91</sup>

As a priority, the Australian Government should therefore:

- Commission the development of national guidelines for health and related service providers that describe expectations for compliance with the CESC, CEDAW and CRPD.
- Through the National Registration and Accreditation Scheme for the Health Professions (NRAS),<sup>92</sup> act to ensure that accreditation of the training of health professionals covered under the *Health Practitioner Regulation National Law Act 2009*, is contingent on disability and human rights specific curriculum components.
- Develop national protocols for health education curriculum (beginning at primary school level) which incorporate models of diversity that portray positive images of women with disabilities as sexual beings, including as parents.
- Act to ensure that relevant training authorities (such as TAFE) develop curriculum content which requires demonstration of competencies in knowledge of human rights of women with disabilities.

## **The social, economic and political empowerment of women with disabilities**

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

In order for women with disabilities to realise their right to health, governments at all levels should take measures to empower women with disabilities and strengthen their economic independence. This includes creating the conditions and structures that improve women with disabilities access to the labour market and affording them more adequate levels of income support.

Organisations and groups of women with disabilities play an important role in raising awareness of, and working to address the violations, denials and infringements of the right to health. There is recognition that the empowerment of women with disabilities is achieved principally through women with disabilities coming together to share their experiences, gaining strength from one another and providing positive role models (DAA 1997). Financial and political support is needed for the establishment and maintenance of such groups of women with disabilities at national, regional and local levels.

As a priority, the Australian Government should therefore:

- Recognise, support and strengthen the role of women with disabilities organisations, groups and networks in efforts to fulfil, respect, protect and promote their human rights, and to support and empower women with disabilities, both individually and collectively, to claim their rights.

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<sup>88</sup> See for example: Barrett, K., O'Day, B., Roche, A. & Carlson, B. (2009) Intimate Partner Violence, Health Status, and Health Care Access Among Women with Disabilities. *Women's Health Issues*, Vol.19, pp.94-100; See also: Howe, K. & Salthouse, S. (2004) Lack of Data Means Lack of Action - A clinical examination of access to health services for women with disabilities. Available online at: <http://www.wwda.org.au/hreocsumm.htm>

<sup>89</sup> Kroll, T., Jones, G., Kehn, M. & Neri, M. (2006) Barriers and strategies affecting the utilisation of primary preventive services for people with physical disabilities: a qualitative inquiry. *Health and Social Care in the Community*; Vol.14, No.4, pp.284-293.

<sup>90</sup> Swift, K. (2009). Joint Brisbane Forum Report for Women With Disabilities Australia's Response to the National Women's Health Policy, Women With Disabilities Australia (WWDA), Rosny Park: Unpublished Report.

<sup>91</sup> Office of the United Nations High Commissioner for Human Rights (OHCHR) & World Health Organisation (WHO) The Right to Health. Fact Sheet 31.

<sup>92</sup> For more information see: <http://www.ahpra.gov.au/index.php>

- Urgently review the adequacy of income support arrangements for those with a disability across all household types, in recognition of the fact that the non-optional costs of disability are a significant barrier to the social inclusion of women with disabilities, and that the setting of income support payment rates for people with disabilities has failed to take account of these non-optional, extra costs.
- Ensure that information on women with disabilities is provided in relevant human rights treaties Periodic Reports as a matter of course. This would include information on the situation of women with disabilities under each right, including their current de-facto and de jure situation, measures taken to enhance their status, progress made and difficulties and obstacles encountered.

## **Conclusion**

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

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

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

## **Correspondence to:**

Carolyn Frohmader  
Women With Disabilities Australia (WWDA)  
PO Box 605, Rosny Park 7018 TASMANIA, AUSTRALIA  
Ph: +61 3 62448288 Fax: +61 3 62448255  
Email: [wwda@wwda.org.au](mailto:wwda@wwda.org.au)  
Web: [www.wwda.org.au](http://www.wwda.org.au)