



“I See That It Is Possible”

Building Capacity for Disability Inclusion
in Gender-Based Violence Programming
in Humanitarian Settings

Acknowledgements

The Women's Refugee Commission (WRC) works to improve the lives and protect the rights of women, children and youth displaced by conflict and crisis. WRC researches their needs, identifies solutions and advocates for programs and policies to strengthen their resilience and drive change in humanitarian practice.

The International Rescue Committee (IRC) helps people whose lives and livelihoods are shattered by conflict and disaster to survive, recover and gain control of their future. IRC teams provide health care, infrastructure, learning and economic support to people in 40 countries, with special programs designed for women and children.

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Cover photo: Alem and her daughter Tsigab live in a refugee camp in Ethiopia. To read their "Story of Change," please go to http://wrc.ms/disability_GBV

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Acronyms & Abbreviations

| | |
|--------|---|
| CRPD | Convention on the Rights of Persons with Disabilities |
| DPO | Organization of persons with disabilities |
| GBV | Gender-based violence |
| GBVIMS | Gender-based violence information management system |
| IASC | Inter-agency Standing Committee |
| IEC | Information, education and communication |
| IPV | Intimate partner violence |
| IRC | International Rescue Committee |
| NGO | Nongovernmental organization |
| UNHCR | United Nations High Commissioner for Refugees |
| VSLA | Village Savings and Loans Associations |
| WPE | Women's Protection and Empowerment |
| WRC | Women's Refugee Commission |

Executive Summary

Gender-based violence (GBV) is a widely recognized human rights and public health concern, affecting at least one in three women globally.¹ GBV may become even more pervasive in crisis situations, where social, community and institutional protection mechanisms are often weakened or destroyed. Men and boys are also vulnerable to violence during conflict and displacement, particularly sexual violence, though to a lesser extent than women and girls.

The estimated 7.6 million² persons with disabilities living in situations of forced displacement are understood to face even greater risk of GBV because they are “less able to protect themselves from harm, more dependent on others for survival, less powerful, and less visible.”³ Caregivers of persons with disabilities, most of whom are women and girls, may also be at increased risk of GBV, as their caregiving responsibilities may preclude them from accessing social and economic opportunities, contributing to their isolation and dependence.

Despite the scale and gravity of the problem, persons with disabilities in humanitarian settings are often excluded from programs and services designed to prevent and respond to GBV,^{4, 5} due to the multiple and intersecting forms of discrimination they experience on the basis of both gender and disability. In response to this, the International Rescue Committee (IRC) and the Women’s Refugee Commission (WRC) conducted a project to identify these barriers to access, and to pilot and evaluate solutions for promoting disability inclusion in GBV programs in conflict-affected settings. The project was conducted in conflict-affected communities in Burundi, Ethiopia, Jordan and the Northern Caucasus in the Russian Federation. It employed a participatory approach to solicit inputs from women, girls, boys and men with disabilities and their caregivers to inform the development of activities and tools to facilitate disability inclusion, and understand what worked and what change mattered most to them.

This report documents the key findings and lessons learned from the project, and concludes with practical recommendations for a range of humanitarian actors, governments and donors to improve disability inclusion in GBV program-

ming in humanitarian settings. Stories of Change from women and girls with disabilities involved in project, and A Toolkit for GBV Practitioners, including tools and guidance to assist them in strengthening disability inclusion in their work, are available at http://wrc.ms/disability_GBV or www.gbvresponders.org

Key findings and lessons learned

Types of violence

Sexual violence was the most common type of GBV reported by focus group participants in the project settings, with some women and girls with disabilities reporting being subjected to sexual violence, including rape, on a repeated and regular basis and by multiple perpetrators. Women and girls with mental⁶ and intellectual disabilities were perceived to be most at risk of sexual violence, and family and service providers may only become aware of sexual violence against them when they become pregnant. Sexual violence against men and boys with intellectual disabilities was also reported in Burundi and Jordan, though to a lesser extent than for women and girls. Social isolation, loss of protective community networks and changes in gender roles, particularly in households where a person may have a newly acquired disability, increases vulnerability of persons with disabilities, but also female caregivers, to violence both inside the home and in the public space.

Barriers to access

Project participants most frequently reported that **negative attitudes and discrimination** by GBV service providers, family and community members prevented their access to GBV prevention activities and response services. The fact that survivors with disabilities may not be believed when reporting violence, lack of confidentiality and the prospect of facing further stigmatization and marginalization were all reported to deter survivors with disabilities from seeking services and assistance. The capacity of persons with disabilities to participate in and benefit from GBV prevention activities is underestimated by program managers and community members, and thus they are not invited to join. **Inadequate transportation** to activity locations and service centers and **lack of use of appropriate communication**

approaches by GBV practitioners, particularly for people who are deaf or with intellectual disabilities, were also cited as barriers to access and participation. **Caregivers** of persons with disabilities reported also being excluded from activities as a result of being **unable to leave the people they care for**.

Positive practices to facilitate disability inclusion

Building capacity of GBV practitioners: GBV practitioners reported a **positive change in their attitudes** toward working with persons with disabilities, particularly as a result of the **experiential and reflective learning activities** in the project. Working directly with survivors with disabilities allowed practitioners to see beyond the person's impairment, appreciate their skills and capacities, and recognize that they can benefit from and make positive contributions to GBV activities. Practitioners also learned to recognize that survivors with disabilities have many of the same needs as those without disabilities, and that the practitioners could apply their existing training in using a survivor-centered approach to working with this group. GBV practitioners also learned to **better tailor their services to survivors with disabilities** — including through **home visits, home-based activities and specialized case management services** with more effective and appropriate communications approaches.

Providing social and economic empowerment activities for women and girls with disabilities and their caregivers to establish peer networks and greater financial independence: The most important outcome cited by women and girls with disabilities and female caregivers was the development of more robust **peer networks** through various social empowerment activities, including discussion groups, asset-based programming for adolescent girls and Village Savings and Loan Associations (VSLAs). These activities fostered **relationship building and trust** among women and girls with disabilities, as well as with others in the community. They also led to **information exchange and skills building, improved self-esteem** and opportunities for women and girls with disabilities to be **recognized not for their impairment, but for their roles as leaders,**

friends and neighbors making positive contributions to their communities — all of which can serve as protective factors against GBV. Women with disabilities and caregivers in the VSLAs also reported **increased independence and decision-making and greater respect and status within the family and community as a result of their newfound access to income-earning opportunities**, which can also serve to reduce vulnerability to GBV. Project participants noted that **building programs around the skills and capacities of persons with disabilities** was an important enabler for inclusion, but also reported that for many persons with disabilities, existing programs did not always require adaptations — **simply being invited to join was sufficient to lift the barrier to participation and successfully promote inclusion**.

Promoting the representation and leadership of women with disabilities and caregivers in community institutions and activities led not only to better attention to the concerns of these groups in organizations and programs, but also to **greater appreciation by other community members of the skills and capacities of persons with disabilities**.

Introduction

Over 51 million people worldwide are currently displaced due to conflict and crisis.⁷ The World Health Organization estimates that 15 percent of any population are persons with disabilities,⁸ with potentially higher proportions among populations affected by conflict. Thus, there may be as many as 7.6 million persons with disabilities living in situations of forced displacement.

United Nations Convention on the Rights of Persons with Disabilities (2006)

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

Gender-based violence (GBV) is a widely recognized human rights and public health concern, affecting at least one in three women globally.⁹ GBV may become even more pervasive in crisis situations, where society, community and institutional protection mechanisms are weakened or destroyed. Men and boys are also vulnerable to GBV, particularly sexual violence, during conflict and displacement, though to a lesser extent than women and girls. Programs and activities to mitigate the risk of GBV and provide support to survivors are thus considered integral components from the earliest phases of humanitarian response.¹⁰

What is gender-based violence?

Gender-based violence (GBV) refers to “any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life.”

(IASC, *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery* (Draft, publication pending, 2015))

Persons with disabilities are understood to face even greater risk of GBV during crises because they are “less able to protect themselves from harm, more dependent on others for survival, less powerful and less visible.”¹¹ Caregivers of persons with disabilities, most of whom are women and girls, may also be at increased risk of GBV, as their caregiving responsibilities may preclude them from accessing social and economic opportunities, contributing to their isolation and dependence.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) requires States Parties to ensure that persons with disabilities are protected in situations of risk or humanitarian crisis (Article 11), and that international cooperation is accessible to and

inclusive of persons with disabilities (Article 32). It also requires States to “ensure that protection services are age-, gender- and disability-sensitive” (Article 16).¹²

Research shows, however, that persons with disabilities do not have the same access to GBV programs as other community members in humanitarian contexts. For example, Human Rights Watch documented that female survivors with disabilities in conflict-affected Uganda had limited access to response services, including medical services and justice systems.¹³ Women and girls with disabilities remain largely excluded from prevention programs, including the variety of women’s empowerment initiatives aiming to break the cycle of vulnerability to violence. Adolescents and youth with disabilities are often excluded from sexual and reproductive health education, livelihoods and peer support programs that could reduce their risk of GBV in these contexts.¹⁴ Finally, few studies have explored the GBV risk of caregivers of persons with disabilities in these contexts, who are largely women and girls.

Gender-based violence practitioners operating in humanitarian contexts are increasingly aware of the heightened risks of GBV faced by persons with disabilities and recognize the need to improve the accessibility and inclusiveness of their GBV programs. To date, however, there have been no evaluations of strategies to promote disability inclusion in GBV activities in humanitarian settings, no detailed examples of positive practices and limited programmatic guidance to assist field practitioners.

From 2013 to 2015, the International Rescue Committee (IRC) and the Women’s Refugee Commission (WRC) conducted a project designed to strengthen capacity and contribute to the evidence base on effective strategies for disability inclusion in GBV programs in conflict-affected settings. This report documents the findings of the project, identifies positive practices for including persons with disabilities in GBV programs and concludes with recommendations for advancing disability inclusion in GBV programs in the humanitarian sector.

What is disability inclusion?

The term “disability inclusion” refers to a broad range of strategies to promote the full and equal participation of persons with disabilities in society. Disability inclusion in humanitarian contexts is thought to be achieved through a twin-track approach that both *mainstreams* disability issues and the participation of persons with disabilities in all aspects of program development and implementation, and takes *targeted actions* to meet their specific needs and empower them to participate fully.¹⁵

The impact of disability goes beyond the individual and affects households and communities, reinforcing poverty and hindering human and social development.¹⁶ As such, caregivers and family members of persons with disabilities may also face reduced opportunities, social exclusion and stigma. GBV programs should therefore consider how disability affects individuals, family members and the wider community when developing strategies for inclusion.

The intersection of gender, disability and displacement

The root causes of GBV are structural and systematic gender inequalities, underpinning harmful gender norms and reinforcing abuse of power between men and women as social groups. Violence against women and girls is both a consequence and a cause of this inequality, reinforced by economic disadvantage and dependence, and constrained social spaces. Many individuals, however, do not experience structural inequalities and unequal power due to gender alone, and other factors, such as ethnicity and race, religion, age, sexual orientation, socioeconomic status and disability, often contribute to an individual's marginalization in society.¹⁷

Women, girls, boys and men with disabilities and their caregivers who have been displaced due to crisis and conflict experience multiple, intersecting and sometimes mutually reinforcing forms of discrimination and oppression, adding to their risk of violence, including GBV. For women and girls in particular, crisis situations exacerbate and heighten the risks they already face in times

of peace. When this intersects with disability-related discrimination and oppression, and with the demands of caregiving, the violence that women and girls are exposed to is even greater. Approaching GBV through an intersectional analysis helps us to better understand the multiple identities and experiences of persons with disabilities,¹⁸ including inequality and discrimination between men and women, and within subsets of men and women,¹⁹ which may uniquely shape the way they experience GBV, and can in turn be used to improve service provision, advocacy and program priorities.

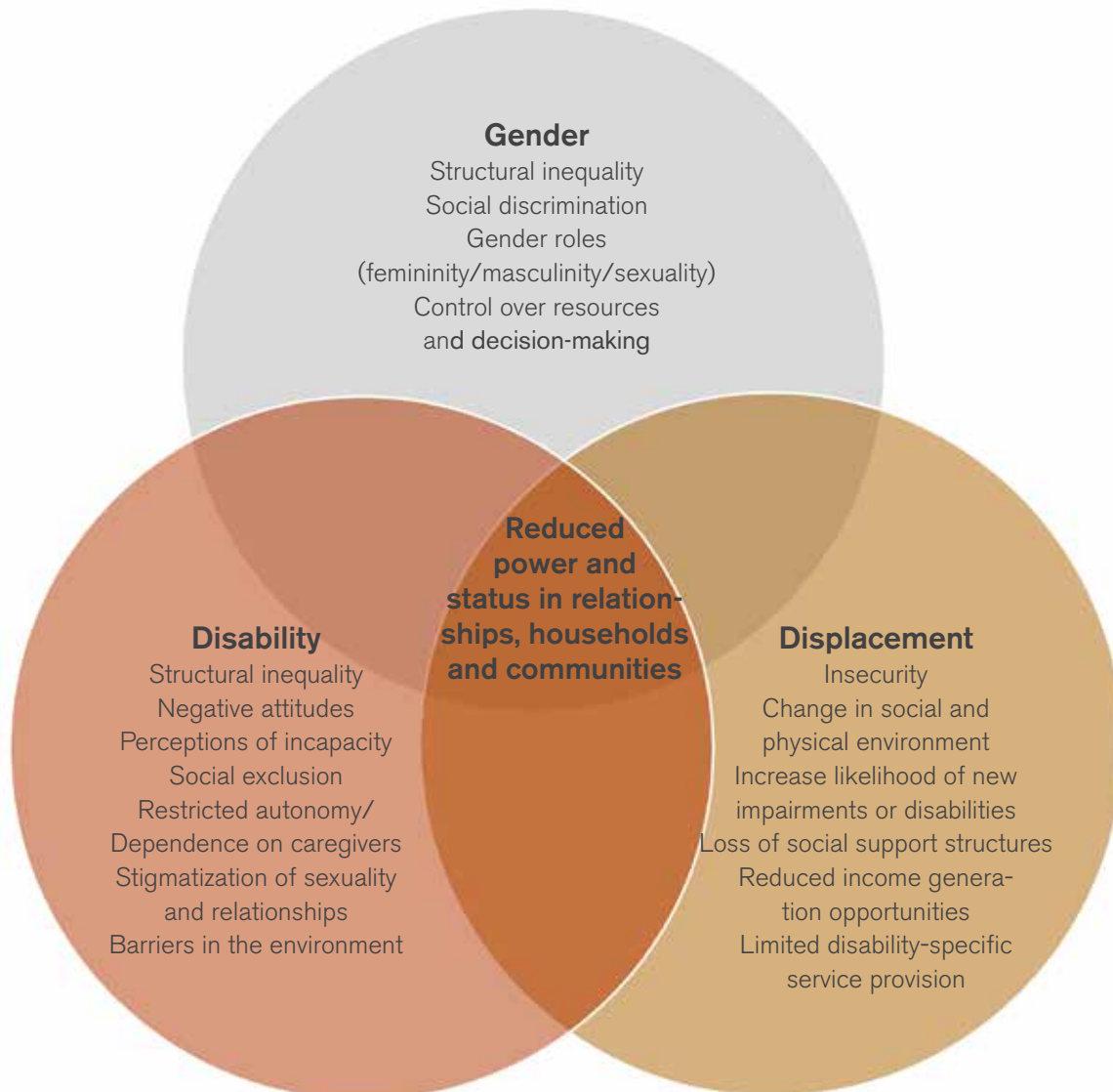
As described in the CRPD, disability is the result of intersections between impairments and other barriers in society.²⁰ Persons with disabilities are not more vulnerable to violence because of their impairment, but rather because they are perceived as different, have less power and status, are marginalized and are even directly targeted for violence.²¹ This project therefore sought to not only understand individual vulnerability to GBV, but also how relationship, community and societal factors relating to both gender and disability in the context of displacement increase risk of violence for women, girls, boys and men with disabilities, and their caregivers.²²

Guiding principles for disability inclusion in GBV programming

The following principles were defined in the early stages of the project to guide GBV practitioners. These principles are intended to complement and strengthen the survivor-centered approach to GBV programming, which “aims to create a supportive environment in which a GBV survivor's **rights** are respected and **safety** is ensured, and in which the survivor is treated with **dignity** and **respect**. The approach helps to promote a survivor's recovery by strengthening his/her ability to identify and express needs and wishes, and reinforcing his/her capacity to make decisions about possible interventions.”²³

The right to participation and inclusion: GBV practitioners should recognize the diversity of the population they serve, including the different risks faced by women, girls, boys and men with different types of disabilities in humanitarian settings, and the need to make services

Diagram 1: Power and Equality — Examples of the intersection between gender, disability and displacement



and activities accessible to and meaningful to these groups. Inclusion of persons with disabilities and caregivers, especially women and girls, to reduce their risk of GBV should be a core part of their work, not something “special” or separate.

Focus on the whole person, not their disability: GBV practitioners should recognize that persons with disabilities

have life experiences, skills and capacities, dreams and goals. They have many identities, including as mentors, leaders, wives, mothers, sisters, friends and neighbors.

Don’t make assumptions: GBV practitioners should not assume that they know what a person with disabilities wants or feels, or that they know what is best. Do not assume that because a person has a disability they are

incapable of certain things or would not be interested in participating in certain activities. Take time to consult with them, explore their interests and provide them with opportunities, as with other GBV survivors.

Identify and utilize strengths and capacities: Work with persons with disabilities, as well as their family members, to identify their skills and capacities, and use these to inform GBV program design, implementation and evaluation. Persons with disabilities are the experts on their disability and can provide critical guidance on how to adapt programs and activities to better serve them. Individual action plans should be built around people's capabilities.

Focus on “working with”: Persons with disabilities, particularly women and girls, often have decisions made for them by other people, including by family members, caregivers, partners and even service providers. GBV practitioners should instead take the approach of working with persons with disabilities through a collaborative process that identifies their concerns, priorities and goals. Avoid reinforcing negative power dynamics by making decisions for them, and instead support them to develop their own sense of agency and power to make their own decisions.

Working with caregivers and families: Disability also affects family members, particularly women and girls who may assume caregiving roles. GBV practitioners should seek to understand the concerns, priorities and goals of caregivers, and to both support and strengthen healthy relationships and balanced power dynamics between caregivers, persons with disabilities and other family members.²⁴

Project Methodology

The goal of this project, conducted from 2013 to 2015, was to improve access and inclusion of persons with disabilities and caregivers in GBV activities in humanitarian settings by:

- i. identifying the gaps and opportunities for disability inclusion in GBV programs in humanitarian settings;
- ii. piloting and evaluating actions that promote the inclusion of persons with disabilities and their families in IRC Women's Protection and Empowerment (WPE) programs in four countries — Ethiopia, Burundi, Jordan and Northern Caucasus in the Russian Federation; and
- iii. documenting and sharing the effective strategies, tools and resources for disability inclusion with the wider humanitarian community.

Phase 1: Initial assessment in GBV programs in pilot countries (August — October 2013)

The first phase of the project sought to understand the needs and capacities of persons with disabilities and their caregivers in humanitarian settings in relation to GBV; to identify potential barriers and facilitators to access and inclusion in GBV activities; and, lastly, to gather ideas on how to address gaps in programs. Four IRC WPE programs were identified to participate in the project — Ethiopia, Burundi, Jordan and Northern Caucasus in the Russian Federation. These programs were selected because their staff had expressed interest and commitment to disability inclusion, and together they reflected different regions, operational contexts (e.g., urban and camp refugees; new and protracted displacement; post-conflict reconstruction) and types of GBV activities (e.g., response services; community mobilization; economic empowerment; and women's movement building).

Focus group discussions and individual interviews with persons with disabilities and caregivers

The WRC Disability Program supported IRC staff and partners in each of the pilot countries to gather information from persons with disabilities and their caregivers. This was done through focus group discussions and individual interviews with women, girls, boys and men with disabilities and their caregivers, and community leaders in selected contexts. Interested participants were identified through community awareness-raising activities and referred by other organizations, including organizations of persons with disabilities (DPOs).²⁵ All activities were conducted in local languages with interpreters.

Over 330 people participated across the four countries: 221 persons with disabilities (126 female, 95 male) and 113 caregivers (76 female, 37 male); a quarter were under the age of 24 years. Most participants with disabilities had physical and intellectual disabilities.

A total of 25 focus group discussions were conducted in this assessment: 14 group discussions with women with disabilities and female caregivers; nine group discussions with men with disabilities and male caregivers; and two group discussions with community leaders and community workers.

Separate group discussions were conducted with men and women to gather more specific information about GBV for these different groups. Group discussions also included participatory activities, such as case studies to identify knowledge of services for survivors, and ranking exercises to determine which GBV activities they were most aware of in the community. In some contexts, smaller groups were employed to elicit the perspectives of adolescent girls and young women with disabilities, or to gather information from people using sign language.

Individual interviews were also conducted to facilitate the participation of those who were unable to attend the group discussions. This approach was most commonly used with people with physical impairments who were confined to their homes, and those with mental and intellectual disabilities who preferred to participate in more familiar environments or required more individualized communication approaches. Where possible, interviews were conducted directly with

individuals with disabilities. In some cases, where no method of communication could be established, information was collected from caregivers. Individuals remained part of the process so that they could hear discussions and participate in any way possible, and staff could continue to learn more about their communication skills.

See Annex 1: Table A (p. 39) for a summary of countries, contexts and activities undertaken in Phase 1 of the project.

Consultations with humanitarian actors

Through informal interviews and small group discussions, staff of the IRC, partner organizations, other NGOs and UN agencies gave their perspectives on the barriers and facilitators to access and inclusion in GBV activities for persons with disabilities, as well as capacity development needs of GBV practitioners.

Review of GBVIMS data

The Gender-Based Violence Information Management System (GBVIMS), launched in 2007 by the IRC, UNFPA and UNHCR, collects de-identified data on the demographics, types of violence and details of the incident,²⁶ and follow-up referrals made for survivors reporting to GBV service providers. This data collected in Burundi and Ethiopia from 2012 to 2013 was disaggregated for disability and analyzed to document violence trends among reporting survivors with disabilities, complementing the qualitative findings from focus group discussions and individual interviews. The GBVIMS in Jordan and Northern Caucasus was not operational during this time frame, and as such no comparative data set was available for analysis in this phase of the project for these countries.

Disability was either self-identified by survivors or identified by GBV practitioners during the course of their consultation with the survivor.²⁷ The number of survivors with disabilities who reported to IRC in Burundi and Ethiopia was small, which makes it more difficult to draw larger conclusions from this data. The data in this report includes only information from survivors who consented to share their aggregate information. This includes reported cases and is no way representative of the total incidence or prevalence of GBV in Burundi or Ethiopia.

Data analysis

Preliminary data analysis was conducted at a country level during the field visits in 2013 to define appropriate pilot activities for implementation. This was followed by a more comprehensive data analysis in 2014 that looked for common themes between different countries and contexts. Thematic coding of group discussion and interview notes from Burundi, Ethiopia and Jordan was undertaken by two coders and analyzed against core research questions using NVivo software. Means were calculated by group and number of participants to minimize errors relating to different sample sizes between the three countries. Group discussion and interview notes were not available from Northern Caucasus, where local partners conducted the assessment, and were therefore excluded from thematic coding. GBVIMS data from 2012 and 2013 in Burundi and Ethiopia were analyzed using STATA to identify parallel themes in the quantitative data, and to locate significant relationships and variance between variables and within variable subcategories.²⁸



WPE staff conducting group activities with adolescent girls and boys with disabilities and their caregivers — Jordan
© IRC Jordan

Phase 2: Activities to strengthen disability inclusion in GBV programs in pilot countries (September 2013 — October 2014)

The second phase of the project focused on the implementation of pilot activities to promote access and inclusion in GBV prevention and response activities.

Pilot actions in WPE country programs

Each IRC WPE program was supported to design and implement pilot actions based on the information and suggestions gathered from persons with disabilities and caregivers in group discussions and interviews. As WPE programs, their focus was particularly on the needs of women and girls with disabilities and for women as caregivers. Men and boys with disabilities and male caregivers, however, were included in community GBV activities. Partners, other humanitarian actors and community leaders were also involved in this process in some countries through action planning workshops. IRC WPE teams then implemented these actions over a 12-month pilot period in the project.

Tools and resources for GBV practitioners

During the second phase of this project, IRC and WRC developed draft tools to help promote disability inclusion in GBV program activities and to strengthen the capacity and skills of WPE staff to provide appropriate, survivor-centered case management to persons with disabilities. These tools and resources were shared with country programs for testing and feedback. In addition, selected tools were adapted for GBV practitioners from other organizations and are available in *A Toolkit for GBV Practitioners* at [http://wrc.ms/disability GBV](http://wrc.ms/disability%20GBV) or www.gbvresponders.org

Phase 3: Positive practices for disability inclusion in GBV programming (September - November 2014)

In the third phase of the project, the WRC Disability Program facilitated a participatory evaluation with IRC

WPE country programs and partners. The evaluation sought to identify:

- **Outcomes** — Changes in capacity of GBV practitioners to include persons with disabilities and caregivers in their work; the factors that contributed to positive changes (facilitators) and ongoing gaps (barriers).
- **Impact** — Changes in access and inclusion for persons with disabilities and their caregivers in GBV prevention and response activities; the factors that contributed to positive changes (facilitators) and ongoing gaps (barriers).

A participatory approach was chosen to engage stakeholders and beneficiaries in the evaluation process as partners, not only in data collection, but also in determining what kind of change matters the most. Participatory approaches also sought to facilitate an ongoing process of reflective learning among beneficiaries (both persons

with disabilities and GBV practitioners) and to promote collaboration between stakeholders beyond the life of the project. The evaluation provided an opportunity for these stakeholders to reflect on project progress together, to generate lessons learned and to plan future priorities for disability inclusion in their relevant programs.²⁹

The participatory evaluation methodology included:

- collecting “Stories of Change”³⁰ from persons with disabilities, caregivers and community leaders involved in the project using verbal storytelling, drawing and photo elicitation;
- a participatory self-assessment exercise with GBV practitioners;³¹ and
- a Stakeholder Workshop³² to share success stories and challenges, discuss the factors that contributed to successes and identify priorities for ongoing collaboration.



Participatory activity with GBV practitioners — Burundi
© Elizabeth Sherwood/WRC

Over 150 persons with disabilities (57 female and 31 male) and caregivers (50 female and 21 male) participated in the evaluation process in Ethiopia, Burundi, Jordan and Northern Caucasus, of whom 56 percent had a disability, 65 percent were women and girls and a third were under the age of 24 years. The majority of persons with disabilities participating in the evaluation had physical and hearing disabilities.

See Annex 1: Table B (p. 40) for a summary of stakeholders and beneficiaries engaged in the participatory evaluation in each pilot country and Annex 2: Summary of recommendations from Stakeholder Workshops (p. 41).

Risk analysis and consent

The principles of protection mainstreaming were used to undertake a risk analysis and to plan appropriate mitigation strategies in each country. Protection mainstreaming is “the process through which fundamental human rights principles, including non-discrimination, meaningful access, safety and dignity are recognized and realized in program design and implementation.”³³ WPE staff were present at every activity to provide information about available services and to initiate referrals for any individuals requesting further support. WPE programs and partners remained operational in all four countries throughout and after the close of the project, facilitating identification and follow-up of any unexpected negative outcomes from project activities.

In all activities, participation was voluntary and informed consent was obtained from persons with disabilities, caregivers and other stakeholders who were willing to participate. Adults (over 18 years) gave verbal consent to participate after a briefing about each activity. For interested participants under the age of 18 years (e.g., adolescents girls), verbal consent was also sought from their parent or guardian. Some adults with intellectual disabilities were invited to have a trusted caregiver, family member or friend of their choice participate with them in the consent process and/or the actual activities. Written consent was obtained from all individuals who are identifiable through photos and personal stories in this report.

Phase 1: Initial Assessment in GBV Programs in Pilot Countries

A number of key issues emerged in the initial assessment that should be considered when designing or adapting GBV programs to include persons with disabilities and caregivers. These include findings about the types of GBV experienced by women and girls with disabilities, as well as violence experienced by men and boys with disabilities; the factors that contribute to this violence; and the barriers persons with disabilities face in accessing GBV programming and services in humanitarian contexts. The findings in this section are drawn from the analysis of data from Jordan, Burundi and Ethiopia.

Violence experienced by persons with disabilities and caregivers

Persons with disabilities, caregivers and community leaders in project sites in Burundi, Ethiopia and Jordan reported that persons with disabilities experienced GBV in their displaced communities, and that women and girls with disabilities and female caregivers were perceived to be most at risk. Data from Ethiopia and Burundi showed that approximately 6 percent of survivors reporting GBV to the IRC have a disability.³⁴ The most common type of GBV reported in group discussions in all countries was sexual violence, including rape and sexual assault, followed by emotional violence and exploitation. Similarly, GBVIMS data from Ethiopia and Burundi show that the most common type of GBV for which persons with disabilities sought assistance from the IRC (men and women combined) was rape (51 percent of reporting survivors with disabilities³⁵) followed by psychological/emotional abuse (27 percent of reporting survivors with disabilities³⁶). Among survivors with disabilities reporting any type of GBV to the IRC, GBVIMS data showed that the most common alleged perpetrator was an intimate partner or former partner, at 36 percent,³⁷ followed by strangers, at 27 percent.³⁸

GBV against women and girls

GBVIMS data from Burundi and Ethiopia showed that 83 percent of survivors with disabilities reporting to IRC services are women.³⁹

Sexual violence

Sexual violence was reported in all countries, with rape most often discussed in Burundi, where some women reported being sexually abused on a regular basis and by multiple perpetrators.⁴⁰ In all three countries, focus group participants expressed the perception that women and girls with intellectual disabilities were most at risk of sexual violence, followed by those with physical and mental disabilities. Participants noted that rape of women and girls with mental and intellectual disabilities is often identified by family or service providers only when the survivor becomes pregnant, and that there may be many survivors of rape who bear perpetrators' children without ever having disclosed violence.

“Women and girls are more vulnerable to sexual violence, but many times they don't want to disclose. There are many unmarried women who have children every year, but never tell who the father is.”

(Participant in group discussion with men with disabilities — Bwagiriza camp, Burundi)

Sexual abuse perpetrated by strangers against adolescents with intellectual disabilities was reported in Jordan (girls and boys alike), leading some caregivers of young persons with disabilities to lock them inside the home to protect them from further violence.

“Her daughter is super active and likes to go out even when it is dark. One night she went to her neighbors' house, and when she came back, she looked different. She asked her what happened, and she explained that some boys took off her underpants.”

(Interpreted from a mother of an adolescent girl

with Down syndrome in a group discussion in Zaatari refugee camp, Jordan)

The most common type of sexual violence reported in urban centers in Jordan was sexual harassment and exploitation by male community members targeting the wives of men with disabilities when they moved around the community unaccompanied by a male, since women going out alone was not considered appropriate behavior.

“One day I was coming back from my brother's house. A taxi stopped and I asked do you know where I can get money for rent. He said come with me and we will look after you. I was scared that he would take me.”

(Participant in group discussion with women with disabilities and female caregivers in Mafrag, Jordan)

Intimate partner violence

It is widely recognized that intimate partner violence (IPV) is the most common type of GBV that women experience, and women with disabilities may experience it at higher rates than non-disabled women.⁴¹ Women with disabilities and female caregivers in Burundi and Jordan testified to experiencing sexual, physical and emotional violence perpetrated by their intimate partners.

Women with disabilities in Burundi reported that their male partners do not “value” them the same as non-disabled women, and are less likely to perceive them as suitable partners for marriage. Men with disabilities corroborated this point in their focus groups, reporting a preference for a wife without disabilities. Both women and men reported that women with disabilities commonly experience rape in their relationships.

“For a woman with a disability it is even harder for her to get married. People don't want to marry her, but rather take advantage of her (“se soulager” literally means relieve themselves...) and she can't defend herself.

So now, she is no longer a virgin and they will want to marry her even less.”

(Participant in group discussion with men with disabilities — Bujumbura, Burundi)

Married women with disabilities said their husbands prevent their participation in family activities out of shame and embarrassment. They also reported that their husbands often have extra-marital relationships, which was not only a source of “humiliation,” but also of fear of potential health consequences, since they felt unable to negotiate safe sex with their partners.

“You can’t refuse him when he comes back and he may bring diseases.”

(Woman with disabilities — Bujumbura, Burundi)

Exploitation

Some women described experiencing extreme poverty, increasing their risk of sexual exploitation in future relationships and/or of engaging in survival sex. Women with disabilities reported concerns that their children are also at risk of this type of violence, with one woman in Bujumbura describing how her daughter has subsequently engaged in prostitution to support the family.

“A husband will give up a disabled wife after she has a child. They are discriminated against in all activities — you don’t have any value. When men propose sex to her, she accepts because she needs money to provide food to her children.”

(Participant in group discussion with women survivors with disabilities and female caregivers of survivors — Bujumbura, Burundi)

Both men and women with disabilities in camp contexts reported paying people, with money or materials, to assist with daily activities and tasks, including transporting water and food distributions to their homes. In Burundi, this was reported to affect women more than men with disabilities. Furthermore, community workers and social workers in Ethiopia described how some women with disabilities who need assistance with daily activities may be coerced into exploitative relationships with individuals who offer to assist.

“They profit from your economic vulnerability....Sometimes for things we can’t do ourselves, [so] we will give money or flour. For example, fetching firewood, transferring stock to the house, repairing our houses, washing clothes and fetching water. Non-disabled women can do these things for themselves.

(Participants in group discussion with women with disabilities — Musasa, Burundi)

Gendered violence against men and boys

GBVIMS data for Burundi and Ethiopia showed that there were proportionately more men among survivors with disabilities (17 percent of survivors with disabilities were men) compared to survivors without disabilities (5 percent were men).⁴²

Sexual violence

Participants in both Jordan (both urban and camp settings) and Burundi (urban settings) also mentioned sexual violence, including rape, against men and boys with disabilities, though to a much lesser extent than for women and girls. Focus group participants shared perceptions that men and boys with intellectual disabilities were most at risk of sexual violence. In Burundi, some participants suggested that this group may be targeted by perpetrators who believe myths that they will be cured of illness or amass wealth by having sex with boys.

“There is a traditional belief that they practice sodomy to cure illness, like HIV, or to become rich. So men will rape boys. Boys with mental disabilities are more at risk than non-disabled boys, because they believe everything people tell them.”

(Caregiver of male survivor in Burundi)

Emotional and psychological violence

Men with disabilities reported emotional and psychological violence perpetrated by family and community members as a result of being perceived as “weak,” “dependent” and unable to live up to conventional norms of masculinity. For example, focus group partici-

pants in Jordan reported that men with disabilities were called a “half man” by other men in the community. In Burundi and Jordan, men with disabilities reported being ridiculed if, as a result of their disability, they could not work and provide income for their family. The inability to secure gainful employment (a challenge faced by men and women in many humanitarian settings, and often exacerbated for those with disabilities) resulted in the perception among family and community members that these men have “no value.” Men with disabilities reported feeling shame and humiliation as a result of these attitudes toward them.

“They don’t have any other role. If he is unable to work, he is despised. When you are disabled in a family, you are not considered as a person in the family.”

(Participant in group discussion with men with disabilities — Kinama refugee camp, Burundi)

Participants in Burundi also reported that men with disabilities faced emotional violence as a result of being perceived as inappropriate partners for marriage and relationships by their own and their partners’ families.

“For example, a man who is disabled and wants to marry a normal girl — the family won’t accept this and the couple will be marginalized.”

(Participant in group discussion with women with disabilities and female caregivers — Kinama refugee camp, Burundi)

This kind of violence against men and boys is harmful, but is different from the continuum of violence that women and girls experience in humanitarian contexts. It does not exist within a structural system of violence and oppression and is not perpetrated at the same level of violence against women and girls.

Other forms of violence against persons with disabilities

Persons with disabilities may be subjected to other forms of violence in humanitarian settings, including as a result of discrimination based on their disability, which may intersect with or compound gender-related discrimination.⁴³ For example, in Jordan, emotional and physical violence by caregivers against persons with disabilities was reported and even observed in some focus group discussions between female caregivers and young adults with disabilities. The verbal abuse observed was largely based on expectations about how the individual with a disability should behave and/or the role expected of them as men or women.

Denial of services was frequently mentioned as a form of violence against persons with disabilities across all countries and contexts. While comments suggest that most of these examples are likely to be discrimination on the basis of disability, there were a disproportionate number of comments relating to access to education for children with disabilities (both boys and girls) across the three countries. This has important implications for GBV prevention and risk mitigation, as schools provide a critical safe space for children and adolescents in displacement settings, and are often a forum for GBV and life skills activities. Education also increases economic and social opportunities, fostering empowerment for women and girls and other at-risk groups to overcome oppression and inequality.⁴⁴

Participants in group discussions in Ethiopia and Burundi also mentioned that men and boys with intellectual disabilities may be particularly vulnerable to “labor exploitation,” as they have the physical capacity to undertake these tasks, but few skills in negotiation. They may take on disproportionately large numbers of chores in a household or jobs in the community with less compensation than others.

“Labor exploitation. For example, if there is a disabled person — they are expected to collect water, etc., for their caregiver. Men

with intellectual disabilities are instructed to do chores.”

(Participant in group discussion with community and social workers — My’Ani camp, Ethiopia)

Finally, participants also reported high rates of physical and emotional violence perpetrated by community members against men and boys with intellectual disabilities in Jordan when compared with other contexts. Hence, men and boys with disabilities may be at heightened risk of different forms of violence in new displacement contexts, where few protection mechanisms have been established to monitor and address this.

“People are out to get us. People call me a retard, they hit me and they say bad names. Some people call us crazy....The other day I was attacked by a guy who ran away in a car....You need to help us and keep them from beating us. Give us the opportunity to make complaints and deal with these people.”

(Man with an intellectual disability — Zaatari refugee camp, Jordan)

Key factors that make persons with disabilities more vulnerable to GBV

There is evidence to support the premise that GBV against persons with disabilities in humanitarian settings is intentional, systematic and happens within the context of power and control. The root causes of GBV against persons with disabilities remain inequality based on the power imbalance that exists between men and women in the community, and within these groups. The risk of GBV, however, is exacerbated in humanitarian settings when paired with the inequalities and oppression associated with disability, particularly for women and girls. The following factors have been identified as adding to the vulnerability of women, girls, boys and men with different types of disabilities to GBV in humanitarian contexts.

Changing gender roles

Women and men with disabilities and female caregivers

are at heightened risk of GBV in humanitarian settings due to changes in gender roles that may occur in a household and the gender stereotypes that accompany this. This dynamic is particularly evident in households and communities where persons have acquired new disabilities. If a man acquires a new disability (for example, as a result of conflict), female family members may be required to find employment outside of the home, replacing the male as the household breadwinner. Insofar as this is not expected behavior within the family or community at large, these women may be exposed to violence, especially if their work requires them to move about the community alone.

“The husband usually becomes dependent on the wife. If he needs to pay for something, the wife has to go out to work....It becomes more work for the wife. There are more risks for the wives of men with disabilities because people will take advantage of her. She may become a maid for another family or have to come home late when it is dark. Sometimes society’s perception of these wives will change because they don’t know why she is going out and this is not normal here. She may become stigmatized by the community.”

(Man with disabilities in group discussion — Zaatari camp, Jordan)

Focus group participants also disclosed that when men have a disability, their wives and children may be exposed to increased risk of violence because perpetrators perceive that men with disabilities will be unable to serve in the traditional role as “protector.”

“Their children are discriminated [against] at school, and even beaten because the other children say your father won’t come here to defend you. They lose their honor and dignity as the head of family because they cannot provide for the family’s needs.”

(Group discussion with men with disabilities — Bwagirizia camp, Burundi)

Although not unique to humanitarian settings, gender stereotypes can increase the risk of IPV for women and girls with disabilities if they do not meet the expectations of their male partners as suitable wives and mothers, which can exacerbate power imbalances in these relationships, increasing vulnerability to GBV. Men, both with and without disabilities, have little incentive to take on other roles, such as caregiving of children, as it is so undervalued in society and further reduces their status among men. The complex interaction of societal norms and expectations placed on both women and men, combined with the perceived failure of women with disabilities to fulfill the roles expected of them in a household, exposes them to heightened risk of physical violence from their male partners.

“Women with disabilities are despised because they can’t do work like other people — like carry water and make meals. Husbands have to do this and some of the other men will tease them saying ‘Why did you marry this disabled woman?’ and this may cause violence in the family between husband and wife. When the husband comes home and is drunk, he can talk to you bad and start beating you — you can’t defend yourself and he knows this.”

(Participant in group discussion with women with disabilities — Musasa refugee camp, Burundi)

Family stress

The extreme stress experienced by families during conflict and displacement can create environments where violence is more likely to be perpetrated, placing persons with disabilities who are dependent on family



Group discussions with adolescent girls with disabilities — Burundi
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caregivers at greater risk. For example, women and girls with disabilities may rely on family members to assist them with daily care. This dependence can contribute to family members’ stress and anxiety, leading to resentment taken out on persons with disabilities in the form of emotional, physical or other forms of violence.

Perceptions about the capacity of persons with disabilities

Community members’ perceptions — and misperceptions — of persons with disabilities can contribute to their vulnerability to GBV. For example, perpetrators of violence may be more likely to target persons with disabilities if they perceive them as less able to defend themselves than people without disabilities. In fact, some incidents recounted by women with disabilities in urban settings in Burundi suggest that perpetrators are targeting those with physical disabilities, and at times when they will be unable to fight them off or even identify the perpetrator.

“My illness happens sometimes — I have ‘attacks’ [in French ‘crises’] — and people take advantage of me during these attacks.”

This is when men come to rape me — I don't know any of the fathers of my children."

(Woman with disabilities — Bujumbura, Burundi)

People with intellectual disabilities are often assumed to be incapable of learning the same concepts or participating in the same activities as others, and thus are excluded from opportunities to learn about violence, sex and healthy relationships, and to develop new skills and strengthen peer networks. As such, they may be more easily manipulated and targeted by perpetrators for rape, abuse and exploitation, or have less capacity to negotiate power in intimate relationships.

Finally, survivors of GBV with disabilities may be perceived as unreliable informants about their own lives and experiences, and thus may not be believed when they report violence. Hence, perpetrators are even more likely to anticipate going unpunished for their actions, which can make persons with disabilities even more vulnerable to violence.

"Persons with mental or intellectual disabilities are also prone [to GBV]. Even if they experience sexual violence, people think they are crazy and don't believe them."

(Participant in group discussion with women with disabilities and female caregivers — Zaatari camp, Jordan)

Loss of community support and protection mechanisms

The separation of families and neighbors, and the weakening or rupture of traditional community support structures and protection mechanisms, was highlighted among project participants as increasing the risk of violence for persons with disabilities. This is particularly relevant in new displacement contexts, such as Jordan, where individuals and families have not yet established relationships and trust with others in the community or rebuilt their support systems. Participants in this setting described high levels of violence in the community and expressed fear that persons with disabilities would be targeted when outside the home. This sometimes led to negative coping strategies, such as locking people with

intellectual disabilities in their home. Similarly, in urban settings in Burundi, parents reported isolated examples when they had relied on less familiar neighbors and community members to assist with caregiving and later discovered that abuse had occurred.

"In Syria, everyone knew each other and would look after each other. Here we are surrounded by people from different towns. If something happened to my neighbor, I wouldn't care about them."

(Participant in group discussion with women with disabilities and female caregivers — Zaatari camp, Jordan)

Social isolation

A lack of contact with community networks, friends and service providers also increases vulnerability to violence for persons with disabilities. Women with physical disabilities who are isolated in their homes due to environmental and physical barriers find it difficult to move outside of their home and meet other people. Adolescent girls with disabilities may be excluded from peer networks and education, as well as asset-based programming activities, which have been demonstrated to promote protection from GBV. Some persons with disabilities, particularly those with intellectual and mental disabilities, may be hidden by family members "so much that neighbors don't even know they exist." A lack of community support and friendships can mean that they do not acquire the information and skills they need, or have people that they trust to go to when they experience violence.

"When we are disabled, even our friends don't want to see us with them. We are left alone, like we have no value. Only my family can support me — all my friends have run away from me."

(Woman with disabilities — Bujumbura, Burundi)

Isolation also increases the vulnerability of female caregivers who may be unable to leave their homes, generate income or to attend community events and activities with other women. In most situations, these individuals will be

the wives or mothers of children and adults with more severe disabilities. In some situations, however, they will also rely on adolescent girls as secondary caregivers, reducing girls' opportunities to access education and other services in the community.

Poverty and lack of income

Poverty was raised as a vulnerability factor, particularly for women with disabilities in female-headed households. Extreme poverty and lack of resources to meet their most basic needs increase the risk that women and girls with disabilities and female family members may be abused and exploited, or resort to survival sex and prostitution.

“Some of my children are the age to go to school and I have no means of sending them to school. I have to seek men to even pay for sugar in the tea, and they can do whatever they want to me. My children can't even have books for school.”

(Woman with disabilities — Bujumbura, Burundi)

Environmental barriers

Environmental barriers, including inadequate transportation in all contexts, add to isolation, but also mean that persons with disabilities must rely on other community members to access services and assistance, including food and non-food item distributions. This increases their vulnerability to exploitation and abuse, and makes it more difficult for them to access GBV response services in a confidential way.

Barriers to accessing GBV services and programming

Data for Burundi and Ethiopia show that approximately 32 percent of survivors with disabilities who reported violence to the IRC did so within three days of the incident, compared to 44 percent of survivors without disabilities who reported within three days.⁴⁵ Forty-one percent of survivors with disabilities waited over one month to report violence.⁴⁶ More work needs to be done to eliminate barriers and facilitate access to GBV

services and programs for all survivors, including and especially for persons with disabilities.

Barriers to access to GBV programs and activities in humanitarian contexts identified by persons with disabilities and caregivers include attitudinal, physical, communication and other barriers. Attitudinal barriers were the most commonly cited barriers to GBV survivors with disabilities accessing services, whereas physical barriers were more frequently mentioned in relation to prevention activities, such as community awareness raising, income generation and women's center activities.

Attitudinal barriers

Discrimination and stigmatization by family members, service providers and the wider community were the most frequently mentioned barriers to accessing services faced by survivors with disabilities. Participants reported that additional stigmatization makes persons with disabilities reluctant to disclose sexual violence, even to service providers, who often assume that they are not at risk because of their disability.

“Family members will take them to service providers, but they don't treat them correctly — they may say things like ‘You are a disabled person, how did you get raped and pregnant?’”

(Participant in group discussion with community workers and social workers — My'Ani refugee camp, Ethiopia)

It is often assumed that persons with intellectual or mental disabilities do not understand what has happened to them. Participants reported that people may not listen to or believe individuals with disabilities, especially when it is a survivor with mental or intellectual disabilities; this, in turn, reduces their access to services. Many persons with mental or intellectual disabilities are also excluded from GBV awareness-raising activities, as parents, community leaders and others assume that they are not at risk or are incapable of learning new things. This presents further barriers to them staying safe in communities, recognizing violence appropriately and/or seeking assis-

tance from trusted individuals if violence happens.

Some survivors with disabilities may need support to access services, but will fear disclosing this violence to family members, who may already carry negative attitudes about disability. Hence, many survivors choose not to disclose this violence or to access services in case it further heightens their marginalization in the family and community. In Bujumbura, some women with disabilities experienced violence so frequently that they preferred not to disclose it, even to supportive family members.

“Families will reject and hate her [a survivor] — they see her not really as a person. She lives with disabilities and now this sexual violence makes her of even less value. They will reject her and think that she is the cause of her own situation.”

(Participant in group discussion with women with disabilities — Musasa refugee camp, Burundi)

Discrimination and prejudice also pose significant barriers to the participation of persons with disabilities in GBV prevention activities and related programs. In Ethiopia, community workers and social workers reported that other community members will often ridicule individuals with mental and/or intellectual disabilities if they try to participate in community activities. This stigmatization means that parents will sometimes prevent staff from speaking to these individuals when undertaking home visits to share information about available services.

“They had a person with disabilities attending a coffee discussion, but the community rejected her and eventually she stopped coming. She is mentally ill and sometimes she doesn’t know what she is talking about, so the participants neglected her.”

(Community worker — My’Ani camp, Ethiopia)

Community leadership groups, including refugee and women’s associations, rarely have representatives with disabilities; disability associations, where they exist, are often male dominated and may actively exclude

people with mental and intellectual disabilities. These organizations often play a central role in communicating information in the community and may even appoint representatives to participate in trainings and other activities. Hence, persons with disabilities, but particularly women and girls with disabilities, may be less likely to be included in these activities.

“Persons with disabilities generally lack consideration....Sometimes the community doesn’t consider them as people for trainings and other activities.”

(Participant in group discussion with community leaders — My’Ani camp, Ethiopia)

Physical barriers

Physical barriers inhibit persons with disabilities from accessing GBV services and activities in humanitarian settings. Women with disabilities in urban centers and in the sprawling Zaatari refugee camp in Jordan reported that the lack or high cost of transportation was a barrier to accessing GBV service centers, as well as to their participation in awareness-raising and other prevention activities.

“There is no transport, so even if you know where services are, you still can’t get there.”

(Participant in group discussion with women with disabilities and female caregivers — Bujumbura, Burundi)

In all countries, female caregivers living in camp settings were unable to attend community awareness-raising and/or women’s activities, as they must remain at home caring for their family member. They attend community meetings and social activities less frequently, and so miss out on campaigns, SASA! (a comprehensive approach to preventing violence against women and girls developed by Raising Voices (www.raisingvoices.org)) and other forms of awareness raising.



"I carry my daughter with me on my back wherever I go. She is getting bigger, but still, it is like she is a part of me."

(Female caregiver of a girl with disability — My'Ani camp, Ethiopia)

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Communication barriers

Communication barriers were most frequently mentioned in relation to community-based prevention activities. People who are deaf were mentioned as being most affected by this type of barrier, as sign language interpreters are rarely available in refugee settings and many individuals use unofficial sign language. Some community mobilizers and GBV staff have attempted to communicate with those who are deaf through SASA! materials and simple gestures, but this is not consistently implemented by all staff. GBV practitioners also expressed challenges in communicating effectively with people with intellectual and mental disabilities, who are often not invited to participate in GBV activities, and/or the information is not conveyed in formats that they can understand. Participants noted that outreach and education materials rarely depict persons with disabilities, and

persons with disabilities are not employed on outreach and community mobilization teams. A variety of communications approaches, including simple messages, pictures, dramas and role plays that include persons with disabilities, would more effectively engage persons with disabilities, while also increasing the awareness of the general community of persons with disabilities.

"To see a picture of a person with disabilities, we will feel more involved with normal people. It also educates people that persons with disabilities should be involved in everything."

(Participant in group discussions with women with disabilities — Bwagirizia camp, Burundi)

Other barriers

Lack of confidentiality and resulting stigmatization by community members were raised as important issues in both urban and camp contexts in Burundi, and in the camp context in Ethiopia. Participants reported that it is harder to maintain confidentiality when a survivor has a disability, as others may have come to their assistance during the incident, and the news will often spread quickly throughout the community. They may need to disclose to others in order to access services, and GBV staff also report needing to involve a wider range of actors in case management processes. Hence, survivors with disabilities may be less likely to access services and assistance after such incidents of violence due to issues of confidentiality and fear of added stigmatization.

"The community will know if a woman with disabilities has been raped. There are no secrets in the camp. People tend to disclose information more when it is women with disabilities. They have to shout for help and so everyone finds out what has happened to them."

(Participant in group discussion with women with disabilities — Musasa refugee camp, Burundi)

Women and girls with disabilities in Bujumbura, Burundi, also reported that they may not be attended to immedi-

ately when presenting to health services after an incident of sexual violence and may be asked to return at another time to receive services, or may be refused services pending a lengthy administrative process related to their refugee status. Survivors with disabilities may face greater disadvantages insofar as it may be more difficult for them to return to the facility, as they may have fewer financial resources to pay for transportation and need to rely on others for assistance to travel.

“They can keep giving you another appointment — come back tomorrow...but this is a problem after rape because you need the medications. She spent all day and night in the hospital with no services, so the next day she went for her own HIV test.”

(Group discussion with women with disabilities
— Bujumbura, Burundi)

GBV programming, in humanitarian contexts and elsewhere, is largely focused on women and girls, as they are the most at risk of GBV. Men and boys, however, are also at risk of sexual violence, particularly during conflict and displacement. While GBV practitioners do provide support to male survivors with and without disabilities, this is not always known, and some men with disabilities in this project demonstrated gaps in knowledge about where to get case management support if they are survivors of sexual violence.

“She [a survivor with disabilities] has to go to the IRC to get help. But where should a man with disabilities go if he is raped?”

(Man with disabilities — Musasa refugee camp,
Burundi)

Phase 2: Activities to Improve Disability Inclusion in GBV Programs in Pilot Countries

Based on the Phase 1 assessment and recommendations made by women, girls, boys and men with disabilities and their caregivers, the following activities were designed and piloted in each of the project settings.

| Summary of Pilot Actions Implemented by the IRC's WPE Programs | |
|--|---|
| Country | Activities |
| Ethiopia | <p>Held "coffee discussions" with women in the homes of persons with disabilities so their caregivers could access information on GBV and to strengthen women's peer networks.</p> <p>Adapted existing GBV prevention community mobilization materials (SASA!) to depict persons with disabilities as part of the wider community.</p> <p>Conducted targeted home visits to disseminate information on GBV prevention and response to persons with disabilities who are isolated in their homes.</p> <p>Held training sessions for community mobilizers and social workers on GBV and disability.</p> <p>Made modifications to improve the physical accessibility of community buildings and latrines throughout the camp.</p> |
| Burundi | <p>Targeted Village Savings and Loan Associations (VSLAs) for persons with disabilities and their caregivers.</p> <p>Organized recreational and professional activities for persons with disabilities and caregivers.</p> <p>Conducted community awareness raising on the rights and inclusion of persons with disabilities.</p> <p>Prioritized home visits to provide more comprehensive GBV case management for persons with disabilities at risk.</p> <p>Recruited women with disabilities as community mobilizers for GBV activities.</p> |
| Jordan | <p>Integrated disability inclusion into inter-agency GBV and child protection case management training.</p> <p>Facilitated a one-day workshop on disability inclusion in sexual and GBV programming with the Inter-agency Sexual and Gender-Based Violence (SGBV) Sub-Working Group.</p> <p>Supported integration of disability into the messages and materials of an ongoing violence-prevention campaign* and into materials about IRC services.</p> <p>Held group discussions with female caregivers of persons with disabilities.</p> <p><i>* The "Amani" campaign in Jordan provided key messages for communities, children and parents, on how to better protect children and adults from harm and various kinds of violence, including sexual and gender-based violence. http://data.unhcr.org/syrianrefugees/download.php?id=5558</i></p> |

Summary of Pilot Actions Implemented by the IRC's WPE Programs

Northern Caucasus,
Russian Federation

Ran training and action planning workshops for women's NGOs on disability and GBV, including on working with girls with disabilities and supporting their parents and caregivers.

Held training and action-planning workshop with women from the All-Russia Society of Disabled People on disability inclusion in programs for women and girls.

Designed a handbook for caregivers of children with disabilities that provides information on disability-related services and assistance.

Organized a community awareness-raising concert where girls who are deaf performed with a Chechen singer.

Held social events for girls with and without disabilities to strengthen peer networks.



Coffee discussion, My'Ani Refugee Camp, Ethiopia
© IRC Ethiopia

Phase 3: Positive Practices for Disability Inclusion in GBV Programming

The participatory evaluation process in each country identified 1) changes in GBV practitioners' knowledge, attitudes and practices relating to disability inclusion, and 2) positive practices for disability inclusion in GBV programming.

Strengthening capacity of GBV practitioners on disability inclusion

GBV practitioners across all four countries were consulted in the participatory evaluation to identify changes in their knowledge, attitudes and practices relating to disability inclusion in their programs and activities over the course of the project. This activity also sought to further identify activities, tools and resources that they found facilitated these changes.

Changes in knowledge, attitudes and practices

While knowledge, attitudes and practices intersect and complement each other, GBV practitioners most commonly reported changes in their attitudes toward persons with disabilities over the course of the project. GBV practitioners reported increased recognition of their responsibility to reach all members of the community, and thus to adapt their programs so they are accessible and effective for all, improving implementation of a more rights-based approach to programming. Many practitioners shared that before the project they assumed that persons with disabilities were not capable of participating in GBV activities because of their impairments. After the project, most reported recognizing that persons with disabilities have skills and capacities to participate, benefit from and make valuable contributions to programs. Practitioners also reported that they initially saw themselves as ill equipped or unqualified to provide GBV services to persons with disabilities, and assumed their skills and training would not be appropriate or suffi-

cient to address the needs of persons with disabilities. They often focused on the individual's impairment or medical condition (also known as the medical model of disability), failing to apply their skills relating to protection and empowerment during the case management process. After the project, these practitioners expressed that they were more comfortable, confident and willing to work with persons with disabilities, having made a shift away from the medical model to a more familiar and appropriate survivor-centered approach.

“At first I thought that I couldn't be helpful to certain persons with disabilities because I am not a doctor, I couldn't make their condition better, I couldn't heal them. But then, once I took time to start to listen more, they were not asking for that type of help, they wanted to talk, they wanted assistance to support themselves, to be safer. I realized that I already knew how to support this person....Before I assumed that I didn't, I assumed that talking to me wouldn't change their situation at all. I should have listened more before, but now I do, I really listen first, before I try to make plans and try to fix things.”

(IRC Community Mobilizer — Muyinga camp, Burundi)

Some practitioners also reported a change in attitude toward caregivers, particularly mothers of children with disabilities, who have needs of their own but often prioritize the needs of others, including their family members with disabilities, over their own psychosocial well-being. Practitioners reported greater recognition of the needs of this group and the critical role they play in the protection and empowerment of persons with disabilities.

“These people have the rights to get all services like others and it is our duty to include [them]. It will be difficult for them to stay at home on their own. It is also important for their families and they can bring their daughters. It is important for mothers of children with disabilities as they also need

psychological support.”

(GBV practitioner — Jordan)

GBV practitioners reported four principal changes in their practices relating to disability inclusion over the course of the project. These practices were closely linked to the reflective process of the project and pilot activities implemented in Phase 2 of the project, including:

- holding more regular consultations with women and girls with disabilities and caregivers to ensure that their needs and ideas are represented in decision-making related to programs and activities;
- providing more comprehensive, holistic support to survivors with disabilities, with a focus on establishing effective communication methods and building trust;
- developing activities around the strengths, skills and capacities of persons with disabilities;
- having more active engagement with family members and neighbors of persons with disabilities in safety planning;
- monitoring the numbers of women, girls, boys and men with disabilities who participate in GBV activities.

“We can’t assess the activity ourselves. We have to assess our performance through the people who participate in our activities.”

(Participant in group discussion with GBV practitioners — Northern Caucasus, Russian Federation)

Practitioners in all countries also reported gaining new knowledge that improved their capacity to incorporate disability inclusion into their work, though they mentioned this less frequently than changes in attitudes and practices. Examples include a deeper understanding of the factors that make women and girls with disabilities and caregivers more vulnerable to GBV, the role of social connections and networks in preventing violence, and increased knowledge about communication strategies for working with people with different types of disabilities.

“We are working in GBV issues, so I was thinking more about how do they feel as women and girls, how do they feel compared to girls without disabilities? Girls with disabilities have less opportunity than girls without disabilities.”

(GBV practitioner — Northern Caucasus, Russian Federation)

Activities, tools and resources that supported change in capacity among GBV practitioners

GBV practitioners described the experiential and reflective learning opportunities of the project as the most important factors contributing to their improved capacity to effectively build disability inclusion into their work. These included direct interactions with women and girls with disabilities, and opportunities to reflect on their own skills and how to apply these in their work with this group.

GBV practitioners in Ethiopia, particularly social and community workers, reported that trainings on GBV and disability successfully supported them to improve their practices relating to disability inclusion. In the other pilot countries, practitioners reported that tools to help them consult persons with disabilities, including guidance on conducting home visits, and participatory activities reflecting on power dynamics between women and men and people with and without disabilities were most helpful to them. Practitioners also mentioned that tools providing guidance on communicating with people with different types of impairments and tools for developing accessible information, education and communication materials were useful.

In the Northern Caucasus, GBV practitioners reported that focusing on a small number of clearly defined activities designed to foster inclusion increased the likelihood that they would be successful, and this success boosted their confidence and willingness to include women and girls with disabilities in subsequent activities.

“I never thought that we could do something in a mixed group [girls with and without

disabilities], and now I see that it is possible and acceptable, and people need this.”

(Participant in group discussion with GBV practitioners — Northern Caucasus, Russian Federation)

Areas for further capacity development

While positive changes in GBV practitioners' approach to working with persons with disabilities were reported during the evaluation, persistent gaps in their capacity were identified that require additional and ongoing attention.

First, some GBV practitioners and service providers still maintained negative attitudes toward persons with disabilities. Hence, there is a need to facilitate ongoing reflection and discussion with GBV practitioners to confront and address any misconceptions and prejudices that may act as barriers to access and inclusion for persons with disabilities. Practitioners should reflect on how their own attitudes might influence the implementation of a survivor-centered approach with a person with disabilities, including the space they provide for the individual to contribute to decision-making and even the options for interventions that they may discuss with a survivor.

Second, GBV case managers reported requiring more guidance on consent processes when working with survivors with intellectual disabilities. In many instances, case managers will defer to caregivers to provide consent, often failing to determine the individual's capacity to provide consent. A guidance note for obtaining consent for persons with disabilities was developed in the project in response to this gap, drawing on consent processes used with people with intellectual disabilities in the health sector in high-income countries, and adapting it to a survivor-centered case management approach.

Lastly, while many GBV practitioners who participated in the project reported success in including people with physical disabilities and hearing impairments in GBV activities, they noted continued challenges in including people with intellectual disabilities. Case managers require guidance and support to identify the skills and capacities of people with more complex disabilities to better connect them with opportunities to participate in

community and social activities in order to break down social isolation and foster empowerment. Such guidance for case managers was developed in the project.

Selected tools from the project were adapted for GBV practitioners from other organizations and are available in *A Toolkit for GBV Practitioners* at http://wrc.ms/disability_GBv or www.gbvresponders.org

Positive practices to promote disability inclusion in GBV programming

The participatory evaluation process in each country elicited “Stories of Change” from persons with disabilities, their caregivers and, where appropriate, community leaders. These stories highlighted the outcomes that were most significant for each group. Analysis of the outputs from stakeholder workshops and the Stories of Change identified the following positive practices to promote disability inclusion in GBV programs in humanitarian settings.

Strengthening peer networks and social capital

Participants across all four countries highlighted more robust peer networks for adolescent girls and women with disabilities, as well as female caregivers, as a positive outcome of project activities. Group discussions with caregivers in women's centers in Jordan, “coffee discussions” in the homes of persons with disabilities in Ethiopia, the creation of inclusive safe spaces and social activities for adolescent girls in the Northern Caucasus, and targeted Village Savings and Loans Associations (VSLAs) in Burundi were all cited as valuable by participants because they facilitated connections among persons with disabilities and caregivers and other community members, allowing for exchange of information, building trust and possibilities for collective action. This not only increases access to support from each other and the wider community, but also opens up opportunities for persons with disabilities to contribute to society, raising their status in the community and allowing them to become identified and valued for aspects of their identities beyond their impairment.

For female caregivers of persons with disabilities, the support groups in Jordan gave them a space to share

concerns, ideas and strategies with other women in similar situations. This helped them feel less isolated and improved their psychosocial well-being.

“I benefit from constructive experiences, ideas and participations offered by the trainer, psychological guide and friends during discussion sessions. When I share my worries with others, I feel that I am not alone.”

(Wife of a man with disabilities — Irbid, Jordan)

For some women with disabilities and caregivers who are isolated in their homes, it is critical to bring peer support activities as close to their homes as possible, so that they can build their networks with other women who live near them. In Ethiopia, women with disabilities and female caregivers hosted traditional coffee discussions in their homes to talk about issues related to GBV. Participants reported that these activities decreased their isolation, improved their relationships with neighbors and made them feel safer as a growing number of women know and understand them.

“We have hosted coffee discussions in our home, right here. This has brought people closer to us. When they come to the home we discuss many things, things that are really important, but they also have a chance to see that we are good parents even though we are a bit different. Now, people understand us better, they even come to say hello and see how we are. It makes me feel safer having neighbors that I know now.”

(Woman who is blind — My'Ani camp, Ethiopia)

Stories of Change collected from adolescent girls with disabilities highlighted the importance of friends and peer networks for them. In Burundi, adolescent girls with disabilities found activities such as organized sewing and crafting sessions a useful way to meet other girls, share ideas and discuss their hopes for the future. They reported subsequently being invited to attend more community activities where they could share their own ideas and opinions. Adolescent girls with disabilities in the Northern Caucasus also discussed the benefits of participating in activities with girls without disabilities, including

the chance to learn from each other. These reports from adolescent girls with disabilities demonstrate that they have developed both human and social assets, such as education, self-esteem, friendship networks and roles in the community. These protective factors reduce vulnerability of adolescent girls to violence, abuse and exploitation.⁴⁷ (See Stories of Change, page 27.)

Women with disabilities participating in the VSLAs in Burundi reported using the income they raised through these programs to pay for transport to reach cultural and religious activities, decreasing their isolation and fostering important social connections with others.

Maipendo - Burundi



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“Now I can save a little for a moto-taxi and I can go [to church]. Each week now I have people to talk to at the church. It is a group that I feel listens and understands me.”

STORIES OF CHANGE: The Girls' Group — Northern Caucasus, Russian Federation

Girls with and without disabilities prepared posters using pictures and photos about what was most important to them in the project, and what activities they want to do next. They presented these to Women's NGOs involved in the project.

"This is our story. Our wish was to sing with Makka Mezheva [a famous Chechen singer]. [When we performed] there were people there, persons with disabilities and without disabilities, they were crying.



© IRC

At the event, we learned about other persons with disabilities, we met them. It was very pleasant for us to know them and to know their type of disability and problems. When I come to the event and I see there are persons with disabilities, I feel like I am not alone, and when I see other [non-disabled] people there, I feel very equal.

We are giving lessons of sign language to girls without disabilities, so we will understand them and they will understand us, because we can't speak. Through sign language we understand each other. These girls without disabilities learn things and us, too. We have a common language through these sign language classes. We also use phones, we text and we also use written notes to communicate with each other. We really like drawing. We think about things and everything that we think about, we show in our pictures. And we also like very much to play different types of games.

Sure, it is important to us that people are listening to us. Sometime people do not pay attention to our opinions. These are our ideas that we would like to see in the future. We would like to meet with some girls at a café or a place for just girls with and without disabilities — just girls, without adults.

We would like [our classmates] to join us and participate in these activities. We will need some paper and markers...a space to meet...transportation."

To read the full Story of Change from the Girls' Group in the Northern Caucasus, please go to: http://wrc.ms/GBV_disability_Change_Caucasus

All of these examples point to an important learning: Persons with disabilities have, and want to be understood as having, multiple identities beyond their impairment. They want to be seen as leaders, women, friends, community members — as people making valuable contributions to the community. This has important implications for inclusion in programs and approaches to strengthen peer networks and social capital.

Esther — Burundi



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"I am a caregiver to my husband, who lives with a disability, but that is not my only identity. I am a mother, a leader, and someone who takes pride in her role as a community mobilizer."

Targeted inclusion in economic strengthening activities

Targeted inclusion of persons with disabilities and caregivers in the VSLA programming featured highly in the Stories of Change from Burundi. Women with disabilities and female caregivers involved in VSLA activities reported that expanded social networks were the most important outcome for them, improving their status in society, earning them greater respect from their husbands and other family members, and increasing their self-esteem and feelings of self-worth. Participation in VLSA activities had a positive impact on their independence as individuals, but also on the contributions that they can make to their households financially, strengthening their role in decision-making.

"I even have a little money to buy things for my family. It is amazing to me how much my husband has changed towards me; he realizes that I have value, that I can be independent, he respects me more, he comes home at night time now. My son with the disability is happier — he sees that there is more peace in the house."

(Women caregiver in Musasa Camp)

Increasing representation of persons with disabilities in community activities

GBV programs work closely with community leaders in the design, implementation and evaluation of activities, and thus it is important to consider how persons with disabilities are being represented and reached by these leadership systems. For example, in Ethiopia, IRC staff worked with the disability association in the refugee community to increase participation of women with disabilities, and to strengthen collaboration with the refugee women's association. Participants in Burundi and Ethiopia also reported that the recruitment of persons with disabilities and caregivers as community mobilizers and social workers not only resulted in greater attention to the concerns of this group, but also led to increased appreciation of the skills and capacities of persons with disabilities by others in the community.

“We never had persons with disabilities on our team before — this is a big change and a really important one. My friends who have disabilities are doing the same job that I am. There are things they are really good at, and there are things that they are teaching others. It is important for the community to see this, to know that when we say we want to include persons with disabilities we really mean it. This is a good way to start to make a change in the way persons with disabilities are viewed.”

(Social Worker — My'Ayni Camp, Ethiopia)

Reaching and supporting individuals at high risk

The isolation of people with intellectual disabilities and/or multiple disabilities was identified as a challenge for service providers. These individuals are often isolated in their homes with their caregivers, and may have little opportunity or support to develop strategies that will protect them from violence. The following practices have been identified as promoting the access and inclusion of these individuals in GBV activities:

Home visits and home-based activities

In Burundi, Ethiopia and the Northern Caucasus, persons with disabilities and practitioners reported conducting home visits to both consult with individuals and families about their needs, and to share information about GBV services and assistance. These visits helped GBV practitioners and service providers to identify survivors in need of comprehensive, specialized support. IRC staff in both Burundi and Ethiopia started to organize group activities, typically held in the women's centers, in other places in the community that were closer to their homes, sometimes targeting these individuals and families. Caregivers of girls with multiple disabilities also highlighted experiencing increased acceptance and support from the community as a result of home-based activities.

“People in the community treat us better now. They are more used to her. They know how she is and they greet us kindly when

they are walking.”

(Mother of an adolescent girl with intellectual disabilities — My'Ani camp, Ethiopia)

Individualized case management

Survivors of GBV with disabilities require individualized and comprehensive case management to support their healing and recovery and to prevent future violence. During the evaluation, participants reported that GBV practitioners had become better at identifying these high-risk individuals and providing them with more comprehensive support tailored to their specific needs. The following factors were described as improving case management support for these individuals:

- identifying different communication methods directly with the survivors;
- increased focus during assessments on identifying existing strengths and capacities of survivors;
- involvement of persons with disabilities, as well as their caregivers, in action planning;
- frequent follow-up and coordination of service provision to meet identified needs.

Women with disabilities reported that these case management sessions helped to develop trust and understanding between them and GBV staff, and that they received support based on their own needs and wishes. This learning also highlights the importance of survivor-centered approaches in working with women with disabilities to define their own goals, objectives and strategies.

STORIES OF CHANGE: Mawazo's Story — Kinama camp, Burundi

Mawazo lives on her own and moves differently from others, crawling rather than walking.

"I live alone. I always have. I try to be very independent and I do many things by myself. I can clean, cook, wash my clothing, and I spend time trying to help my neighbors by taking care of their children.

I have home visits regularly; the people from IRC are like my family. They come to check on me almost every day. When I



© IRC

have a problem, they know about it very quickly and they come to see that I am okay. I feel so much happier, I feel like I have someone to talk to. I love sharing stories and it makes me feel good when someone asks me how I am feeling.

My name, in my language, means both problems and ideas. I have a lot to talk about and a lot to share with others. I am a very open person; I think this is why the children like me so much. I am open to them, I smile with them and I share stories. There is a lot that I can teach them, I have seen and learned many things in my life. I can teach them about their culture, I can teach them respect and I always teach them to share. If someone brings me porridge, for example, even if it is a small amount, I do not drink it all myself, if there are children here, we all share it together. Even if I am very hungry, I know that this is a chance for me to teach something, to help someone, just like others are helping me.

If I could tell the IRC team one thing, it would be to keep remembering the people who are at home, who can't easily come to programs. We have needs too and we have dreams as well. I am getting older now, I think it is important though to focus on the young people, those with disabilities, to make sure that they are included from a young age, so that people can stop discrimination and see us all as equal."

Recognizing the skills and capacities of persons with disabilities to facilitate inclusion

Persons with disabilities and GBV practitioners reported that identifying and building on the skills and capacities of persons with disabilities promoted their greater inclusion in a variety of GBV activities. In Jordan, young women who are deaf were invited to participate in social empowerment activities, including women's center activities and to lead henna sessions. These activities provided a space for the women to share skills and common interests with other women their age.

"Not only did they accept them, they made some friendships. Even before the end of the class, they were exchanging phones numbers and asking them if they can contact them to do henna at their celebrations."

(GBV practitioner — Jordan)

In the Northern Caucasus, adolescent girls with disabilities were included in the design of social activities that were intended to facilitate networking between girls with and without disabilities. Activities were built around the specific skills of the girls with disabilities (e.g., performing

songs in sign language), fostering not only equal participation in program design, but also appreciation for each others' talents.

As family members, community leaders, service providers and others across the project sites expressed, the success of these activities challenges assumptions that persons with disabilities are incapable of benefiting from and contributing to a variety of programs.

"Before people thought that these women were hopeless, they could never be independent. Now they are proving many people in the in the community wrong. They are making us, the few who always believed in them, very, very proud."

(Male community leader — Kinama camp, Burundi)

Many persons with disabilities highlighted the importance of being given a chance "to prove themselves," as many had never before been invited to take part in any activities. The simple act of reaching out to encourage their participation in programs was in many cases the most impactful adaptation made by GBV practitioners.

Diane - Kinama camp, Burundi

"I received a call that IRC was looking to have women with disabilities included in their VSLA programs. I was so excited to register, to be included, to have a chance to prove myself...now, even, I feel it is my obligation to reach out to other persons with disabilities, to raise awareness, to share my story, to tell them that they can be included too."



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STORIES OF CHANGE: Mieraf, Social Worker — My'Ayni Camp, Ethiopia



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“There is so much I enjoy about my role with the [IRC] program and there are so many stories that I could share with you of things that we have accomplished.

But, I think it is important to share with you that I am a woman who has a disability. I walk with a crutch and sometimes I have a lot of difficulty getting through the camp. This doesn't stop me, though, even though it can be challenging, I feel I have a very important job to do.

I am working to make women and girls safer, especially those who have disabilities, those who are not always included in activities, those who are often forgotten about. I can remember times when that was me, when I had so much pain that I couldn't leave my house, or before I had my crutch to walk. I felt really alone. Now, I am very active, I am a leader in our community. I am part of the disability association and I work as a social worker. I feel like I have valuable things to add and that I can advocate for women and children with disabilities and their caregivers as well, because I understand their needs well. Also, I think people look up to me, they see me working hard to do my job.”

Recommendations

The following recommendations are drawn from the lessons learned during this project on how to promote disability inclusion in GBV programs in humanitarian settings.

Recommendations for GBV actors

Include women, girls, boys and men with disabilities and their caregivers in the design, implementation and evaluation of GBV programs. Involving persons with disabilities in program design and evaluation is critical to accurately identifying barriers to their participation in GBV programs, developing strategies to improve their participation and understanding what changes matter most to them. Particular attention should be paid to gathering information and perspectives from women and girls, and those with intellectual and mental disabilities, as they are most at risk of GBV. Participatory approaches, such as ranking, photo elicitation and story-telling are some ways, in addition to more traditional qualitative methods (e.g., focus group discussions and one-on-one interviews), to effectively explore the concerns and ideas of individuals who have different communication needs. Assessments and evaluations should include an outreach component to engage persons with disabilities and caregivers who are isolated in their homes.

Provide training and reflective learning on the intersections between gender and disability for GBV program managers and service providers, and establish a common understanding of and commitment to the rights-based and survivor-centered approaches when working with this group. Training staff to incorporate an analysis of both gender inequality, as well as disability-based discrimination, will assist them in better understanding the unique factors that contribute to GBV risks and vulnerability for women, girls, boys and men with disabilities, and to identify more effective strategies for their inclusion in GBV programming. While GBV practitioners are particularly aware of gender-based power dynamics in their work with female survivors of violence, they may require further support to reflect on their own

attitudes, and the attitudes of others, relating to disability and how these may compound gender-based inequality, discrimination and exclusion in relationships, households and the community.

It is recommended that content about persons with disabilities and their caregivers be integrated and mainstreamed throughout core GBV training packages, including through case studies and examples centered on persons with disabilities. Over time, GBV staff will increasingly recognize that responding to the needs of a persons with disabilities is a core part of their work and that they have the skills to effectively do this in their jobs.

Recruit women and girls with disabilities as staff and volunteers in gender-based violence programs.

Identifying and supporting women and girls with disabilities to play key roles in GBV programs can improve the quality and relevance of programming for this group, while empowering them and increasing their status in the community. Setting a target for the number of women and girls with disabilities who should attend community trainings and meetings on GBV (approximately 15 percent), will encourage staff and partners to directly invite them to these events and can improve representation and participation in GBV programs. Advocating for a gender balance in disability associations and for inclusion of women and girls with disabilities in women's and youth associations can also increase participation where these groups play a role in GBV programming, and their greater representation and leadership in the community.

Prioritize the inclusion of persons with disabilities and caregivers in activities that strengthen social capital and peer networks.

This is particularly important for prevention of violence against adolescent girls with disabilities; women with physical disabilities who are isolated in their homes; female caregivers; and women, girls, boys and men with intellectual disabilities. For "safe space" programming, support women and girls to reflect on what makes a space "safe" for them and for others, and then to establish their own "ground rules" or principles that reflect how they will accept and appreciate differences. These principles may also lead them to think about how to reach out to and include

other women and girls who are more isolated (e.g., girls with intellectual disabilities). In addition to center-based activities, community outreach and home visits are critical to reach persons with disabilities and their caregivers who are isolated in their homes, and in turn strengthen community-based protection mechanisms. GBV program staff should be mindful of any additional workload and responsibilities other women and girls in the household may be required to assume as a result of caregivers' participation in GBV activities, and help them identify strategies for mitigating associated risks and unintended consequences.

Prioritize the inclusion of women with disabilities and female caregivers in economic empowerment programming. Set targets for the number of women and girls with disabilities and female caregivers to participate in such programming and encourage staff and communities to invite them. A careful risk analysis and mitigation strategy should be developed prior to participation, to prevent and/or respond effectively to any unintended consequences. In some contexts, women's economic empowerment activities may represent a step outside their socially prescribed gender roles, increasing their vulnerability to violence from family and community. In some households, it may have a negative impact on the individual with disabilities who may be left with less familiar caregivers, potentially adding to risk of violence or abuse. Alternatively, other women in the household, including adolescent girls, may assume this role, adding to their workload or exclusion.

A Toolkit for GBV Practitioners, including tools and guidance to assist them in strengthening disability inclusion in their work, is available at: http://wrc.ms/disability_GBv or www.gbvresponders.org

Recommendations for disability actors

Ensure that programs and organizations designed to serve persons with disabilities are gender sensitive. Staff of programs or organizations catering to persons with disabilities should undergo training on gender and gender inequality in order to understand the different ways conflict and displacement affect women, girls, boys

and men with disabilities, and adapt their activities and services accordingly. Disability program staff should also be aware of the particular risks of GBV faced by women and girls with disabilities during crises, and receive training on communicating with survivors and in making appropriate referrals to GBV service providers.

Strengthen advocacy on the rights of people affected by crisis and conflict, particularly women and girls, by raising awareness about refugees and displaced persons in organizations for persons with disabilities (DPOs), particularly at regional levels where there may be ongoing or prolonged crises that have a significant impact across multiple countries. This can include networking between women with disabilities and the women's rights movement in crisis-affected countries and regions to develop greater connection, understanding and responsiveness to the needs of women with disabilities in humanitarian settings.

Recommendations for all humanitarian actors

Implement sector-specific guidance to prevent and respond to gender-based violence, as outlined in the Inter-agency Standing Committee *Gender-based Violence Guidelines*.⁴⁸ All humanitarian actors should recognize and respond to the increased risks of GBV during conflict and crisis, particularly for women and girls with disabilities and female caregivers. The minimum standards outlined in the Guidelines provide foundational guidance for all sectors in preventing and responding to GBV.

Undertake protection mainstreaming to effectively address the needs of persons with disabilities throughout all phases of humanitarian response. Protection mainstreaming, including disability inclusion and gender analysis in program design, implementation and evaluation, is critical to ensure that all people, especially women and girls with disabilities, have meaningful access to services and assistance across all sectors, including to mitigate the risk of GBV.⁴⁹

Recommendations for donors and governments

Hold humanitarian organizations accountable for effectively addressing the needs of persons with disabilities and caregivers in GBV programs through monitoring and reporting processes, as well as highlighting positive practices from different organizations across humanitarian settings as a means of encouraging compliance with disability and gender-sensitive approaches.

Advocate for meaningful recognition of the full range disability- and gender-related concerns, including GBV, in all international instruments, standards and conventions relating to conflict, displacement and humanitarian action. International instruments can play

a critical role in determining priorities for humanitarian action during conflict and displacement. The concerns particular to women and girls and all persons with disabilities should be front and center of any international agreements, as they are among the most vulnerable populations during crisis. Ongoing advocacy is required at international and national levels to encourage governments to sign on to and ratify all relevant instruments, and to hold all relevant actors accountable for full implementation of new and existing agreements, including the Convention on the Rights of Persons with Disabilities, the Convention on the Elimination of All Forms of Discrimination against Women and Security Council resolutions on women, peace and security.



Stakeholder workshop in Burundi
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Notes

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 25. DPOs are representative organizations of persons with disabilities. They are usually established and led by persons with disabilities.
 26. The GBVIMS records the type of violence reported by survivors, including: rape; sexual assault; physical assault; forced marriage; denial of resources, opportunities or services; and psychological/emotional abuse.
 27. Consultations with GBV staff in Ethiopia and Burundi demonstrated that they had a good understanding of different types of impairments, and could identify these based on functional questions and observations during their consultations with survivors. It is important, however, to recognize that not all survivors with disabilities may have been identified as having a disability in GBVIMS data.
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 29. <http://betterevaluation.org/approaches> (accessed 12 August 2014) and http://depts.washington.edu/ccph/pdf_files/Evaluation.pdf (accessed 12 August 2014).
 30. Our “Stories of Change” tool is adapted from the Most Significant Change (MSC) technique. MSC is a form of participatory monitoring and evaluation that collects and analyzes accounts of change, to learn about what changes are most valued by individuals and groups, and why. <http://betterevaluation.org/approaches> (accessed 12 August 2014).
 31. Adapted from Before and Now Diagram tool (page 68) in the Tools together now! 100 participatory tools to mobilize communities for HIV/AIDS. <http://www.aidsalliance.org/assets/000/000/370/229-Tools-together-now-original.pdf?1405520036>
 32. Adapted “Summit Workshop” from the Participatory Performance Story Reporting Technique <http://www.clearhorizon.com.au/wp-content/uploads/2009/05/report-on-outcomes-and-get-everyone-involved-the-participatory-performance.pdf> (accessed 12 August 2014).
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 34. Of those recorded in the GBVIMS (Ethiopia and Burundi combined), 120 out of 2,025 survivors have a disability.
 35. Of those recorded in the GBVIMS (Ethiopia and Burundi combined), 50.83 percent (61 out of 120) of survivors with disabilities have been raped, and 32.23 percent (614 out of 1905) of survivors without disabilities have been raped. Tests confirm that this 18.6 percent difference is statistically significant, with a Fischer’s p-value 0.000.
 36. Of those recorded in the GBVIMS (Ethiopia and Burundi combined), 26.67 percent (32 out of 120) of survivors with disabilities have experienced psychological/emotional abuse, compared with 23.25 percent (443 out of 1905) of survivors without disabilities. Tests confirm that this 3.42 percent difference is not statistically significant, with a Fischer’s p-value 0.377.
 37. Of those recorded in the GBVIMS (Ethiopia and Burundi combined), 35.83 percent (43 out of 120) of survivors with disabilities report violence in which the alleged perpetrator is a partner or spouse, compared with 48.71 percent (928 out of 1905) of survivors without disabilities. Tests confirm that this 12.88 percent difference is statistically significant, with a Fischer’s p-value 0.006.
 38. Of those recorded in the GBVIMS (Ethiopia and Burundi combined), 26.67 percent (32 out of 120) of survivors with disabilities report violence in which the alleged perpetrator is a stranger, compared with 22.73 percent (433 out of 1905) of survivors without disabilities. Tests confirm that this 3.94 percent difference is not statistically significant, with a Fischer’s p-value 0.316.
 39. Of those recorded in the GBVIMS (Ethiopia and Burundi combined), 83 percent (100 out of 120) of survivors with disabilities are female, compared with 95 percent (1812 out of 1905) of survivors without disabilities are female. Tests confirm that this 12 percent difference is statistically

- significant, with a Fischer's p-value 0.000.
40. During the informed consent process, women were advised that they did not have to share personal experiences, and consented to their information being used in reports to improve programs in Burundi and other countries. All women with intellectual disabilities had only mild impairments and therefore were able to understand this consent process, but they also had caregivers present. Group discussion questions did not ask for such personal information. The women in this group, however, continued to disclose personal experiences throughout the discussion. All participants were advised of services available for GBV survivors and ongoing support was provided by IRC WPE staff.
 41. Laurie E. Powers, Rosemary B. Hughes and Emily M. Lund, *Interpersonal violence and women with disabilities: A research update* (Harrisburg, P.A.: National Resource Center on Domestic Violence: 2009).
 42. Of those recorded in the GBVIMS (Ethiopia and Burundi combined), 16.67 percent (20 out of 120) of survivors with disabilities are male and 4.88 percent (93 out of 1905) of survivors without disabilities are male. Tests confirm that this 11.70 percent difference is statistically significant with a Fischer's p-value 0.000.
 43. Women, girls, boys and men with disabilities may experience violence as a result of both gender and disability. The specific contribution of each of these factors will vary and the underlying causes of oppression and abuse are often complex and intersecting, making it difficult to parse out or respond to separately. As such, it is critical to monitor and respond to all forms of violence and discrimination in humanitarian settings, especially against the most marginalized groups in the community, in order to advance gender equality for extremely marginalized and oppressed groups in the community. Wider findings from the project that reflect the intersection of gender, disability and other factors for women, girls, boys and men; and more detailed research reports on this topic will be made available at the Women's Refugee Commission website: <https://womensrefugeecommission.org/programs/disabilities/research-and-resources/document/945-building-capacity-for-disability-inclusion-in-gender-based-violence-gbv-programming-in-humanitarian-settings-overview?catid=232>
 44. IASC, *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery* (Draft, publication pending, 2015).
 45. Of those recorded in the GBVIM (Ethiopia and Burundi combined), 32.5 percent (39 out of 120) of survivors with disabilities reported to IRC within 3 days of the incident and 43.98 percent (837 out of 1905) of survivors without disabilities reported to IRC within 3 days. Tests confirm that this 11.48 percent difference is statistically significant with a Fischer's p-value 0.017.
 46. Of those recorded in the GBVIMS, 40.83 percent (49 out of 120) of survivors with disabilities reported to the IRC over 1 month after the incident, and 34.42 percent (655 out of 1905) of survivors without disabilities reported over 1 month after the incident. Tests confirm that this 6.41 percent difference is not statistically significant with a Fischer's p-value 0.166.
 47. Women's Refugee Commission, *Strong girls, powerful women: Program planning and design for adolescent girls in humanitarian settings* (2014) <https://womensrefugeecommission.org/resources/document/1036-strong-girls-powerful-women-report>
 48. IASC, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies* (2005). http://interagencystandingcommittee.org/system/files/legacy_files/tfgender_GBVGuidelines2005.pdf
 49. Global Protection Cluster, *Protection mainstreaming* (n.d.). <http://www.globalprotectioncluster.org/en/areas-of-responsibility/protection-mainstreaming.html>

Annex 1: Summary of Activities Undertaken in Project Methodology

| Table A: Summary of Countries, Contexts and Activities Undertaken in Phase 1 | | |
|---|--|---|
| Country | Operational context | Activities undertaken |
| Ethiopia | My'Ani — Protracted camp setting | <p>Group discussions with Eritrean refugee with disabilities and their caregivers (25 participants); community leaders (11 participants); and community workers and social workers (13 participants).</p> <p>Interviews with persons with disabilities and caregivers (4 interviews — 7 people).</p> <p>Consultations with the Disability Association (32 people).</p> <p>Consultations with humanitarian actors (19 people).</p> |
| Burundi | Bujumbura — Urban setting Kinama, Mussasa and Bwagiriza — Camp settings | <p>Group discussions with Congolese refugees with disabilities and their caregivers (161 participants).</p> <p>Interview with a girl with disabilities and her caregiver (1 interview — 2 people).</p> <p>Consultations with humanitarian actors (13 people).</p> |
| Jordan | Zaatari — Camp setting Irbid, Mafraq and Ramtha — Urban settings | <p>Group discussions with Syrian refugees with disabilities and their caregivers (113 participants); and refugee community volunteers (11 participants).</p> <p>Interviews with girls with disabilities and their caregivers (2 interviews — 4 people).</p> <p>Consultations with humanitarian actors (30 people).</p> |
| Northern Caucasus, Russian Federation | Grozny, Chechen Republic — Urban post-conflict reconstruction setting | <p>Group discussion with caregivers of children with disabilities (12 participants).</p> <p>Interviews with women and girls with disabilities (11 interviews — 11 people).</p> <p>Consultations with staff from women's NGOs (16 people).</p> <p><i>These group discussions and interviews were conducted by NGO partners of the IRC in the Northern Caucasus.</i></p> |

| Table B: Summary of Participatory Evaluation Activities in Each Pilot Country | |
|--|---|
| Country | Activities undertaken |
| Ethiopia | Group discussions about stories of change with Eritrean refugees with disabilities and their caregivers (24 participants); and community leaders (11 participants). Stakeholder workshop (21 people). |
| Burundi | Group discussions about stories of change with refugees with disabilities and their caregivers (89 participants); and community leaders (10 participants). Participatory activities with GBV practitioners (18 participants). Stakeholder workshops (41 people). |
| Jordan | Group discussions and interviews about stories of change with Syrian refugees with disabilities and their caregivers (14 participants). Interviews with GBV practitioners (3 participants). <i>Stories of change were conducted by WPE staff in Jordan and interviews with GBV practitioners were conducted over the phone.</i> |
| Northern Caucasus, Russian Federation | Group discussions about stories of change with refugees with disabilities and their caregivers (26 participants). Participatory activities with GBV practitioners (7 participants). Stakeholder workshop (26 people). |

Annex 2: Recommendations from Stakeholder Workshops

Stakeholder workshops in Burundi, Ethiopia and Northern Caucasus, and Stories of Change from Jordan sought to capture key messages and recommendations from different groups involved in the project about disability inclusion in GBV programming. Their recommendations focused on:

- Strengthening advocacy on non-discrimination

“Continued, targeted community awareness-raising sessions highlighting the rights of persons with disabilities, particularly around issues relating to women and female caregivers.” (Recommendations from women and girls with disabilities — Stakeholder workshop, Burundi)

- Ongoing consultations with persons with disabilities in program planning

“It is important to us that people are listening to us. Sometime people do not pay attention to our opinions....We would like to meet with some girls at a café or a place for just girls with and without disabilities. Just girls, without adults. We will need some paper and markers...a space to meet...transportation.” (Presentation from the girls’ group — Stakeholder workshop, Northern Caucasus, Russian Federation)

- Highlighting the skills and capacities of persons with disabilities

“Develop a plan or medium to share success stories of persons with disabilities who have done well in economic and vocational activities. Use these successes as a way to encourage other groups to also include persons with disabilities into these types of program.” (Recommendation from men with disabilities — Stakeholder workshop, Burundi)

- Strengthening outreach and peer support activities

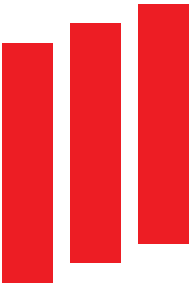
“Do more house-to-house visits to the homes of women and girls with disabilities who are most isolated. Develop a plan for consistent visits and contacts between [GBV] teams and these families.” (Recommendation from women and girls with disabilities — Stakeholder workshop, Ethiopia)

- Working with families

“Form a committee of caregivers to advise on programming. Set aside time to teach lessons on how to be a better family advocate, provide information on how to better navigate systems and be less reliant on community mobilizers.” (Recommendation from caregivers — Stakeholder workshop, Burundi)

- Providing material support and transportation strategies

“Recommend providing transportation due to the difficult financial situation (or transportation allowances).” (Interview with a female caregiver — Ibid, Jordan)



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