DECEMBER 2020

DISABILITY INCLUSION IN GBV PROGRAMMING

Irish Consortium on Gender Based Violence
& CBM Ireland

TABLE OF CONTENTS

EXECUTIVE SUMMARY

People with Disabilities face marginalisation and discrimination throughout and across all aspects of life, including cultural, educational, economic and political spheres. Adults and children with disabilities also experience higher rates of violence than people without disabilities. The aim of this paper is to provide an overview of causes and consequences of gender-based violence (GBV) against women and girls with disabilities in development and humanitarian settings. In doing so this paper seeks to demonstrate and inform good practice in programmes aiming directly or indirectly to address GBV and gender inequality.

Women and girls with disabilities experience some of the highest rates of GBV, and women and girls with intellectual disabilities are particularly vulnerable to sexual violence. However, the lived experience of each individual is unique and an outcome of a diversity of intersecting factors. The first section of the paper - GBV against women and girls with disabilities - looks at the various root causes of and contributing factors to GBV against women and girls with disabilities, including inequality, disability stigma, racism and discrimination based on ethnicity. There are also other factors that affect the life experiences of women and girls with disabilities and their experience of GBV, including their perceived asexuality and contextual factors such as conflict or displacement.

The second section of the paper - Disability Inclusion - presents good practice in preventing and responding to GBV against women and girls with disabilities. It highlights that vulnerability to violence is in part a product of discrimination evident within and across all socieities, in our own organisations and in our ways of working. This section discusses the importance of centring the experiences and voices of women and girls with disabilities and organisations of persons with disabilities in meaningful participation, decision-making, and in the programme cycle, from inception through monitoring and evaluation. Guidance is also given regarding increasing staff capacity on disability and how to ethically collect data on disability.

Finally, at the end of the paper there are programme recommendations on disability inclusion and key resources on interventions to prevent and respond to GBV against women and girls with disabilities.

DISABILITY: A GLOBAL OVERVIEW

Approximately 15% of people—or 19% of women and 12% of men—live with a disability.[1] Among persons with disabilities globally, about 80% live in low- and middle-income countries.[2] The disproportionate number of people with disabilities living in development and humanitarian contexts is due to factors such as poverty, natural disaster, conflict, and limited access to health care or rehabilitation, all of which can cause or exacerbate disability.[3]

Persons with disabilities include anyone who has long-term physical, mental, intellectual and/or sensory impairments that, along with other barriers, affects their full and effective participation in society on an equal basis with others.[4] These barriers to participation are not inherent to persons with disabilities but rather are social and environmental—for example, discriminatory barriers like rejection by others to participate in activities or inaccessibility to buildings (see Figure 1 on page 6, regarding the models of disability). Although every context is unique, globally there is a lack of understanding and sensitisation to both disability and the experiences of persons with disabilities.

This lack of understanding and sensitisation leads to stigmatisation which, coupled with a lack of legal protections or enforcement, lead to the marginalisation of persons with disabilities from social, cultural, economic and political participation. Persons with disabilities face direct and indirect discrimination across all sectors of society and consistently throughout life. Compared with persons without disabilities, they are more likely to live in poverty, to be hungry, to lack adequate access to healthcare and education and to be unemployed.[5]

The lived experiences of many persons with disabilities indicate that they are often isolated and excluded from community participation, which can result in their feeling invisible and in turn reinforce the perceived absence of disability in society as a whole—because when people with disabilities are excluded from participation they are neither seen nor heard by society broadly speaking. Women and men with disabilities also have significantly lower access to the internet than women and men without disabilities, illustrating the extent to which persons with disabilities are excluded even behind closed doors.[6]

These realities are inextricable from the fact that adults and children with disabilities also experience violence at higher rates than adults and children without disabilities do, beginning with the risk of infanticide.[7] According to the World Report on Disability, persons with disabilities are anywhere from 4-10 times more likely to experience violence compared to non-disabled persons, depending on context. Children with disabilities are subject to this high level of violence—they are 3-4 times more likely to experience all forms of violence compared to their non-disabled peers, and they are 3 times more likely to experience sexual violence specifically.[8]

KEY TERM: DISABILITY

Any long-term physical, mental, intellectual and/or sensory impairment which in interaction with various barriers may hinder someone's full and effective participation in society on an equal basis with others. (The Convention on the Rights of Persons with Disabilities)

GBV AGAINST WOMEN AND GIRLS WITH DISABILITIES:

UNDERSTANDING ROOT CAUSES AND CONTRIBUTING FACTORS

Each of us is unique. This is no different for women and girls with disabilities whose individual experiences are shaped by the intersection of many factors, including gender inequality, stigma against disability and many other potential factors, such as racism, discrimination on the basis of ethnicity and ageism, as well as contextual factors such as conflict or displacement. This section provides a brief overview of the root causes and contributing factors of GBV that affect women and girls with disabilities uniquely, particularly regarding their disproportionate risk of experiencing GBV.

GENDER INEQUALITY AND DISABILITY STIGMA: THE 'DOUBLE DISCRIMINATION'

The fact that women and girls with disabilities face stigma on the basis of their gender and disability is often called 'double discrimination'. Although global data shows that women and men with disabilities are equally likely to live in poverty, there are other ways that women with disabilities are specifically disadvantaged. For example, compared to all other groups, women with disabilities have the lowest literacy and employment rates and they are the least likely to be in a position of power, illustrating their exclusion from educational and decision-making spaces.[9] While women of all identities experience discrimination as a result of patriarchal power structures, disability exacerbates this. The harmful social attitudes and discrimination of their gender and disability combined leads directly to violence perpetrated against them.

It is widely cited that one in three women will experience GBV during their lifetime, and for many this is not a one off experience. However, knowing the double discrimination that women and girls with disabilities face, we know that they are at higher risk of GBV. Country based studies show clearly that women and girls with disabilities experience higher rates of GBV than both non-disabled women and men with disabilities.[10] One study estimated that women with disabilities are twice as likely to experience GBV as non-disabled women[11] and that they are over four times more likely to experience controlling behaviour by partners, such as having their whereabouts or activities restricted.[12]

KEY TERM: GENDER BASED VIOLENCE

GBV is any harmful act—including physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty—that is perpetrated against a person's will and that is based on socially ascribed differences between women and men. (Inter-Agency Standing Committee)

It is not uncommon for women and girls with

disabilities to be kept within the home and out of sight of the community, either forcefully or because their carers do not have the support systems and resources to enable them to leave the home with them, in the safe company of others, or independently (of their own accord). Carers may be occupied with their essential livelihoods activities or other chores, giving them no choice but to leave children with disabilities unsupervised by another adult, sometimes in the care of other children, and ultimately highly vulnerable. Not only does this send a message to the community that women and girls with disabilities are not visible - which only exacerbates the negative stereotype held by society that persons with disabilities are not active and capable - but it also leaves them vulnerable to GBV by outsiders, within the home.

It is important to acknowledge the varied experiences among women and girls with disabilities. Women and girls with physical impairments, deafness and/or blindness are seen by perpetrators as less able to anticipate, flee from or fend off violence. It is well documented, though, that people with intellectual, psychosocial and cognitive disabilities are the most marginalised from social, cultural, economic and political aspects of life and the most likely to be institutionalised. Women and girls with these disabilities are the most at risk of all forms of violence—including emotional, physical, sexual and institutional abuses—and it is unfortunately not uncommon for women with intellectual disabilities to be subject to sexual abuse, including rape, while they are alone at home.[13] This abuse, which can be perpetrated by caregivers or other members of the community, often occurs repeatedly and is entirely hidden until the survivor becomes pregnant.

RACISM, DISCRIMINATION BASED ON ETHINICITY OR RELIGION AND AGEISM: MOVING BEYOND DOUBLE DISCRIMINATION

In addition to gender inequality and disability stigma, there are other aspects of systemic oppression, including racism, discrimination on the basis of ethnicity or religious identity and ageism. These injustices also shape the lives of women and girls with disabilities.[14]

GBV against women and girls on the basis of their ethnicity has been documented. Human

DISABILITY MODELS

Moral Model: Views Disability as a sign of moral failing or the result of a divine or supernatural act.

Charitable Model: Views persons with disabilities as having minimum capacity, requiring care and protection.

Medical Model: Focuses on 'curing' disability or providing medical interventions to treat the diagnosis rather than the individual.

Social Model: Considers the barriers to exclusion for persons with disabilities and works to remove them to enable inclusion and participation.

Rights-based Model: Centres on disability rights as human rights and promotes and protects equal social, economic and physical accessibility and inclusion.

Despite the good intentions of medical and charitable models, both have proven to further marginalise young persons with disabilities by limiting their social and economic inclusion and independence. The CRPD promotes the use of the social and rights-based models.

Figure 1: ICGBV reproduction based on UNFPA (2018), Young Persons with Disabilities: Global Study on Ending Gender-Based Violence, and Realising Sexual and Reproduuctive Health and Rights.

rights organisations have documented campaigns of genocidal rape over many decades, notably during conflicts in the Former Yugoslavia, Rwanda and Democratic Republic of the Congo.

Regarding age, it is known that young people with disabilities are at increased vulnerability of violence. This is due not only to their age but also disability. Children with disabilities under the age of 18 are almost four times more likely than their peers without disabilities to experience abuse. Young people with intellectual disabilities, especially girls, are at greatest risk of abuse[15].

Overall, however, there is an alarmingly large quantitative data gap around ethnicity, race, religious affiliation and age when it comes to the life experiences of women and girls with disabilities in development and humanitarian contexts[16]. The focus for organisations and governments has primarily been on scaling up data on gender, disability and age. Qualitative studies, however, show clearly that all societies create hierarchies based on race, ethnicity and religious affiliation, and that violence against marginalised people is normalised. This reality undoubtedly affects the lives of women and girls with varied and complex identities, and there is a need to learn more about their lived realities.

PERCEPTIONS OF (A)SEXUALITY TOWARD WOMEN AND GIRLS WITH DISABILITIES

GBV against women and girls is also linked to how society views their sexuality and reproductive needs. In daily life, women and girls with disabilities are discriminatorily viewed by others as inferior, undesirable, and/or not fit for intimate partnerships or marriage. In essence, many women and adolescent girls—particularly women and girls with intellectual disabilities—are therefore perceived as asexual, or lacking in desire for intimate relationships and not having sexual or reproductive health needs[17]. Unfortunately, this perception leads to the assumption that women and girls with disabilities could not be the target of sexual violence, and it means that women and girls' reports of GBV are not treated seriously.

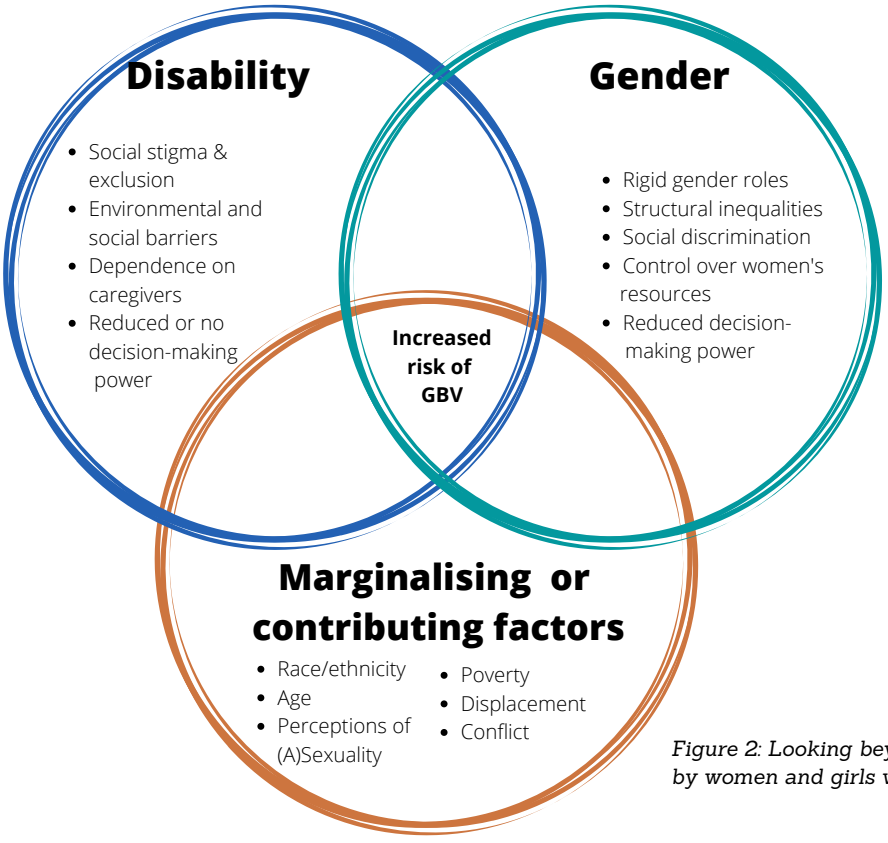

Figure 2: Looking beyond the 'double discrimination' experienced by women and girls with disabilities regarding GBV

As a result of their assumed asexuality, many women and girls with disabilities are treated very differently than women without disabilities, including being denied or excluded from sexual and reproductive health and rights[18], which leads to women and girls with disabilities being less likely to learn about their bodies and topics such as consent. There also exists a very common societal belief that women with disabilities are unable to be good caregivers, coupled

with the discriminatory belief that all women with disabilities will produce a child with disabilities. Many women with disabilities have been subjected to forced sterilisations or forced abortions, which represents both a violation of human rights and constitutes GBV[19].

Furthermore, the assumptions about girls' and women's perceived lack of sexuality and assumed 'virginal status' actually puts them in danger. The 'virgin myth', or the belief that having sex with a virgin will cure HIV/AIDS, is one example showing how perpetrators may target women and with disabilities due to their assumed 'virginal status.' There are other dangerous myths, including a belief in Nigeria that sex with a person with disabilities brings wealth or good luck,[20] or in Uganda the myth that sex with people with albinism in particular, brings good fortune.[21]

Despite perceptions of asexuality, it should be underlined that all women and girls with disabilities have the same reproductive health needs and rights as women without disabilities and should be included in programming regarding GBV.

CONTEXTUAL FACTORS: CONFLICT AND DISPLACEMENT

There are also context-specific factors that have a direct impact on the lives of women and girls with disabilities, such as conflict or displacement. In all humanitarian crises, tensions rise, law and order may break down, families are separated and social norms disrupted. The risk of GBV increases for all women and girls, and this danger is even more heightened for women and girls with disabilities who are often not adequately, or not at all, included in the design, implementation and monitoring of humanitarian response plans. People with hearing impairments may not hear emergency warnings or approaching danger, and people with visual or physical/mobility impairments may not be able to flee and seek protection. It is also important to acknowledge that conflict and displacement can lead to disability, including psychosocial disabilities and physical disabilities. Indeed, over 20% of refugees may have a disability, which is 5% higher than the global average.[22]

Displacement can increase the risk of GBV for women and girls with disabilities, who may be separated from their families' personal and financial support systems. Women with disabilities living in a refugee camp in Burundi, for example, have reported resorting to or being coerced into adopting coping mechanisms for survival such as transactional sex or exchange of essential food rations for money or tasks that they may not be able to perform themselves, such as collecting firewood and food distributions or transporting water.[23] There have also been reported instances of sexual violence against women with disabilities in refugee camps in Northern Uganda.[24] In sum, the context in which women and girls find themselves greatly influences their vulnerability to GBV.

REPORTING GBV: UNDERSTANDING THE SIGNIFICANT BARRIERS FOR WOMEN AND GIRLS WITH DISABILITIES

Lack of reporting of GBV is common among all women and girls, due to the fear of not being believed, being shamed and possible retaliation. This fear can be even greater for women with disabilities, who are facing added discrimination on the basis of their disability and possibly other factors. Because women and girls with disabilities are almost entirely excluded from social, cultural, economic and political participation, they are often lacking the social, legal and protective interpersonal supports that are usually necessary to raise awareness of one's rights and the difficult action of reporting GBV. Additionally, because caregivers or intimate partners can be (although should not be assumed to be) perpetrators of violence, they may directly or

indirectly prevent survivors from seeking assistance or reporting violence.

For women and girls with disabilities who do report violence, there can be steep barriers. These include lack of financial resources, lack of transportation, and/or lack of services necessary to those with physical or communicative disabilities. As can happen with women without disabilities, police and other service providers may also question claims of abuse, but for women and girls with disabilities this questioning is deepened on the basis of their disability; for example, questioning a blind woman who may report that she knows the perpetrator or questioning the capacity of women and girls with intellectual disabilities to report violence. Women and girls with disabilities may also be discriminated against in the judiciary process in their attempts to access justice. These additional barriers and discriminations against women and girls with disabilities make it nearly impossible to speak out about the abuse experienced.

GENDER, DISABILITY AND GBV INTERACT IN MUTIPLE AND COMPLEX WAYS

Thus far, this paper focuses specifically on how the intersection of gender, disability and a multitude of other factors contribute to increased vulnerability of women and girls to GBV. It should be noted that GBV can also contribute to disability e.g. by causing physical injury and impairments or trauma that impacts on long-term mental health.

Disability can also contribute to other unanticipated forms of social exclusion. As one example, a study from the Women's Refugee Commission and the International Rescue Committee found that women married to men with a disability have been reported to be targets of GBV by community members in refugee settings in Jordan, as their husbands are not seen to be fulfilling the expected role of breadwinner and the family may be experiencing economic hardship (WRC & IRC, 2015). As another example, in refugee camps in Northern Uganda, children of women with disabilities were prevented by the community from playing with other children, due to the myth that they could spread their mother's disability.

Finally, it is also important to note that caregivers of women and girls with disabilities are impacted by the intersection of gender and disability. Lacking opportunities for economic participation due to time occupied by care responsibilities, women caregivers can be isolated in ways that cut them off from community participation and services such as GBV programmes.

INCREASING DISABILITY INCLUSION IN GBV PROGRAMMES IN ZIMBABWE

MUSASA - RESPONDING TO GBV IN ZIMBABWE (OXFAM PARTNER)

Oxfam's partner Musasa has undertaken comprehensive measures over the past few years to make its services and outreach disability inclusive.[i] The organisation, which is co-Chair of Zimbabwe's GBV sub-Cluster alongside the Ministry of Women's Affairs, has over 20 years of experience supporting, advocating for and protecting women's human rights. When a strong national evidence base emerged in the country showing that persons with disabilities are at increased vulnerability to abuse (see for example the Zimbabwe Demographic Health Survey, 2016), Musasa took action and began a process of promoting disability inclusion within their organisation.

From the beginning, Musasa has endeavoured to partner with disability specialist organisations, which have both imparted key knowledge and now monitor the implementation of Musasa's annual disability plans. In 2017, with support from Oxfam, Musasa conducted a disability inclusion training provided by Disability and HIV Trust, a disability specialist organisation. The training took a holistic approach, responding to a number of identified gaps across staff knowledge, disability sensitivity and accessibility of services and community outreach.

> *"Training in disability inclusion changed the outlook to my work as a counselor; I became more conscious and confident in helping survivors with disability. I am now using respectful and disability sensitive language and able to communicate using basic sign language.... What an achievement."*
>
> - Counsellor, Musasa

Not only did Musasa's staff receive basic sign language training but the organisation also employed a full-time basic sign language translator at the centre to support staff, paralegals and/or lawyers and established a text and audio platform for survivors with speech impairment and blindness. As a result of the engagement with the Disability and HIV Trust, Musasa also refurbished their shelters and one stop centres to improve disability access and inclusion.

Beyond working on making their services and facilities more disability inclusive, Musasa also created a comprehensive community outreach plan to engage persons with disabilities in the community. This included working closely with mobile village health workers and case workers, who have influence at the household level and play a key role in encouraging persons with disabilities to participate in community programmes and access support services where needed. Since the implementation of the community outreach plan, the number of persons with disabilities accessing Musasa's meetings and direct services centres has significantly increased.

Musasa as an organisation is cognizant of the remaining barriers in society for survivors with disabilities. Legal services and access to justice for persons with disabilities is one of these challenges. Musasa relies heavily on other government departments in pursuing GBV cases, but there are instances where departments lack facilities and resources to offer PWD a survivor centred approach. One client's case has been postponed in court, for example, because there is no sign language certified translator to bring to court, risking the trial being continuously extended. Ultimately, these legal barriers have discouraged some survivors from pursuing their cases, as they feel that the system is not adequately prepared to respond to and meet their needs. Relying on its evidence base and extensive experience working with survivors with disabilities, Musasa continues to advocate at local and national level for survivor friendly courts so that people with disabilities have access to justice without discrimination.

[i] Musasa through the partnership with Oxfam Ireland receives funding support from Irish Aid

DISABILITY AND GBV DURING COVID-19

GBV increases during all emergencies, including crises due to conflict, natural disasters or epidemics. The COVID-19 pandemic, declared in March 2020, poses unique challenges. As governments around the world have issued lockdown, shelter in place or curfew orders, many women and girls, including women and girls with disabilities, are living in close confines with an abusive partner, family member or caregiver.

Some persons with disabilities have underlying health conditions that could result in developing more serious complications if they contracted COVID-19. For this reason, the World Health Organisation (WHO) recommended that persons with disabilities avoid large groups of people and minimise their number of close contacts in general (WHO, 2020). This means, however, that women and girls with disabilities, as well as women carers who experience GBV in the home are at greater risk than ever, as they are cut off from protective social networks and services including or in-person supports, and/or economic participation, essential to the their livelihoods and well-being.

Women and girls living in institutional settings such as group homes for adults with disabilities or orphanages for children with disabilities may be at risk of GBV as institutional oversight lapses during crises (Women Enabled, 2020). Exacerbating these risks is the fact that women and girls with disabilities may not be able or willing to seek help outside of the home or institution if they or service providers feel it would expose them to COVID-19 or to further abuse (Pearce, E. 2020. 'Disability Considerations in GBV Programming during the COVID-19 Pandemic.' GBV AoR Helpdesk.)

Shortly after COVID-19 was declared a global pandemic, Women Enabled International released a report, 'COVID-19 at the Intersection of Gender and Disability: Findings of a Global Human Rights Survey March to April 2020,' capturing testimonies of women, non-binary, and trans persons with disabilities across the globe. Stories shared in the survey reveal incidents of violence or fear of violence. The report issues specific recommendations for States, U.N. agencies, and others on how to respond to the pandemic, including ensuring that States understand that GBV services are essential and that communications including information dissemination and helplines must be available in accessible ways, including in Braille, sign language and plain language.

UNFPA has also stressed the importance of considering women and girls with disabilities as GBV programmes adapt to include more remote services during COVID-19. For example, phone, internet or SMS based services may not be sufficiently accessible for women and girls with disabilities (Erskine, 2020). There is therefore a need for fulfilment of aspirations of Community centred approaches through greater accountability and an inclusion lens that captures and/or targets the needs, rights, perspectives, aspirations and amplifies the voice of women with disabilities and considers whether services are accessible for women needing varying physical or communicative accommodations.

IN ZIMBABWE COVID-19 HAS POSED CHALLENGES TO GBV SERVICE DELIVERY

Musasa has documented an unprecedented increase in calls to its GBV helpline during COVID-19 lockdown in Zimbabwe. Recognising the increased demand for services, it expanded SRHR and GBV services and legal and medical referrals available on-line. Musasa produces comprehensive GBV statistics and is one of the recognised sources of GBV statistics used by the Zimbabwean government."

DISABILITY INCLUSION:

AN OVERVIEW OF GOOD PROGRAMMATIC AND ORGANISATIONAL PRACTICES

Women and girls living with a disability are at higher risk of experiencing GBV, and they face greater barriers to protection, accessing services and reporting cases of GBV. Despite these increased risks, they are less likely to be consulted or included in GBV prevention and response programmes or mitigation measures, because development and humanitarian actors reflect the assumptions that exist in wider society, and this has an impact on programming.[25] While there are existing toolkits and guidelines to make development and humanitarian programmes disability inclusive, very few focus on GBV specifically (See page 21 for a list of Key Resources).

This section points to the need for organisations to work more effectively toward the elimination of disability stigma within society while simultaneously taking concrete steps at programmatic and organisational levels in order to make gender equality and GBV programmes disability-inclusive.

GOOD PROGRAMMATIC PRACTICES TO INCREASE DISABILITY INCLUSION

- *Addressing Disability Stigma Across All Aspects of Society*

Women and girls with disabilities face significant stigma and discrimination across all levels of society, including within their own home, schools, at the community level and up through national institutions like health services and the judiciary. Taking this into consideration, it is important that organisations conduct contextual analyses or assessments regarding disability issues and marginalisation within the communities where they work. Such assessments should always centre the lives, experiences and voices of persons with disabilities as well as the expertise and advocacy of organisations of persons with disabilities (OPDs). The needs, rights, aspirations and dignity of all people including people with disabilities and other members of society subject to discrimination, must be integral to an inclusive community centred approach that leaves no one behind.

WHAT IS DISABILITY INCLUSION?

The meaningful participation of a diverse group of persons with disabilities, ensuring rights are promoted and the consideration of disability related perspectives in all policies and programmes in compliance with the Convention on the Rights of Persons with Disabilities

Tackling stigma at the intersection of disability and other marginalising factors—whether through engagement of national authorities, local organisations, women's groups, or religious and traditional leaders—will require long-term and sustained efforts. During community engagement, efforts can include incorporating reflection on the community's attitudes toward women and men with disabilities; considering the causes and consequences of attitudes toward people with disabilities; and developing suggestions not only on how to improve the lives of persons with disabilities in the community but also how to centre persons with disabilities in decision making, particularly women and girls with disabilities (See Plan International's

Disability Awareness Toolkit, which includes open-source facilitation materials for community engagement, listed in Key Resources on page 21).

Where possible and if safe to do so, persons with disabilities and organisations for people with disabilities should be part of or, ideally, lead community engagement, in order to promote their voice and agency as well as design and implement programmes that work best for everyone. Ensuring that community-related programmes address disability stigma serves to increase buy-in among communities —particularly community leaders—and create more space for persons with disabilities to play an increasingly active role in the community. In other words, tackling disability stigma across the various layers of society whether at the household, community, and/or national level—lays essential groundwork for other programmatic and organisational practices on disability inclusion in GBV programmes to thrive.

- *Centering the experiences and voices of women and girls with disabilities throughout all stages of decision-making and programme intervention, from inception through monitoring and evaluation.*

Interventions in humanitarian, development and/or fragile contexts are often weak in community accountability, failing to be fully inclusive of, or promote leadership in decision making and implementation by all members of society, including women and girls, persons with disabilities, carers of persons with disabilities or organisations of persons with disabilities consistently and throughout the project cycle. Such exclusion from consultations and implementation undermines the intended equitable impact of programmes across all community members and reinforces discrimination that leads and adds to vulnerability in the first instance.

International guidance on GBV and inclusion of persons with disabilities stresses the importance of placing people, especially women and girls, at the centre of decision-making processes. This means inclusion, active participation and leadership by all impacted stakeholders, especially the most vulnerable.[26] It is recommended to consider the most appropriate way for these consultations to take place in order to achieve the highest amount of participation and ensure that participants feel comfortable expressing themselves. This means thinking about time, location and communications. For example, this may entail conducting consultations primarily with women and girls with disabilities, from different age groups, rather than holding mixed consultations with either men and boys with disabilities or women and girls without disabilities.

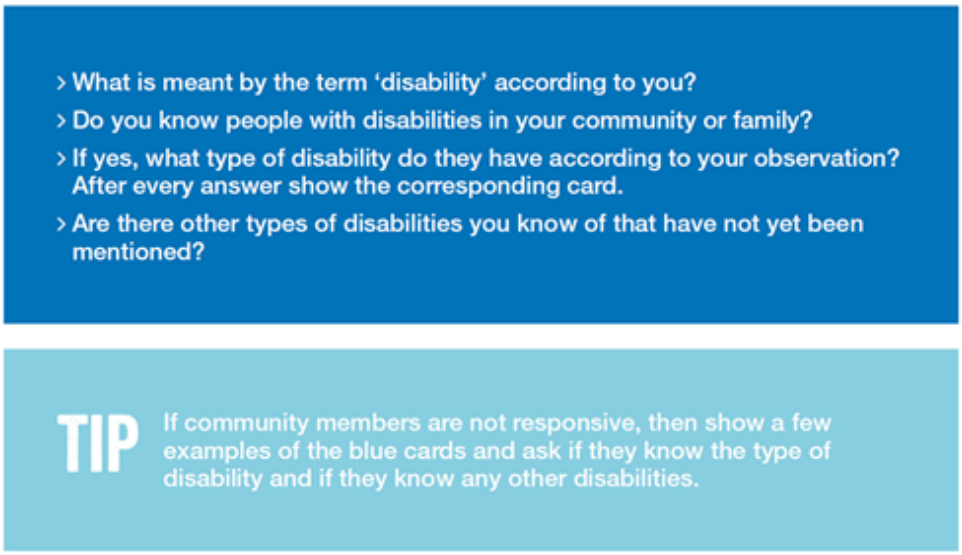

Figure 3: Questions to facilitate community conversations, from Plan International's Disability Awareness Toolkit. See the toolkit in Key Resources on p. 21 for more open-source visual materials

Consultations should also consider women and girls' type of impairment. In instances where interviews or focus group discussions may not be appropriate options for consultation—for example with children, particularly those with intellectual disabilities—participatory alternatives, such as using photos, storytelling or ranking in order to solicit responses should be considered. These types of approaches can be empowering for many women and girls with disabilities, as they facilitate the ability to make decisions. Not only this, but having confidence and skills are initial elements in accessing services or beginning to claim fundamental rights. Such empowerment and inclusion is especially important given that women and girls with intellectual disabilities are at high risk of experiencing sexual abuse and are often excluded from health, gender equality or GBV programmes due to their perceived asexuality or need for reproductive healthcare. More on identifying persons with disabilities and conducting monitoring of programmes can be found in the final sub-section on data disaggregation by disability, gender and age.

- *Comprehensive Accessibility*

In many contexts globally, women and girls are expected to stay and work in the home. Due to stigma around disability and their lack of access to essential services such as healthcare and education, women and girls with disabilities may be even further confined to the home, or in some cases even physically restrained from leaving the house. Taking into account that women and girls with disabilities are at higher risk of experiencing GBV, it is critical that GBV programmes reach them. While physical accessibility is often the first element that comes to mind for many people, accessibility goes beyond issues of physical barriers and includes information barriers as well as attitudinal barriers and institutional or organisational barriers (discussed in the following sub-section starting on page 16).[27]

LEADING RESOURCE ON DISABILITY INCLUSION AND GBV FROM THE WOMEN'S REFUGEE COMMISSION AND THE INTERNATIONAL RESCUE COMMITTEE:

'Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings: A Toolkit for GBV Practitioners' includes 11 practical and ready-to-use materials/tools for practitioners on the following topics:

1. Guidance on including persons with disabilities and caregivers in GBV assessments
2. Group discussion guide
3. Individual interview tool
4. Gender-based violence and disability: A training module for GBV practitioners in humanitarian settings
5. Pre- and post-training test for the GBV and disability training module
6. Guidance on communicating with people with disabilities
7. Accessible information, education and communication (IEC) materials
8. Guidance for GBV caseworkers: Applying the guiding principles when working with survivors of disabilities
9. Guidance for GBV service providers: Informed consent process with adult survivors with disabilities
10. Working with caregivers of survivors with disabilities
11. Reflection tool for GBV practitioners

Comprehensive accessibility begins with inclusive internal policies and outreach with the community. For example, recruitment materials for consultations with women and girls with disabilities and for GBV programmes should be provided in diverse and locally appropriate formats, such as Braille, pictorial, easy to read, sign language or open-captioning in videos (See Figure 4, below). Many of these options for community outreach are low-tech and can be used in spaces in the community that women and girls and/or their caregivers frequent, as well as during home visits or community events (See WRC & IRC's Toolkit on Building Disability-Inclusion Capacity for GBV Practitioners, Tool 7, on page 14). GBV response services, such as GBV hotlines, but indeed all initiatives, must account for women with varying communication needs, including women living with visual and hearing impairments. Finally, inclusive communication methods are particularly important during crisis contexts, where essential information is disseminated on provision of services or emergency updates.

Accessibility should also be addressed at the site of consultations or programmes. Women and girls with disabilities who are involved in GBV prevention activities in the community, for example at women's centres, have reported that reduced isolation improves social networks.[28] In addition to considering whether physical sites are accessible, programmes may also or alternatively consider whether it would be appropriate to go to women and girls with disabilities in their homes, for home-based activities with neighbours, home visits or individualised case management. In a recent report, the Women's Refugee Commission and International Rescue Committee found this to be an effective way to reach women and girls with disabilities.[29]

There are existing tools for carrying out accessibility audits,[30] which can be used alongside organisations' gender assessments when designing and implementing GBV prevention and response programmes.

SPOTLIGHT ON CAREGIVERS OF PERSONS DISABILITIES

It is essential to acknowledge caregivers of children and people with disabilities. Caregiving is a complex role, and caregivers themselves can experience a range of emotions, including fear and worry, about their child or family member with disabilities and the stigma that they face in society.

Caregivers are most often women, and they are often faced with challenging responsibilities and difficult decisions. For example, imagine a woman who is the primary caregiver for her 14 year old daughter who has an intellectual disability. Her daughter has been excluded from education because the school is not accommodating, but she cannot stay at home with her daughter because she needs to pursue income-generating activities. She spends her time at work in fear that her daughter may be vulnerable to abuse.

It is important to include and work with caregivers when aiming to work with persons with disabilities. Caregivers themselves may often be left out of programming, due to time constraints or stigma from the community.

See WRC/IRC's Tool 10 'Working with caregivers of survivors with disabilities' for more on how GBV programme staff can support survivors and their caregivers in the case management process.

It is also recommended to account for accessibility budgeting in programme design. For physical accessibility, guidance suggests budgeting at least an additional 0.5 - 1% of overall budgets, and for non-food items and assistive devices, it is recommended to budget an additional 3 – 4% of the overall budget.[31] However, accessibility goes beyond physical accessibility, and this percentage should be adapted to suit the accessibility needs of people included in programmes.

Accessible information, education and communication (IEC) materials

Types of disability/impairment and effective and communication methods	People who are visually impaired or blind	People who are hearing impaired or deaf	People with intellectual disabilities	People with physical disabilities
Radio	✓	✗	✓	✓
Television	For audio content	For visual content	✓	✓
Printed Materials: Posters, Billboards and Flyers (dependant on literacy)	✗	✓	Simplified picture-based messages	✓
Drama	For spoken content	For visual content	✓	✓
Discussion Groups	✓	With appropriate sign interpretation	If simplified and accepted by group members	✓

Figure 4 ICGBV reproduction based on WRC/IRC's Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings: A Toolkit for GBV Practitioners (see Tool 7)

- *Data disaggregation by disability, gender and age*

There is a push for the humanitarian and development sector to disaggregate data based on disability, gender and age. The Convention on the Rights of Persons with Disabilities, for example, called for gender and disability sensitive indicators for the 2030 Agenda. However, such disaggregation or aligning of programme indicators has yet to be effectively mainstreamed.

Data disaggregation takes several forms and will not capture all inclusion issues, nor should it be prioritised over inclusion, but it is has been identified as one opportunity for identifying vulnerability and monitoring project progress in responding to it. For surveys or assessments of any nature, including GBV assessments, that seek to account for persons with disabilities, the Washington Group questions are recommended as best practice.

The Washington Group questions can be used during GBV specific and other assessments, although it is simultaneously essential to adhere to best practice on collecting data on GBV. Among other requirements, the incidence of GBV should only be recorded if confidentiality and anonymity are continuously guaranteed, so as to not put women and girls with disabilities at further risk [32] (See WHO's Guidelines on Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies for comprehensive best practice) .

ORGANISATIONAL PRACTICES ON DISABILITY INCLUSION IN GBV PROGRAMMES

- *Staff capacity on disability-inclusion*

Humanitarian and development practitioners are not immune to having or perpetrating negative attitudes toward persons with disabilities and women and girls with

SPOTLIGHT ON WASHINGTON GROUP QUESTIONS

The Washington Goup Questions are six standardised questions which were initially designed to identify persons with disabilities in national censuses. The six questions ask the respondent if they have any difficulties with performing the following tasks: walking, seeing, hearing, cognition, self care or communication. Given that impairments vary in severity, each question has four options for how the participant performs the task: no difficulty experienced while performing the task; yes, some difficulty experienced; yes, a lot of difficulty; or cannot do this task at all. If someone answers 'yes, a lot of difficulty' or 'cannot do at all', then this person is considered a person with disabilities according to the Washington Group Questions.

The Washington Group Questions can be utilised on small or large scales. However, there are ethical considerations to be made regarding their usage. One ethical concern relates to an organisation's capacity (or lack thereof) to respond to newly identified needs of persons with disabilities. A study by Humanity and Inclusion and Leonard Cheshire—'Disability Data Collection: A summary review of the use of the Washington Group Questions by development and humanitarian actors'—has shown that asking questions about disability can increase beneficiaries' expectations that the needs identified will be addressed. It should be noted that this was particularly in relation to the issue of glasses and hearing aids. Regardless, organisations should think meaningfully about their data collection intentions and ability to respond to newly identified needs.

Resource: Humanity and Inclusion– Disability Data in Humanitarian Action: Factsheets on collecting disability data in humanitarian settings, at the household level, with persons with mental disabilities and on cause of disability.

disabilities. Even gender or GBV specialists may not necessarily have sufficient capacity in disability-inclusion and may inadvertently contribute to the exclusion of persons with disabilities.[33] Existing guidelines on increasing staff capacity on disability inclusion, which are based on direct consultations with persons with disabilities and organisations of persons with disabilities, focus on two key areas:

1. increasing existing staff capacity via trainings, to combat attitudinal barriers;
2. increasing representation of staff with a disability, to reduce institutional barriers.

The Women's Refugee Commission and the International Refugee Committee created a Toolkit for GBV Practitioners focusing specifically on building capacity for disability inclusion in GBV programmes (see Key Resources on page 21). The Toolkit includes 12 tools, including group discussion guides for reflecting on power dynamics as well as participatory activities on how to communicate about disability and how to work with caregivers. Following on from a study showing that GBV caseworkers wanted more training on working with persons with disabilities, one of the Tools is specifically for caseworkers to build their capabilities on ways to ensure consent during the case management process.[34]

In addition to staff capacities, another area of importance in increasing disability inclusion at the organisational level is recruiting persons with disabilities, including women with disabilities, as development and humanitarian workers. Currently the sector employs very few people with disabilities, which feeds into prejudices as well as the lack of services for women and girls with disabilities. The recruitment of women with disabilities as front-line aid workers as well as throughout an organisation—including in administrative functions, senior management and board levels—has been shown to increase the community's concerns of persons with disabilities in the community as well as show the community the skills and capacities of persons with disabilities. [35]

‘MAKING SPACES MORE INCLUSIVE FOR WOMEN AND GIRLS’:

WORLD VISION INTERNATIONAL DEVELOPS AN E-LEARNING PLATFORM ON DISABILITY INCLUSION IN SYRIA

According to a recent study by OCHA, as many as 30% of people living in Western Aleppo may be living with a disability. Alarmingly, this proportion is twice the global average, suggesting that ongoing conflict in Syria has increased the number of persons with disabilities within the country.

In such a challenging context, humanitarian aid must be responsive to the needs of those with disabilities, particularly women and girls with disabilities, who are both at higher risk of facing gendered violence and experience greater barriers to accessing services. As part of an interagency response, World Vision International works in coordination with the North Syria Protection Cluster, Gender-Based Violence (GBV) Sub-Cluster and co-leads the Child-Protection Sub-Cluster to promote disability inclusion.

To develop an online training course on disability inclusion, World Vision spoke with women and men with physical disabilities to better understand the experiences of people with disabilities in the Northern Syrian context. Such conversations showed that there were barriers to attending community centres, including lack of outreach and accessibility as well as the idea that people with disabilities do not have their own independence. These barriers were even higher for women with disabilities, who typically had less access to information and transport than men with disabilities. For both women and men with disabilities, existing barriers were compounded by a lack of staff capacity and prejudices toward people with disabilities.

Based on these findings and other evidence that women and girls with disabilities face greater risk of GBV, World Vision created and launched a free eLearning course in Arabic called “Making Spaces More Inclusive for Women and Girls”, hosted online by Disaster Ready. The 90-minute course was launched in November 2019 and was designed for social workers and program managers, who are responsible for creating women and girls’ safe spaces.

The course consists of three units: i) rights of persons with disabilities, ii) basic concepts on disability and iii) fostering the independence of persons with disabilities. These units aim to provide participants with a comprehensive overview of disability inclusion principles, as well as to look at the obstacles faced by women with disabilities and consider how their independence can be maximised through with family and social supports. All concepts are applied to the context of women and girls safe spaces.

In the six months since the training’s launch, almost 1000 people have registered in the course, and over half have already completed it. Survey feedback from participants has been very positive. Moreover, as staff have adapted their centres to be sensitive to the needs of women and girls with disabilities, they have said that more women and girls living with disabilities have started participating in programmes offered.

Given the success of the course, World Vision plans to expand the eLearning course and incorporate three additional units. These will focus on i) Ensuring that accessibility goes beyond physical accessibility, ii) The difference between the integration of services and creating special services for women and girls with disabilities and the elderly and iii) Considering gender and people with disabilities in crisis and armed conflict, with a focus on how women and girls face risks of GBV. The additional units aim to continue education on the challenges facing girls and women with disabilities and provide suggestions on practical ways to make programmes more sensitive to their needs.

ENGAGING GIRLS AND BOYS WITH DISABILITIES THROUGH SPORT AT SCHOOL

PLAN INTERNATIONAL USES THE 'PLAN2INCLUSIVIZE' METHODOLOGY IN GUINEA & MALI

The prevalence of GBV worldwide is largely due to systemic gender inequality that disempowers women, girls, and other minorities, and stifles their voices so that their stories are not heard, and their natural human rights can be more easily taken away. This is doubly the case of women and girls with disabilities. Plan International works towards inclusive, quality education to keep girls in school giving them greater chance to be heard and claim their human rights.

In 2017, Plan International conducted a training of trainers (ToT) on Plan2Inclusivize, a methodology developed by Plan International and the UNESCO Chair to transform the lives of children and young people with disabilities, their families, and communities, through physical education, sport, recreation, and fitness.

Mamadou Saliou Balde and Ibrahim Touré from Guinea and Mali, respectively, participated in the ToT, and they have rolled out this training within their countries as part of the Irish Aid funded Education, Quality, Inclusive, Participative Programme (EQuIP).

ICGBV: Could you tell us about the P2I trainings you led following the ToT?

Ibrahim: While cascading the training, to take a gender inclusive approach, we took steps like aiming to have gender parity amongst the teachers selected for training. As trainers, we all had the responsibility of making sure that women's voices were heard.

Balde: We also took efforts to ensure that there was gender balance among the children and parents who participated and that all training facilities were accessible by the participants.

Ibrahim: Despite our efforts, we have had more men teachers attend the trainings. One of the challenges is that the proportion of women teachers is lower than men teachers in Mali, and another is that Timbuktu is a religiously conservative region, so it can be difficult to encourage women's participation. One challenge faced during implementation is that schools have infrastructure and accessibility issues. Also, we see that the enrolment rate of girls in general, including girls with disabilities, declines toward the secondary school level, when pressures to marry or work rise.

ICGBV: How is the project impacting on children with disabilities?

Balde: In Guinea, we have seen the EQuIP project have a positive impact on the primary school retention rate of children with disabilities. At the national level, 2% of students who finish primary school are children with disabilities. In contrast to this, in the 150 schools targeted by the EQuIP project, there has been a slow progression showing an increase to 4.4% of children with disabilities finishing primary school in 2019.

ICGBV: Is the P2I methodology still being used in Guinea and Mali?

Balde: Yes, P2I trainings were attended by local and national government representatives, and this helped boost the discussion on inclusive education. The P2I approach has now been introduced in the national primary school physical education curriculum and is part of thee national 2020-2029 National Education plan, which addresses the intersectionality of gender, protection, and disability.

"Before these activities, my classmates made fun of my impairment, but now I am more involved. I am a member of the Children's Parliament of my school."

- Sia

The EQuIP programme has had a positive impact on many girls and boys with disabilities, including Sia from Guinea. Sia is 15 years old and lost her right arm at age 10, following an infection in her hand that spread and required amputation. During this time, Sia was out of school for two years. She has been back since the 2016/17 school year and involved in P2I through the EQuIP project.

PROGRAMME RECOMMENDATIONS

- Centre the experiences, voices, and lives of people with disabilities and ensure the inclusion of women and girls in programming, including promoting their participation and leadership in decision-making.
- Work closely with Organisations of Persons with Disabilities (OPDs) whenever possible.
- Take into consideration the perspectives of caregivers of persons with disabilities, as they are often women who are excluded from programmes due to their added caregiving tasks.
- Promote the social and rights-based models of disability, which focus on breaking down barriers for people with disabilities and strengthening their rights in society.
- Context always matters: Conduct contextual analysis in the areas your organisation works in order to better understand the unique needs of women and girls with disabilities.
- Work toward mainstreaming disability inclusion across all aspects of programming, not just programming on gender equality or GBV.
- Think about accessibility comprehensively: It is often not just physical barriers that prevent people with disabilities from participating but also communication barriers and attitudinal barriers such as stigma and misunderstanding of disability.
- Address disability stigma and discrimination within your organisation, with partners and other interlocutors through staff training, codes of conduct, inclusive recruitment and career progression opportunities.
- Hire persons with disabilities and women with disabilities as staff in your organisations. People with disabilities increase the skills available within your organisation, and having people with disabilities in staff roles illustrates that people with disabilities in communities can be leaders and decision makers too.
- Dissaggregate programme data by disability and gender. Where appropriate, include questions on disability in data-collection materials to better understand the needs of persons with disabilities in the areas you work.
- Be informed and stand ready to constructively challenge discriminatory behaviour.

Key Resources on Disability Inclusion and GBV

RESOURCES AND TOOLKITS FOR DISABILITY INCLUSION:

- Women's Refugee Council & International Refugee Committee - 'Building Capacity for Disability Inclusion for Gender-Based Violence Programming in Humanitarian Settings: A Toolkit for GBV Practitioners' (Available in English)
- Plan International – 2016 – Disability Awareness Toolkit: Introducing Disability Inclusion in our Community (Available in English, Spanish, Arabic).
- CBM – 2019 - Disability and Gender Analysis Toolkit. (Available in English)
- Women's Refugee Commission and Child Fund International – 2016 – Gender-Based Violence against Children and Youth with Disabilities: A Toolkit for Child Protection Actors. (Available in English, French, Arabic)

INTERNATIONAL HUMANITARIAN GUIDELINES:

- Age and Disability Consortium - Humanitarian inclusion standards for older people and people with disabilities. (Available in English)
- Inter-Agency Standing Committee – Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action (Available in English and Braille)
- Inter-Agency Standing Committee – Guidelines on Integrating Gender-Based Violence Interventions in Humanitarian Settings (Available in English, French, Spanish, Arabic).

RESOURCES RELATED TO REPRODUCTIVE HEALTH AND RIGHTS FOR WOMEN AND GIRLS WITH DISABILITIES:

- UNFPA – 2018 – Guidelines for Providing Rights-Based and Gender-Responsive Services to Address GBV and Reproductive Health and Rights for Women and Young Persons with Disabilities. (Available in English, Spanish, French)
- UNFPA – Your rights: Information for women and young persons with disabilities. (Easy read version)

WEBINARS:

- GBV and Child Protection Area of Responsibility Community of Practice – 2020 - Applying a Rights Based Approach to Supporting Child and Adolescent Survivors with Disabilities
- GBV and Child Protection Area of Responsibility Community of Practice – 2020 -Key Considerations for a Case Management Approach with Child and Adolescent Survivors with Disabilities

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ACKNOWLEDGEMENTS

This paper was developed and written by staff at the Irish Consortium on Gender Based Violence and CBM Ireland: Brianna Guidorzi, Abby Ryan, Mary Keogh, and Lou Talbot Beirne. Members of the ICGBV provided invaluable feedback and contributed case studies. Special thanks also go to MSc students, Esther Breffka and Rocío Freytes Martín, who provided preliminary research on the topic which informed the development of this paper.