Gender-Based Violence and Disability Inclusive Training User Guide for Practitioners Gender-Based Violence

1.0 Introduction

This easy-to-use Gender-Based Violence (GBV) guideline has been compiled by the Gender Officer of Lesotho National Organization of Organizations of the Disabled (LNFOD) under the Gender and Disability in Practice Project 2020/2023.[1] It is one of the outputs of the four-year project which is implemented by Lesotho through LNFOD and National Union of Disabled Persons of Uganda (NUDIPU) in Uganda.

The guide comes at the right time now more than ever when there is a clear gap both in theory and practice in gender and disability issues resulting in GBV against persons with disabilities (PWDs). The tool is therefore not only an educator manual but it is a GBV handbook intended to raise awareness on GBV and related issues. In particular it adopts a human rights-based approach and as such it is founded on principles of equality and non- discrimination. Most importantly it upholds an intersectional approach to ensure no one is left behind, particularly women and girls with disabilities. The guide embraces empowerment as an integral strategy for embracing inclusion and gender equality for and amongst marginalized groups in order to achieve full realization and enjoyment of fundamental human rights and freedoms by all PWDs

2.0 Background to the Manual

The Gender Analysis Report compiled by Lesotho National Federation of Organizations (LNFOD) of the Disabled (LNFOD) in 2020,[2] has revealed that there is high incidence of GBV especially affecting women with disabilities. This is especially so amongst women and girls with mental disabilities. LNFOD and its affiliate disabled people's organizations

[1] The Project is funded by Diakonne Act Austria

[2] Unpublished

(DPOs)[3] are often confronted with cases of sexual violence at an alarming rate. Women with disabilities are easier prey, firstly because of womanhood and secondly because of impairment. According to the report, GBV against persons with disabilities (PWDs) is further compounded by lack of access to sexual and reproductive health and rights (SRHR) information and services for PWDs mainly due to disability related barriers such as communication, environmental and attitudinal barriers.

Neither the community including the PWDs nor the duty bearers like the chiefs, councilors, the police and even the courts sufficiently understand GBV in the context of disability which has usually meant impunity for perpetrators. This is over and above the fact that PWDs have not been adequately included in mainstream GBV interventions in the country, a situation which LNFOD is determined to change through lobby and advocacy of stakeholders like Department of Gender.[4] Outstandingly, the Gender and Development Policy[5] directly highlights that PWDs fall under marginalized groups, especially as victims of GBV. Unfortunately, there are no visible steps that have been taken to mitigate the scourge of GBV against PWDs to date. Even worse, the ministry responsible for Department of Disability[6] hardly alludes to issues of GBV in its newly adopted Disability Mainstreaming Plan[7] whether through highlighting the gap and or how the gap can be bridged in the five years of the implementation phase of the strategy. This means that there is need to scale-up joint interventions for prevention and protections against GBV. The guideline therefore aims to equip various stakeholders working as GBV practitioners, including PWDs on GBV against PWDs.

[3] Lesotho National League of the Visually Impaired Persons (LNLVIP), Lesotho National Association of the Physically Disabled (LNAPD), Intellectual Disability Association of Lesotho (IDAL) and National Association of the Deaf Lesotho (NADL)
[4] Under the Ministry of Gender and Youth, Sports and Recreation
[5] 2018/2030
[6] Under the Ministry of Social Development
[7] Adopted in 2020

3.0 Importance of the Training Manual

The GBV toolkit serves as a guideline on GBV and disability and it includes related prevention, protection and response measures at community level and even the national. This toolkit was created compiled by LNFOD and will be validated with input from LNFOD, DPOs, PWDs and the Gender and Disability Networking Forum representatives.[8] It is intended to support GBV staff to build gender and disability inclusion into their work, and to strengthen their capacity to use a survivor-centered approach when providing services to survivors with disabilities. It is important to bear in mind that the tools provided in this toolkit are designed to complement existing guidelines, protocols and tools for GBV prevention and response, and should not be used in isolation from these. GBV staff are therefore encouraged to adapt the tools to their individual programs and contexts, and to integrate gender and disability pieces into standard GBV tools and resources.

5.0 Objectives of the Manual

The training module is designed to support GBV practitioners to:

- Understand the intersections of disability, gender and violence in the communities where they work; and
- Develop ideas and strategies to improve inclusion of persons with disabilities in GBV programming
- Raise specific GBV and SRHR related challenges affecting PWDs and propose inclusive recommendations to ensure GBV and disability prevention, access to justice and SRHR services post GBV.
- Explore referral pathways for GBV survivors with disabilities for increased protection and access to justice.

6.0 Target Training Beneficiaries/ Participants

The user guide is intended to be a user-friendly but comprehensive manual for personnel in the disabled people's organizations as well as GBV practitioners from all other civil society organizations and government

[8] The Forum comprises the following gender and women's rights organizations like

ministries to promote disability inclusive GBV response. In particular it is targeting gender and women's rights institutions to mainstream disability in all GBV initiatives as well as the PWDs to always mainstream gender in their programmes to be in the position to address GBV effectively in the disability sector. PWDs irrespective of the nature of disability, whether; visual, deaf, mental or physical disability, general community members and the local authorities on the ground, will also be directly targeted through public gatherings in liaison with LNFODs focal persons working within the project area. All these stakeholders play a vital role in raising awareness against GBV in the context of disability including to ensure that all local and national GBV advocacy initiatives are not only gender responsive but that they are also disability inclusive.

Therefore, the training manual can be used for:

- Training of facilitators
- Training of trainers
- Organisations level training
- Community level training

7.0 Overview Training Toolkit

Section A: Disability inclusion in GBV program implementation. The tool used in this section focus on building the capacity of GBV program staff to work with people with disabilities and their caregivers.
Modules 1- 8: Gender-based violence and disability This training modules are designed to support GBV practitioners to understand the intersections between disability, gender, and violence in the communities where they work, and to develop strategies to improve the inclusion of persons with disabilities in GBV prevention and response programming.
Section B: Post Training Monitoring and Evaluation for GBV practitioners. These tools have been developed to help GBV staff monitor their progress with disability inclusion.
Tool: Pre- and post-training test for the GBV and disability training module This test can be used with GBV practitioners to identify changes in their knowledge and attitudes relating to disability inclusion, and is accompanied by an answer key for scoring the tests. It should be used in conjunction with the GBV and disability training module.

Section C: Disability inclusion in GBV program planning. These are practical tools that can help GBV practitioners to include persons with disabilities through consultations with persons with disabilities and their caregivers in the design of programs and services as well as to set in place for GBV survivors with disabilities as well as ascertain the role of service providers
Handout 1-5: Practical tools to help understand the modules better

8.0 Section A: Disability Inclusion in GBV Program Implementation

Table 1: Overview of Contents under Section A

Activity	Purpose	Time	Page Number
Module 1: Where do we stand? Establishing a common ground	To reflect on beliefs and assumptions relating to GBV and disability.	15 min	
Module 2: Understanding disability	To develop a common understanding of disability	45 min	
Module 3: Gender, disability and inequality	To identify potential consequences for persons with disabilities who don't meet societal expectations of men and women, and/or gender stereotypes in society	30 min	
Module 4: Root causes of GBV against women and girls with disabilities	To identify the root causes of GBV against persons with disabilities To reflect on power in relationships between persons with disabilities, perpetrators, care-givers and service providers	30 min	
Module 5: Sexual and Reproductive Heath and Rights of persons with	To understand that SRHR are basic human rights for persons with disabilities on	30 minutes	

disabilities	equal basis with others and that all barriers including discriminatory practices must be removed	30 minutes	
Module 6: Vulnerabilities to GBV of women and girls with disabilities	To identify the factors that make persons with disabilities more vulnerable to GBV	30 minutes	
Module 7: Principles of working with persons with disabilities	To define guiding principles for working with persons with disabilities in GBV programs	30 minutes	
Module 8: Barriers to access and participation	To identify barriers to access and participation of persons with disabilities in GBV prevention and response activities	30 minutes	
Module 9: Strategies for inclusion	To define strategies for removing barriers and promoting participation of persons with disabilities in GBV programs	30 minutes	
Module 10: Guidance for GBV Caseworkers	to support GBV caseworkers to uphold a survivor-centered approach to working with GBV survivors with disabilities		

A note about language for training facilitators

In different contexts, different language is used to describe disability and to refer to persons with disabilities. Some words and terms may carry negative, disrespectful or discriminatory connotations and should be avoided in our communications.

In Lesotho, DPOs can also provide guidance on the terminology preferred by

persons with disabilities specifically.

Words or Phrases to Avoid	Consider the Following Instead
Emphasizing a person's impairment or condition For example: Disabled person	Focus on the person first, not their disability For example: Person with disabilities (CRPD language)
Negative language about disability For example: • "suffers" from polio "in danger of" becoming blind "confined to" a wheelchair "crippled" "Insane / lunatic" "idiot"	Instead use neutral language For example: "has polio" "may become blind" "uses a wheelchair" "has physical disability" "has psychosocial disability" "has intellectual disability"
Referring to persons without disabilities as "normal," "fit" or "healthy"	Try using "persons without disabilities"
Referring to objects as "having disability just because they have a flaw, gap or abnormality of some kind?	Instead using disability only in reference to people have impairments and are discriminated because of those impairments"

Refer to Additional Training Tool 2 Section C: Pre-Test (and Post-Test) for disability and GBV training module

Name: _____

Date: _____

1. How do you define persons with disabilities?

2. Persons with disabilities are not vulnerable to domestic violence.

o True

o False

3. GBV survivors with disabilities should go to separate, more specialized services designed for persons with disabilities.

o True

o False

4. The root causes of GBV against persons with disabilities are (circle all that apply):

(a) Perceptions that persons with disabilities are weak and unable to defend themselves

(b) Low status in the community

(c) Inequality in power relationships with other people

(d) Poverty and lack of basic needs

(e) All of the above

5. The following factors make women and girls with disabilities more vulnerable to GBV (circle all that apply):

(a) Not going to school

(b) Having contact with other women and girls their own age

(c) Staying inside their home all day

(d) Reliance on others to access services and assistance

(e) All of the above

6. List three things that may prevent persons with disabilities from accessing GBV services and

programming.

(i)

(ii)

(iii)

7. Girls with intellectual disabilities may be at increased risk of GBV because (circle all that apply):

(a) They don't have the same knowledge and skills about GBV and personal safety as other girls

(b) Information on GBV is not conveyed in a way that they can understand

(c) They are unable to learn new things

(d) Family and caregivers hide them inside the home

(e) All of the above

8. Persons with disabilities are unable to access services or participate in our activities because of their heal condition.

o True

o False

9. The community may perceive persons with disabilities as unable to, or should not, have the same opportunities as other men and women.

o True

o False

	I have a strong understanding of…	Strongly Disagree				Strongly Agree
		1	2	3	4	5
10	… who "persons with disabilities" are in the community					
11	… the factors that make women, girls, boys and men with disabilities more vulnerable to GBV					
12	…the potential barriers that prevent persons with disabilities from accessing our services or participating in our programs					
13	… potential actions I can take to address these barriers					

8.1 Module 1: Where do we stand?

Purpose of the Module:

- To reflect on our own beliefs and assumptions relating to GBV and persons with disabilities.

Please note: this activity can also be conducted at the end of the module to reflect change in knowledge and attitudes of participants.

Refer to Handout 4.1

Activity

Activity description

Timing: 15 minutes

Place three signs on the wall around the room – "**True**," "**False"** and "**Don't Know."** Ask participants to move to the sign according to whether they are answering "True," "False" and "Don't Know" to the following statements. Record the number of people selecting each response. Alternatively, people can stay seated, and hold up signs to indicate their answer.

1. Some disabilities may be hidden or difficult to see.

2. Persons with disabilities are not vulnerable to domestic violence.

3. GBV survivors with disabilities should go to separate, more specialized services designed for persons with disabilities.

4. Persons with disabilities can participate in our activities and programs if we make some adaptations.

5. Women with disabilities experience discrimination based on both gender and disability.

6. Persons with disabilities are unable to access services or participate in our programs solely because of their physical condition.

7. Family members of persons with disabilities may also be more vulnerable to GBV.

8. Girls with intellectual disabilities don't need knowledge and awareness about GBV.

9. Persons with disabilities can contribute to our GBV programs and activities.

10. There are things that I can do to prevent GBV against women and girls with disabilities and support survivors with disabilities.

8.2 Module 2: Understanding Disability

Purpose of the Module:

- To develop a common understanding of disability

Learning Points
United Nations Convention on the Rights of Persons with Disabilities Article 2 **"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."**

- Disability happens when a health condition interacts with societal barriers that make it difficult to do everyday things and participate in community life in the same way as others.
- There are different kinds of disabilities. Some disabilities are obvious, like not being able to walk and thus using a wheelchair, and some are invisible, like a mental disability or being deaf. Some people have more than one type of disability.
- There are many different ways in which society may view or interact with persons with disabilities that can result in their exclusion or inclusion in our society.

  Charitable model: People may look at persons with disabilities as not having any capacity to help themselves and think they must be "cared for" or "protected."

  Medical model: People may think that persons with disabilities need to be cured through medical interventions before they can actively participate in the community.

  Both of these approaches result in other people making decisions for persons with disabilities and keeping them separate from our society. It is better to use a social or rights-based model, which is also in line with approaches to working with survivors of GBV without disabilities.

  Social model: People instead look at the barriers that exist in the community and remove them so that persons with disabilities can participate like others.

  Rights-based model: Persons with disabilities have the right to equal opportunities and participation in society. We all have a responsibility to promote, protect and ensure this right is actualized, and persons with disabilities should be able to claim these rights

Activity

Activity Description

Types of disabilities

Timing: 15 minutes

Refer to Training Handout 4.2, 4.2.1: and 4.2.2 Guidance on including persons with disabilities and caregivers in GBV assessments and Understanding Disability

Ask participants: "What is disability? Who are people with disabilities?"

Ask everyone to draw a picture representing the different types of disabilities they know exist in the community. Stick these on the wall. Alternatively, you can use your own pictures of persons with different types of disabilities (see Training Tool 2 Types of disabilities).

If it is not raised, ask the group about persons who are isolated in their homes, or those with more “hidden” disabilities, like intellectual or mental disabilities. Highlight that today we are talking about the GBV concerns of persons with different types of disabilities and how they can access our programs.

8.3 Module 3: Gender, disability and inequality

Purpose of activity:

- To identify potential risks for women and girls with disabilities and their experiences within the wider community.

Learning points
United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) Article 3 and 6 **Article 3(g)** Equality between men and women; **Article 6** 1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms. 2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

• Household roles may change when someone has a disability. Men with disabilities may have less opportunity to work, making women in the household responsible for income, service and assistance, adding to their workload and risk of violence. Women caregivers experience additional risk of violence and exploitation, since they may be isolated and face constraints in accessing social and economic assets and support.

• In some settings, community members perceive persons with disabilities are as unable to, or that they should not, undertake tasks or do things they want or need to do, or that are expected of other men and women. They may be denied the right to marry, to have children or to earn income because of these perceptions, or face stigma and discrimination when engaging in these activities. This affects their status in the community, opportunities to be self-supporting, and power in relationships, which in turn can increase their risk of GBV.

• Women with disabilities may find it hard to continue performing the many duties expected of her by her family, spouse and society. She may subsequently be alienated from her family, abused by her husband or stigmatized by the community.

• Persons with disabilities are exposed to violence and discrimination based on both gender and disability, which results in inequality and power imbalances in their relationships with spouses, family and wider community members.

• Some persons with disabilities are dependent on others for daily care and activities, and to access services and assistance. This may be used by others as a way of exercising power over the individual. It also hinders their ability to socialize, access services or move about freely in the community.

Activity

Activity description

Timing: 30 minutes

Handout 4.3: The intersection of disability and gender

Handout 4. 3.1 Gender and Disability Mainstreaming

Group Work

Guiding question 1: What types of disabilities do people in our community have? Do women and girls have disabilities that are different from men and boys?

Purpose: This question will help gather information about what disabilities exist in the community and whether there are differences between men and women.

Facilitation: Ask everyone to draw a picture representing the different types of disabilities they know exist in the community. Stick these on the wall or draw them in the sand. Alternatively, you can use your own pictures of persons with different types of disabilities and ask people to identify which ones are most common in their community.

• Ask the group to talk about persons who are isolated in their homes, or those with more “hidden” disabilities, like intellectual or mental disabilities.

• Ask the group: Do women and girls have disabilities that are different from men and boys?

Guiding question 2: How does the community treat women and girls with disabilities? How does the community treat men and boys with disabilities?

Purpose: This activity will help identify how the community perceives women, girls, boys and men with disabilities and how this affects their roles, responsibilities and opportunities. It will also help to understand the expectations of women, girls, boys and men with disabilities and the reality of their daily life, including the support they may or may not receive from others in the community.

Facilitation: You can use pictures of women and men with disabilities undertaking different roles in the community to stimulate the discussion.

• Begin by asking the group:

» What tasks or roles are women with disabilities expected to undertake in the community? What about men?

» Is it expected that women with disabilities will also undertake the tasks expected of women without disabilities? Why or why not?

» Is it expected that men with disabilities will also undertake the tasks expected of men without disabilities?

» How might the spouse or family treat a woman with disabilities if they are unable to undertake these roles? How might the community treat women with disabilities if they are unable to undertake these roles? How would they treat men with disabilities if they are unable to undertake these roles?

Card set – Disability and gender inequality

Place cards depicting persons with disabilities undertaking different tasks and roles in the community on the wall. In a large group discussion, ask the group:

- Which cards show men and women with disabilities undertaking tasks that are part of their regular activities?
- Is it expected that women and men with disabilities will undertake these tasks in this community? Why/why not?
- How is it different for those with intellectual and/or mental disabilities?
- What might happen to women with disabilities if they do not or cannot do the tasks expected of them?
- What might happen to men with disabilities if they do not or cannot do the tasks expected of them?
- How might tasks need to be adapted or modified for someone with a disability?
- How is it different for those with intellectual and/or mental disabilities?
- What tasks might a caregiver need to adapt or start doing if someone in their household has or acquires a disability?
- What happens if a women caregiver begins to take on a role that is traditionally held by men?
- How do spouses, family or community members treat caregivers of children and/or adults with disabilities? How might this affect their power in relationships or status in the community? How would they treat men with disabilities if they are unable to undertake these roles?

8.4 Module 4: Root causes of GBV against women and girls with disabilities

Purpose of activity

• To identify the root causes of GBV against persons with disabilities.

• To reflect on power in relationships between persons with disabilities, perpetrators, caregivers and service providers.

Learning points
United Nations Convention on the Rights of Persons with Disabilities Article 16 Requires states parties to take measures to protect persons with disabilities from violence and abuse, including gender-based violence and abuse.
The root causes of GBV against persons with disabilities are the same as for other people: • Abuse of power • Inequality • Disrespect • For many women and girls, their experience of violence based on their gender intersects with other inequalities. This includes the oppression inflicted by majority populations against others based on race, religion, age, class, sexual orientation and disability, all of which contribute to further marginalization and result in less power and status in relationships, households and the community for women and girls with disabilities. • Most women and girls with disabilities have experienced a long history of discrimination and disempowerment — by family members, caregivers, partners and even service providers. People with new disabilities may be facing changes in their independence, decision-making ability and status in relationships, households and communities. • As GBV practitioners, we must work with women, girls and all survivors with disabilities to support them to develop their “power within” and have “power to” make their own decisions about services and assistance. We must be careful not to reinforce negative and harmful

power dynamics between persons with disabilities and others and/or exercise “power over” these individuals in the design or implementation of programs.

Activity

Activity description

Timing: 30 minutes

Ask participants to: recap the root causes of GBV that were described in previous trainings they have received — abuse of power, inequality and disrespect of women’s rights.

Put signs on the wall that read “Power over”/” Power within”/” Power to”/” Power with.” Read out the following quotes and ask participants to move to the sign that they think best reflects the type of power being demonstrated. Alternatively, people can stay seated and hold up signs to indicate their answer.

“My daughter with intellectual disabilities is safer if she stays inside the house. So I don’t let her go out – I keep the door locked.” (Power over – Other people are making decisions for her)

"She is very outgoing and enjoys being around other people. She is always following her sister to other activities, even though she can't participate." (Power to – she is actively seeking support)

"My sister is deaf, but she is very good at sewing. So she shows the other women in our group, using demonstrations, while I translate her instructions." (Power with – women working together)

"I can't work anymore, but I want to be useful again. Maybe I can share information with other people with disabilities." (Power within – growing self-agency)

"When I was talking to her mother about making a referral for a medical examination, Inaam became upset and started yelling. I think she may have behavioral problems." (Power over)

Ask participants to discuss the types of power women and girls with disabilities typically have in their relationships with:

• spouses

• caregivers

• service providers

Ask participants to reflect on their own experiences and interactions with persons with disabilities. What kind of power relationship do they think they have with these individuals? What assumptions or stereotypes do they hold? What concerns or fears do they have about working with women and girls with disabilities?

As GBV practitioners, we must work with survivors with disabilities to support them to develop their "power within" and "power to" make their own decisions about services and assistance. We must be careful not to reinforce negative power dynamics between persons with disabilities and others and/or to exercise "power over" them. We must also support spouses, caregivers and other service providers to share "power with" women, girls and all survivors with disabilities, as well as caregivers, to ensure their needs are met and that programs are made more friendly and accessible to them.

8.5 Module 5: Sexual and Reproductive Health Rights of Persons with disabilities

Purpose of the Activity

•To identify perceptions and myths surrounding SRHR of persons with disabilities

•To understand that SRHR are basic human rights for persons with disabilities on equal basis with others and that all barriers including discriminatory practices must be removed.

Learning Points

United Nations Convention on the Rights of Persons with Disabilities – Articles 9, 22, 23 and 25

- **Article 9** calls for accessibility, including access to medical facilities and to information.
- **Article 22** asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information.
- **Article 23** requires states to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life.
- **Article 25** requires that states ensure equal access to health services for persons with disabilities, with specific mention of SRH and population based public health programmes

The International Conference on Population and Development Programme of Action (ICPD PoA) recognizes:

- the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (Paragraph 7.3)

The ICPD PoA explicitly calls for governments at all levels to consider the needs and rights of persons with disabilities and to eliminate discrimination against persons with disabilities with regard to reproductive rights and household and family formation:

- Governments at all levels should consider the needs of persons with disabilities in terms of ethical and human rights dimensions. Governments should recognize needs concerning, inter alia, reproductive health, including family planning and sexual health, HIV/AIDS, information, education and communication. Governments should eliminate specific forms of discrimination that persons with disabilities may face with regard to reproductive rights, household and family formation, and international migration, while taking into account health and other considerations relevant under national immigration regulations. (Paragraph 6.30)
- Governments should ensure community participation in health policy planning, especially with respect to the long-term care of the elderly, those with disabilities and

those infected with HIV and other endemic diseases. Such participation should also be promoted in child-survival and maternal health programmes, breastfeeding support programmes, programmes for the early detection and treatment of cancer of the reproductive system, and programmes for the prevention of HIV infection and other sexually transmitted diseases. (Paragraph 8.7)

Sexual health is an integral part of overall health, well-being and quality of life. It is a state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled.

All too often, the SRH of persons with disabilities has been overlooked by both the disability community and those working on SRH. This leaves persons with disabilities among the most marginalized groups when it comes to SRH services. Yet persons with disabilities have the same needs for SRH services as everyone else. In fact, persons with disabilities may actually have greater needs for SRH education and care than persons without disabilities due to their increased vulnerability to abuse.

The challenges to SRH faced by persons with disabilities are not necessarily part of having a disability, but instead often reflect lack of social attention, legal protection, understanding and support. Persons with disabilities often cannot obtain even the most basic information about SRH. Thus, they remain ignorant of basic facts about themselves, their bodies, and their rights to define what they do and do not want.

As a group, persons with disabilities fit the common pattern of structural risks for HIV/AIDS and other sexually transmitted infections – e.g. high rates of poverty, high rates of illiteracy, lack of access to health resources, and lack of power when negotiating safer sex.

Persons with disabilities – often incorrectly assumed to be sexually inactive (hence virgins) – are also now at risk. Both men and women with disabilities, regardless of age, are at risk for "virgin rape". Accounts from many areas report that persons with disabilities have been raped repeatedly. Obviously, any SRH programme that seeks to protect people from such sexual violence must include persons with disabilities in all outreach efforts.

While many issues faced by persons with disabilities apply equally to men and women, some issues are gender specific. Among the special issues more often faced by women with disabilities than by men are forced marriage, domestic violence, and other types of physical, emotional, and sexual abuse, the burdens of household responsibilities, and issues concerning pregnancy, labour, delivery, and childrearing. Nonetheless, men with disabilities are also at greater risk of sexual abuse than men who do not have disabilities.

Women and disability. It has been said that to be a woman and a person with a disability is

to be doubly marginalized. Among obstacles faced particularly by women are the following:

- **Survival rates:** In many societies the survival rate for women with disabilities is lower than that for men with disabilities.
- **Unstable relationships**: Considered in some societies as less eligible marriage partners, women with disabilities are more likely to live in a series of unstable relationships, and thus have fewer legal, social and economic options should these relationships become abusive. Maternal morbidity and mortality: Women with disabilities are not only less likely to receive general information on sexual and reproductive health and are less likely to have access to family planning services, but should they become pregnant, they are also less likely than their non-disabled peers to have access to prenatal, labour and delivery and post-natal services. Physical, attitudinal and information barriers frequently exist. Often community level midwifery staff will not see women with disabilities, arguing that the birthing process needs the help of a specialist or will need a Cesarean section - which is not necessarily the case. Of equal concern is the fact that in many places women with disabilities are routinely turned away from such services should they seek help, often also being told that they should not be pregnant, or scolded because they have decided to have a child.
- **Women without disabilities in households with family members with a disability:** Parents of children with disabilities often find themselves socially isolated. Stigma, poverty, and lack of support systems take a toll on such families. The burdens often fall disproportionately on women in such households.

Men and disability. Men with disabilities also face gender-related issues:

- **SRH education**: In many societies, while women receive instruction about SRH either at home or in school, young men are left to pick up information "on the streets" – casually, through other men's comments, jokes and innuendoes. Young men with disabilities are often shielded from even this information, unreliable and incomplete as it may be. Young men with mental and intellectual impairments are particularly likely to be deprived of SRH information.
- **Sexual exploitation:** It is widely believed that men are not sexually abused. This is not true, however. In particular, men with disabilities are susceptible to sexual abuse, from both male and female perpetrators. Accessible abuse reporting and effective intervention programmes are as important for men with disabilities as they are for women with disabilities.

SRH services are often inaccessible to persons with disabilities for many reasons, including physical barriers, the lack of disability-related clinical services, and stigma and discrimination. In many situations barriers to health services include:

- Lack of physical access, including transportation and/or proximity to clinics and, within clinics, lack of ramps, adapted examination tables, and the like;
- Lack of information and communication materials (e.g. lack of materials in Braille, large print, simple language, and pictures; lack of sign language interpreters); health-care providers' negative attitudes;
- Providers' lack of knowledge and skills about persons with disabilities;
- Lack of coordination among health care providers;
- Lack of funding, including lack of health-care insurance.

Activity

Activity description:

Handout 4: It is best and usually easy to mainstream health services that accommodate persons with disabilities.

Timing: 30 minutes

Ask the Participant to must break into small. Hand out the case study First - ask the groups to discuss the cases, to share their ideas on the situations, emotions and attitudes. Suggest that some situations can be complicated or ambiguous. 3. Next, the participants are asked to imagine they are professionals involved in working with client/s and they have to analyze and solve the case.

Case Study

A 29-year-old woman with intellectual – institution for persons with disabilities, moves from a closed institution to group flats. She enjoys her new freedom, likes shopping and cooking for herself. After a few months it seems she has gained some weight. Her social workers get suspicious – if it's from better food or ...pregnancy. And so therefore they send her to visit a gynecologist. The young woman tells the doctor that she has no complaints, denies she has been in sexual relationships and refuses to be examined. She tells the social workers that the visit had been OK and that no problems were discovered. After some more weeks the social workers decide to take her to a

gynecologist once more and ask for an examination. She is confirmed as eight- month pregnant. The young woman shows surprise and says she is not aware of any sexual relationships in the past. She has no idea how babies are born, fed or raised. By law group flats are not for families with children, and there is no medical staff or other staff prepared for taking care of newborns. Formally it can take a few months to move the young woman to some other social service.

Each small group will present the results of their group discussion to the whole audience ask the groups to analyze the situation on 4 levels:

The Individual– what does this situation tell us about the clients' situation, what are the rights of the client, what are the needs we can see through this case; what reactions, activities or education is needed;

Specific Questions

The family - what does this situation tell us about the clients' possible family; what reactions, activities or education is needed;

The organization – how can we see this case in the context of the organization: what reactions can be appropriate or needed from the part of the professionals and the organization;

State or legislation level – what do local and international laws tell us about this case, what are possible gaps we can see, what are suggestions.

1. Ask the group: "If the person with disabilities in the story reported that she experienced rape, how do you think people would respond?"

2. Ask the group: "Do survivors with disabilities share experiences like this with other people? What makes it difficult for them to do so?"

3. Ask the group: "Where could this person go to receive appropriate assistance? What kind of assistance and support could the survivor receive?"

4. Ask the group: "Is it likely that this survivor would seek such assistance? What might prevent her from seeking assistance?

8.6 Module 6: Vulnerabilities of women and girls with disabilities

Purpose of activity

• To identify the factors that make persons with disabilities more vulnerable to GBV.

Learning points

Persons with disabilities are vulnerable to all forms of GBV. There are many factors that increase their vulnerability, but the root causes of GBV against persons with disabilities are always the same: inequality based on gender and disability. Gender inequality is based on the power imbalance between men and women, and is exacerbated by the inequalities, oppression and abuse of power associated with disability.

Factors related to disability that may increase vulnerability to GBV include:

• Stigma and discrimination: Persons with disabilities experiencing negative attitudes in their communities, which leads to multiple levels of discrimination and greater vulnerability to violence, abuse and exploitation, especially for women and girls with disabilities. It may also reduce their participation in community activities that promote protection, social support and empowerment.

• Perceptions about capacity of persons with disabilities: Perpetrators perceive have a perception that with disabilities will be unable to physically defend themselves or effectively report incidents of violence, which makes them a greater target for violence. This is particularly true for women and girls with physical disabilities, and persons with intellectual disabilities, who experience a number of barriers to reporting violence and/or negotiating sex in an abusive relationship. People may not listen to them or believe them, especially when it is a survivor with mental or intellectual disabilities, which reduces their access to services. It is often assumed that they do not understand what has happened to them or are not able to express their needs, adding to impunity for perpetrators of such violence.

• Loss of community support structures and protection mechanisms: This is particularly severe in contexts of new displacement where families and communities have already been separated. In general, women and girls with disabilities are often shunned or alienated from others if they have a disability. Some families may resort to tying up their relative and/or locking them inside the home to prevent them from moving around the community where they fear they may experience violence. Adolescent girls with disabilities may also be excluded from protective peer networks and programs, which could otherwise serve to strengthen important assets and support their transition into adulthood.

• Extreme poverty and lack of basic supplies: The lack of income or basic supplies increases the risk that women and girls with disabilities may be abused and exploited, including by service providers or community members. It could also increase the risk of abuse and exploitation perpetrated by partners, and reduce their ability to leave violent relationships due to their

dependence on others.

• Environmental barriers and a lack of transportation: Persons with disabilities must rely on other community members to access services and assistance, including food and non-food item distributions, which increases risk of exploitation and abuse, and makes it difficult to access GBV response services in a confidential way.

• Isolation and a lack of community support: This increases women with disabilities' risk and vulnerability to violence, particularly inside the home. Some persons with disabilities may be hidden by family members. Others find it difficult to move outside of their homes and meet other people. A lack of community support and friendships can mean that they do not acquire the information and skills they need or have people to go to when they experience violence. It also means that violence is often perpetrated in private, with few options to report or seek outside assistance.

• Lack of information, knowledge and skills: Women and girls with disabilities often have little information about GBV and personal safety, which means that they are less able to protect themselves. This is particularly true for women and girls with intellectual disabilities who may be more easily targeted by perpetrators. They are also consistently excluded from all programs and activities, and information is usually not conveyed in a way that they can understand, making it more difficult for them to seek assistance.

Activity

Activity description

Timing: 30 minutes

Safety and security of women and girls with disabilities

Facilitation:

• Begin by explaining that "we would now like to ask you a few questions about the safety and security of women and girls with disabilities in the community."

• Use pictures of places in the community or ask participants to draw a map of the general area or site. Maps can be created on paper with colored pens or in the dirt/sand using natural materials such as sticks and pebbles. Make sure that they include common places where women and girls spend time throughout the day or gather for social reasons (e.g., home, school, market or community spaces).

1. Ask the group to select the places where women go to meet each other. Ask the group to select the places where girls go to meet each other.

2. Ask the group “Do women and girls with disabilities also go to these places where their peers are going? Why/Why not? What types of barriers do they experience? Are these barriers different depending on the type of disability?” (e.g., physical versus intellectual disability). Be sure to ask this question for women and girls separately. Do not put them together in a single question.

3. Ask the group: “In this community, where do women with disabilities feel safe? Where do they feel unsafe or avoid going? What makes this place safe or unsafe?” Refer to the map or drawings as appropriate. Repeat the questions asking about girls.

4. Ask the group: “Can you describe the kinds of violence women with disabilities face in the community? What about girls with disabilities? How does it differ according to the type of disability?” (e.g., physical versus intellectual disability).

5. Ask the group: “What happens to the people who commit these acts of violence against women and/or girls with disabilities? Are they punished? If so, how?”

6. Ask the group: “How does the family respond to a woman with disabilities who has been raped or sexually assaulted? How do they support her? What about for girls with disabilities?”

7. Ask the group: “What do women and girls with disabilities do to protect themselves from violence? What support systems do they have? What does the community do to protect them?”

OR

Break into small groups. Give each group a case study to discuss. Each group should discuss the same questions:

• What types of violence are persons with disabilities experiencing in this case study?

• How are other people in the case study affected? In what ways?

• Identify three factors that make persons with disabilities in the case study vulnerable to GBV.

• What other factors exist that have not already been mentioned?

Ask each group to present back the three factors that make the person with a disability vulnerable to GBV. Write these on a flip chart.

What factors increase vulnerability of persons with disabilities to GBV? Do these affect both men and women with disabilities in the same way? If not, how are they different?

8.7 Module 7: Guiding principles of working with persons with disabilities

Purpose of activity

- To define guiding principles for working with persons with disabilities in GBV programs

Learning Points
Article 29: The right to participation in political and public life for persons with disabilities **Article 30:** The rights to participation in cultural life, recreation, leisure and sport for persons with disabilities
The following are guiding principles should be considered when working with persons with disabilities in GBV programs: **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, men and boys with different types of disabilities, and the need to make services and activities accessible to and meaningful to these groups. Inclusion of people 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**: They 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. Don't assume that because a person has a disability that they are incapable of certain things or wouldn't 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 people 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. People 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":** People 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 people 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, people with disabilities and other family members.

Activity

Activity description

Timing: 30 minutes

Ask participants to split into three groups to discuss the following topics:

Group 1 – What does stigma of women and girls look like?

Group 2– What does stigma of persons with disabilities look like?

Group 3 – What does stigma of women and girls with disabilities look like?

Each group should write words on cards or sticky notes that reflect the experiences of stigma experienced by each of these groups. Ask each group to present these ideas and stick their words on the wall.

As a large group, discuss the common features of stigmatization of women and girls, stigmatization of persons with disabilities and stigmatization of women and girls with disabilities. What kinds of principles are most important when working with women and girls with disabilities?

How can we integrate these principles into our work? What principles do we want to encourage in staff, partners and the community?

Write these up as principles for your activities and programs in addition to those included above

8.8 Module 8: Barriers to access and participation

Purpose of Module

• To identify barriers to access and participation of persons with disabilities in GBV programs.

Learning points

There are many things that prevent persons with disabilities from being included in our activities, not just their health condition. Potential barriers include:

- Attitudinal barriers – Negative stereotyping of persons with disabilities, social stigma and discrimination by staff, families and community members.
- Physical or environmental barriers – Such as buildings, schools, clinics, water pumps, roads and transport that are not accessible to persons with disabilities.
- Communication barriers – From written and spoken information, including media, flyers and meetings, and complex messages that are not understood by persons with disabilities. Other barriers – Rules, policies, systems and other norms that may disadvantage persons with disabilities, particularly women and girls.

• Analyzing potential barriers is a first step in planning strategies and actions to include persons with disabilities in our programs

Activity

Activity description

Timing: 30 minutes

Put four signs on the wall: “Physical barriers”; “Attitudinal barriers”; “Communication barriers”; “Other barriers. In the same groups as in Activity 6, ask participants to discuss the barriers persons with disabilities face in each case study. Ask them to write each “barrier” on a sticky note. They should present these barriers and place them on the wall under the sign which relates to that type of barrier.

Key questions:

• What barriers are preventing access to services or inclusion of persons with disabilities in our activities? How is it different for women, girls, boys and men with disabilities?

• Does this barrier only affect the person with disabilities? Are caregivers or other family members and community members also affected?

• What barriers do you think are most common in this community?

Allow other participants to comment and make suggestions. Leave the barriers on the wall for the next activity

8.9 Module 8: Strategies for inclusion

Purpose of Module

• To define strategies to address barriers and promote access and participation of persons with disabilities in GBV programs

Learning points
• Persons with disabilities have a right to access our services and participate in our activities on an equal basis with other members of the community. We must remove as many barriers as possible that prevent persons with disabilities from accessing and being included in GBV our programs • We should consult with persons with disabilities to identify the best ways to improve their access to and participation in our programs. Particular attention should be paid to consulting with women and girls with disabilities, and female caregivers. Including them in decision-making and utilizing their skills and capacities will make our programs more inclusive and facilitate longer-term healing and empowerment of survivors with disabilities in the community. It will also help to inform the best ways to improve accessibility for women, girls, boys and men with disabilities to the services we provide.

Activity

Activity description

Timing: 30 minutes

Break into small groups again. Give each group one category of GBV activities to discuss:

i. Services (e.g., counseling or case management)

ii. Empowerment (e.g., classes and activities at the women's center)

iii. Prevention (e.g., community mobilization)

iv. Advocacy (e.g., working group meetings and or conversations with other civil society organizations those in the leadership)

Each group should identify:

• One specific activity that is undertaken in their context.

• One barrier that prevents persons with disabilities from accessing services or participating in the activity identified (e.g., adolescent girls who are blind are not able to fi nd their way to the women's center for classes). Note: The participants may wish to look at the list on the wall from the previous activity to get ideas.

• One thing we could do to help to overcome this barrier (e.g., we could organize for the girls to walk together to the women's center and escort girls who are blind).

• One way in which persons with disabilities could provide input or feedback in order to improve our Learning points

• Persons with disabilities have a right to access our services and participate in our activities on an equal basis with other members of the community. We must remove as many barriers as possible that prevent persons with disabilities from accessing and being included in GBV our programs.

• We should consult with persons with disabilities to identify the best ways to improve their access to and participation in our programs. Particular attention should be paid to consulting with women and girls with disabilities, and female caregivers. Including them in decision-making and utilizing their skills and capacities will make our programs more inclusive and facilitate longer-term healing and empowerment of survivors with disabilities in the community. It will also help to inform the best ways to improve accessibility for women, girls, boys and men with disabilities to the services we provide.

Ask participants to report back in a plenary and document their suggestions.

Discuss as a large group:

• What suggestions are feasible to implement now in your program?

• What suggestions require additional support (e.g., time, funds or expertise) to implement?

8 .10 Module 10: Guidance for GBV Caseworkers: Applying the guiding principles when working with survivors of disabilities

Purpose of this Module

- Many of the issues faced by survivors with disabilities are similar to those faced by all GBV survivors, though in the case of persons with disabilities they may be magnified by the discrimination, misunderstandings and assumptions often associated with disability.
- This module has been developed to support GBV caseworkers to uphold a survivor-centered approach to working with GBV survivors with disabilities**.**

Learning Points
The two key issues we must consider in our implementation of the guiding principles with survivors with disabilities are: Applying the core GBV guiding principles to survivors with disabilities The core GBV guiding principles described below should always be upheld when working with survivors with disabilities. The two key issues we must consider in our implementation of the guiding principles with survivors with disabilities are: (i) **Communication**: How do we need to adapt our communication methods to convey the same ideas when we cannot rely solely on verbal communication? In most cases, survivors with disabilities can communicate directly with GBV practitioners with no adaptations, or relatively small adaptations, such as identifying someone who can interpret their form of sign language or by using simplified language in discussions. In other cases, it may be less clear what the best way to communicate with a survivor is, and additional steps may be required to determine this. When working with persons who find it difficult to communicate: • Take time, watch and listen. This is a process, not a one-time event. Each time you meet the person you will learn something new about them and understand better how they communicate and what they mean. • Conduct open conversations with caregivers in which the individual can hear what is being said and participate in any way possible. **N.B. Remember that people who cannot speak or move may still understand what is happening around them and what people are saying about them./////** • Pay attention to any way in which the individual wishes to communicate. This could be through gestures and sometimes their emotions. Some persons with intellectual and mental disabilities can exhibit a wide range of behaviors. This is sometimes the way they communicate with others. (ii) **Caregiver involvement:** How and when do we involve caregivers in the care and support of the survivor? For some individuals with disabilities, family members and caregivers may assist with communication and daily care. While we want wherever possible to have direct communication with and participation of survivors with disabilities, in some cases we may also need the advice and support of their caregivers. Family members and caregivers can be critical

partners in helping us define and implement strategies for effective communication and participation with persons with disabilities. The relationship between the survivor and the caregiver is sometimes an enduring, central relationship, and we can focus on supporting and strengthening positive features of this relationship throughout the case management process. Working with and establishing trust with caregivers will also create space for more effective direct engagement with the survivor.

Summary of how the guiding principles are implemented in working with GBV survivors.

Respecting the wishes, rights and dignity of survivors: the essence of this guiding principle is that the caseworker should always seek to validate and empower the survivor. Validating the survivor means that we believe her story and we let her know this. It means that we do not judge her actions, opinions and decisions, but rather we affirm that she is not to blame for the violence or abuse she experienced.

Empowering the survivor: means that we let her know she is brave for sharing her story and for coming for help, and we communicate that we are here to listen and support her. We allow her to make the decision that is best for her, and we trust that she knows what is best for her.

When implementing this guiding principle, we have to be mindful of the following:

(i) **Communication**: If verbal communication is limited, we can validate a survivor's feelings and convey empowering messages through non-verbal techniques — we can use drawing, pictures or body language, particularly facial expressions. It may take us some time to establish ways of communicating with the survivor that allow us to convey these important messages.

(ii) **Caregiver involvement:** Societal attitudes, stigma and discrimination relating to disability can affect the way service providers approach case management with survivors with disabilities. In many societies, persons with disabilities are perceived as individuals who must be "cared for" or "protected."

This may result in assumptions that the survivor is incapable of making their own decisions, and staff may defer to others, including family members or other service providers, to make decisions on their behalf. These attitudinal barriers often result in a failure to fully investigate the survivor's capacity to consent, and reinforces their disempowerment by having others make decisions for them.

(iii)**Ensuring the physical and emotional safety and security of the survivor**: all case actions must safeguard the survivor's physical and emotional well-being in the short and long term. This means that we must ensure that the space in which we speak to the survivor feels safe to her. In our assessment of the survivor's needs and in our case action planning with the survivor, we must prioritize discussions and actions that will minimize the survivor's risk for further harm.

Care and treatment provided by the caseworker and others must be carried out in a space and in such a manner that the survivor can trust that she will not be not be physically or emotionally

harmed by the caseworker or the caseworker's actions.

(i) **Communication**: Getting to know the individual with disabilities — the things they like

and dislike, and the ways they behave and communicate — may help us understand when a survivor does not feel safe talking to us and why. It may also help us to understand when they are assenting to certain activities in the case management process. Watch for signs of agita tion, anger or distress that may indicate the individual is not happy to proceed at this time, and respect this, especially if you are talking with the caregiver.

(ii) **Caregiver involvement**: While many caregivers play a supportive role in the survivor's disclo sure of abuse and healing, there may also be cases when the caregiver is the perpetrator of abuse, or we have concerns that the survivor will be harmed if the caregiver finds out about the abuse and/or the survivor's disclosure. It is important to remember that in many GBV cases, a survivor seeking help can significantly increase their risk of further harm if the perpetrator or perpetrator's family and friends find out.

In such cases, safety is paramount, and we need to support the survivor in telling us who and where is not safe for her and with whom and where she feels safe. It may be possible, then, with the survivor's consent, to involve this person/people in the survivor's care and to make sure the survivor has a safety plan in place.

Maintaining confidentiality and only sharing necessary information with permission from the survivor. This principle requires that caseworkers and others involved in the care and treatment of the survivor protect information gathered about survivors and agree to only share information about a client's case with their explicit permission. This means ensuring

1) the confidential collection of information during interviews;

2) that sharing information happens on a need-to-know basis or in line with laws

and policies, and that permission is obtained from the survivor before information is shared;

3) case of referrals, only the details relevant to the referral are shared with the other service provider, and survivor and caseworker reach a decision together about what information should be shared; and

4) case information is stored securely.

All standard rules of confidentiality apply when working with adult survivors with disabilities. Case workers and service providers should only share information about a survivor with the survivor's explicit permission. They should never discuss case details with family and friends, nor with colleagues unless knowledge of the abuse is necessary for service provision.

Activity

Activity description**: As a large group, consider the GBV referral pathways in your country.**

Refer to handbook 5: Referral Pathways in GBV Cases

Timing: 30 minutes

Key Questions:

- Is there a clear laid out GBV referral pathway system in your country for victims of GBV?
- Is the pathway gender responsive and disability inclusive?
- What about women with disabilities versus women without disabilities, are they equally accessible, non-discriminatory and generally user friendly for all women?
- According to **Handout 5** which pathway is most common for women and girls with disabilities?
- What is it that can be done to ensure that all pathways are utilized by all groups equally?

Section C

3.0 Monitoring and evaluation

Purpose of this Tool

- This tool is designed to support program staff to reflect on the process of disability inclusion that their GBV program has undertaken (if any already taken).
- It provides questions to guide a group discussion among staff to help them identify changes in their own knowledge, attitudes and practice that have allowed greater accessibility and participation for people with disabilities and caregivers.

- It also allows staff to identify persistent gaps and further actions to be taken to remedy such gaps.

NB Give all participants the post- training test to be filled individually and returned to the facilitator.

3.1 Pre-and post-training test (answer key)

1. How do you define persons with disabilities?

The answer should reflect three key components:

(i) A long-term impairment in the body (1 point)

(ii) Interaction with other barriers (1 point)

(iii) Preventing participation in society on an equal basis with others (1 point)

2. Persons with disabilities are not vulnerable to domestic violence.

o True

o False

False – Persons with disabilities are vulnerable to all forms of GBV. They may have less power in relationships, as well as weaker social networks, making them especially vulnerable to GBV. Women and girls with disabilities in particular face structural and systematic gender inequalities, reinforcing abuse of power between men and women as social groups. (1 point)

3. GBV survivors with disabilities should go to separate, more specialized services designed for persons with disabilities.

o True

o False

False – Services designed for GBV survivors should be accessible to ALL survivors. These services and their staff should have the right skills and capacities to respond to the unique needs of GBV survivors, including those with disabilities. (1 point)

4. The root causes of GBV against persons with disabilities are (circle all that apply):

(a) Perceptions that persons with disabilities are weak and unable to defend themselves

(b) Low status in the community

(c) Inequality in power in relationships with other people

(d) Poverty and basic needs not being met

(e) All of the above

Answer: (b) and (c) (1 point)

5. The following factors make women and girls with disabilities more vulnerable to GBV (circle all that apply):

(a) Many women and girls with disabilities don't go to school

(b) Having contact with other women and girls their own age

(c) Staying inside their home all day

(d) Reliance on others to access services and assistance

(e) All of the above

Answer: (a), (c) and (d). Please note: Having contact with other women and girls their own age can help with acquiring information and skills, but also provide support to women and girls with disabilities should they experience violence. (1 point)

6. List three things that may prevent persons with disabilities from accessing GBV services and

activities.

(i)

(ii)

(iii)

Answer: A range of environmental, communication, policy and attitudinal barriers may prevent persons with disabilities from accessing GBV services and activities. Any examples provided in activity four can be included in this answer. (3 points)

7. Girls with intellectual disabilities may be at increased risk of GBV because (circle all that apply):

(a) They don't have the same knowledge and skills about GBV and personal safety as other girls.

(b) Information on GBV is not conveyed in a way which they can understand.

(c) They are unable to learn new things.

(d) Family and caregivers hide them inside the home.

(e) All of the above.

Answer: (a), (b) and (d). Please note: Girls with intellectual disabilities can learn new skills if taught to them in a way that is accessible and appropriate to their learning needs. (1 point)

8. Persons with disabilities are unable to access services or participate in our activities because of their health condition and ability.

o True

o False

False – There are many things which may prevent persons with disabilities from being included in our activities, not just their health conditions. Environmental and societal barriers all affect access and inclusion and can be partially addressed through better targeting and accessibility of services. (1 point)

9. The community may perceive persons with disabilities as unable to, or should not, undertake some tasks expected of other men and women.

o True

o False

True – Persons with disabilities may experience additional stigma and discrimination relating to their disability in addition to social norms determined by their gender. In some cases, community members perceive persons with disabilities are as unable to, or should not, undertake some tasks expected of other men and women. They may be denied the right to marry, to have children or to earn income because of these perceptions. They may also face stigma and discrimination when engaging in family or community responsibilities and tasks that are not deemed suitable because of their disability or gender. This affects their status in the community and power to negotiate in relationships. (1 point)

	I have a strong understanding of…	Strongly Disagree 1	2	3	4	Strongly agree 5

10	… who “persons with disabilities” are in the community					
11	… the factors that make women, girls, boys and men with disabilities more vulnerable to GBV					
12	… the potential barriers that prevent persons with disabilities from accessing our services or participating in our programs					
13	… potential actions I can take to address these barriers					

For questions 10 –13, we want to know if their confidence changes as a result of the training.

Give 1-5 points depending on which box they select. (5 points each question)

Total Score: _____ out of 33

Section C

4.0 Handouts

4.1 Handout 1: Where do we Stand?

Place three signs on the wall around the room – "**True**," "**False"** and "**Don't Know."** Ask participants to move to the sign according to whether they are answering "True," "False" and "Don't Know" to the following statements. Record the number of people selecting each response. Alternatively, people can stay seated, and hold up signs to indicate their answer.

1. Some disabilities may be hidden or difficult to see.

True – Some disabilities, such as mental and intellectual disabilities, are not visible, but people with these types of disabilities may be stigmatized in communities and experience severe discrimination.

2. Persons with disabilities are not vulnerable to domestic violence.

False – Persons with disabilities are vulnerable to all forms of GBV. They may have less power in relationships and weaker social networks, making them especially vulnerable to GBV.

3. GBV survivors with disabilities should go to separate, more specialized services designed for persons with disabilities.

False – Services designed for GBV survivors should be accessible to ALL survivors, and their staff should have the right skills and capacities to respond to the needs of all GBV survivors, including those with disabilities.

4. Persons with disabilities can participate in our activities and programs if we make some adaptations.

True – We should adapt our programs and activities to address physical, communication, attitudinal and others barriers, so that persons with disabilities have the same opportunity to participate as others. Even small changes can help develop GBV programs that are more accessible to persons with disabilities.

5. Women with disabilities experience discrimination based on both gender and disability.

True – For women and girls with disabilities, their gender and disability make them especially vulnerable and at increased risk of violence. They may be isolated in their homes, discriminated against by the community, unable to access services or protect

themselves from violence. Women with disabilities are also often expected by their families, husbands and society to undertake the many duties and responsibilities, as well as access services, in the same ways as other women without the support or adaptations they need. They also experience extreme forms of discrimination when families, husbands and societies do not understand or seek to recognize their situation or their abilities. They may become alienated from their families and partners, unable to interact or socialize with friends or family, or be abandoned — which can in turn lead to greater stigma, rejection and violence in the community.

6. Persons with disabilities are unable to access services or participate in our programs solely because of their physical condition.

False – There are many things that may prevent persons with disabilities from being included in our programing, not just their physical condition. Environmental and societal barriers all affect access and inclusion and can be partially addressed through better targeting and improved accessibility of services.

7. Family members of persons with disabilities may also be more vulnerable to GBV.

True – Disability affects the whole family or household. Family members of persons with disabilities may need to take on more household responsibilities and may experience more poverty, making them vulnerable to violence and exploitation. This is particularly true for women caregivers who already experience vulnerabilities and discrimination on the basis of gender. For example, the wife of a man with new disabilities may have to seek income and assistance for the family, in addition to all her other roles, exposing her to violence at home and in the community.

8. Girls with intellectual disabilities don't need knowledge and awareness about GBV.

False – Girls with intellectual disabilities are especially vulnerable to GBV, in part because they do not receive the same education or have the same peer support as other girls. They also have a right to know about issues and services available to them even though the information may need to be adapted to their cognitive abilities.

9. Persons with disabilities can contribute to our GBV programs and activities.

True – Persons with disabilities are the best people to advise us on the barriers they experience, and to make suggestions for how we can address these barriers. Women and girls with disabilities also have unique perspectives on life and the community, which enriches our experience and understanding of the overall context and can help us make program improvements. It is only when we include all women and girls in our

activities that we will truly be able to develop a movement to end violence against women and girls.

10. There are things that I can do to prevent GBV against women and girls with disabilities and support survivors with disabilities.

True – There are many things we can do to remove barriers and promote access and participation of persons with disabilities. These may be simple or sophisticated interventions that help to reduce the risks that women and girls with disabilities face.

4.2 Handout 2: Guidance on including persons with disabilities and caregivers in GBV assessments.

Purpose of this guidance note

This document provides an overview of the process and tools to use when conducting an assessment with persons with disabilities, particularly women and girls with disabilities, and their caregivers about the risks of GBV in their communities, potential barriers to accessing response services and participating in programs and activities, and their suggestions for improving GBV programs.

Who do we want to consult?

We are interested in the perspectives of women, girls, boys and men with different types of disabilities, including:

• Those with difficulty moving and walking (since birth or due to an impairment acquired later in life);

• Those with difficulty seeing, even when wearing glasses (visually impaired);

• Those with difficulty hearing, even when using hearing aids (deaf);

• Those with intellectual disabilities who may have difficulty understanding, learning and remembering new things;

• Those with mental disabilities and mental health conditions;

• Those with multiple disabilities, who are often confined to their homes and who may need assistance with personal care.

In GBV program assessments, it is particularly important to consult with women and girls, including those with disabilities and those who are caregivers, to understand their needs, perspectives and priorities. Women and girls often take on the role of caregiver for family members with disabilities, in addition to their other roles and responsibilities.

Women and girls may have been caregivers in various settings, or could find themselves in this new role when a family member acquires a new disability. Caregivers may be isolated and at greater risk of violence, both inside and outside the home. They are important to include in consultations so that their perspective and needs are always taken into account.

How can we best facilitate the participation of people with disabilities and caregivers?

We all have experiences and skills we can draw upon when consulting with persons with disabilities. Every day we use speech, writing, gestures, pictures and posters, and activities to convey and information. These basic approaches can also work with people with disabilities. It is important to find the approach that works best for the particular individual or group with whom you are consulting. You can ask persons with disabilities or their caregivers for their preferred communication method, and you should always be prepared to try an alternative approach if one method does not work. Persons with disabilities have many different skills and capacities that you can use in communication and consultation.

Wherever possible, persons with disabilities should participate directly in the discussions. If an individual does not feel comfortable communicating with you on their own, or you cannot find an appropriate method of communication, you can also collect information from the caregiver. It is key, however, to try to communicate with the person with disabilities first. Some individuals can communicate directly with you, but may not want to be separated from their caregivers, or may want support from someone they trust, particularly during the consent process. In these cases, allow the individual to make their own decision about what type of support they need, and who they trust to provide that support.

Handout 4.2.1 Communicating with People with Disability Guideline

Purpose of this tool

This tool provides guidance on how to communicate effectively with persons with disabilities. It is not specific to communicating with GBV survivors with disabilities, but can be used to help staff understand basic ways to adapt verbal and non-verbal communication when working with survivors with disabilities or involving persons with disabilities in community activities. Persons with disabilities have a right to participate in our activities on an equal basis with other members of the community. As service providers and practitioners, the way we interact and communicate with persons with disabilities and talk about them can help to break down barriers to participation and send positive messages to colleagues, partners and community members. It also improves the quality of our programs by ensuring that they are inclusive of all ideas, skills and capacities that exist within the community.

Communication tips

Use respectful language

Different language is used around the world to describe disability and to refer to persons with disabilities. Some words and terms may carry negative, disrespectful or discriminatory connotations and should be avoided in our communications. The Convention on the Rights of Persons with Disabilities is translated into many languages and can be a useful guide to using terms about disability that are both sensitive and appropriate.

Organizations of persons with disabilities (DPOs) can also provide guidance on the terminology preferred by persons with disabilities in a given country.

General Tips

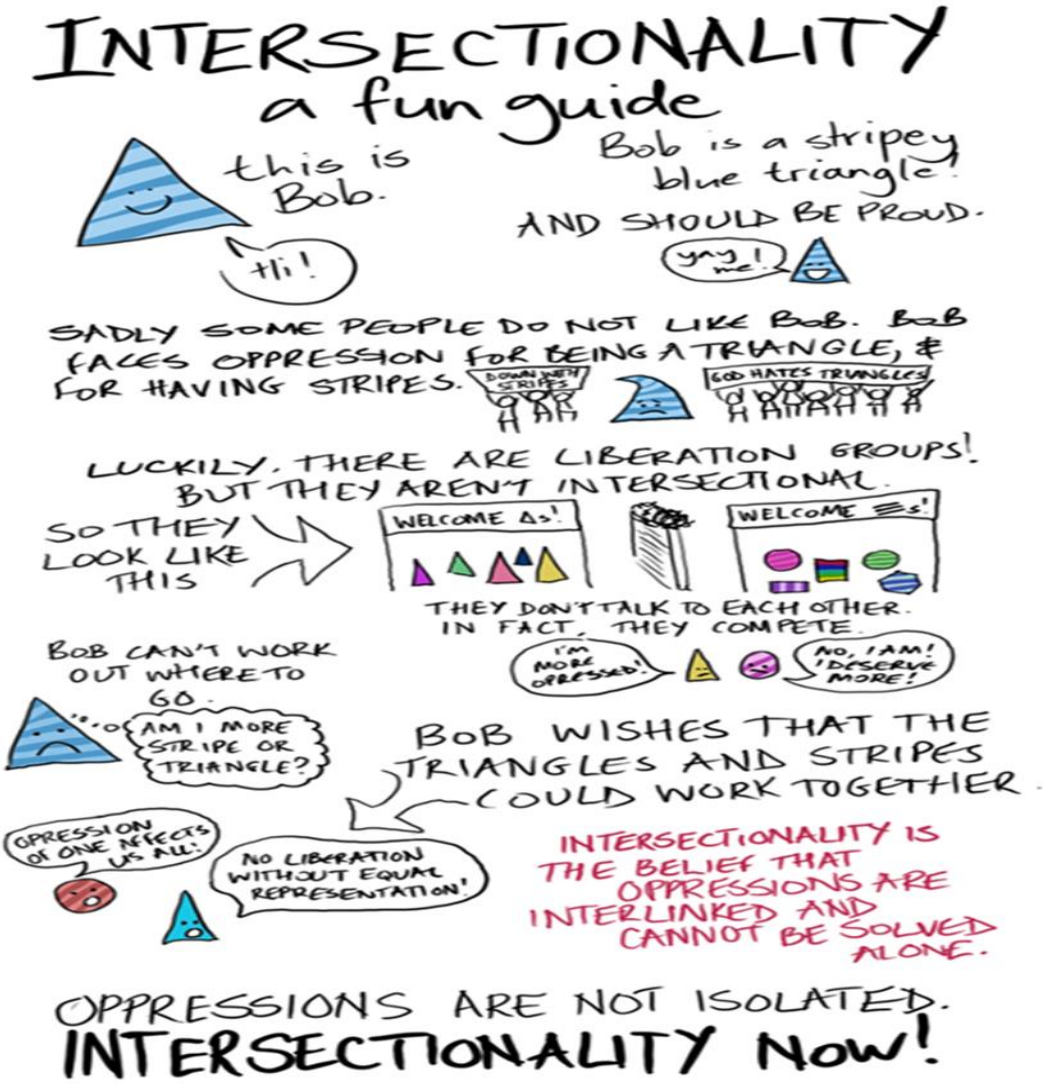
- Use a strengths-based approach Do not make assumptions about the skills and capacities of persons with disabilities — this can affect the way we communicate and interact with them. Remember that persons with disabilities are people, first and foremost. Just like all people, they have different opinions, skills and capacities.
- Look at what they can do. This can often give insight into how they can communicate and participate in your activities.

- Greet persons with disabilities in the same way you would other people. For example, offer to shake hands (if culturally appropriate), even if they have an arm impairment.
- Speak directly to the individual with disabilities, not to their interpreter or assistant/caregiver.
- When speaking for a length of time, try to place yourself at eye level with the person if they are not already at the same height (e.g., by sitting in a chair or on a mat).
- Treat adults with disabilities like you treat other adults. Discussions and activities should continue to be age appropriate and then adapted for the communication needs of the individual.
- Ask for advice. If you have a question about what to do, how to do it, what language to use or the assistance you should offer — ask them. The person you are trying to work with is always your best resource.
- There are specific communication and engagement strategies to consider, depending on the type of disability the person has.

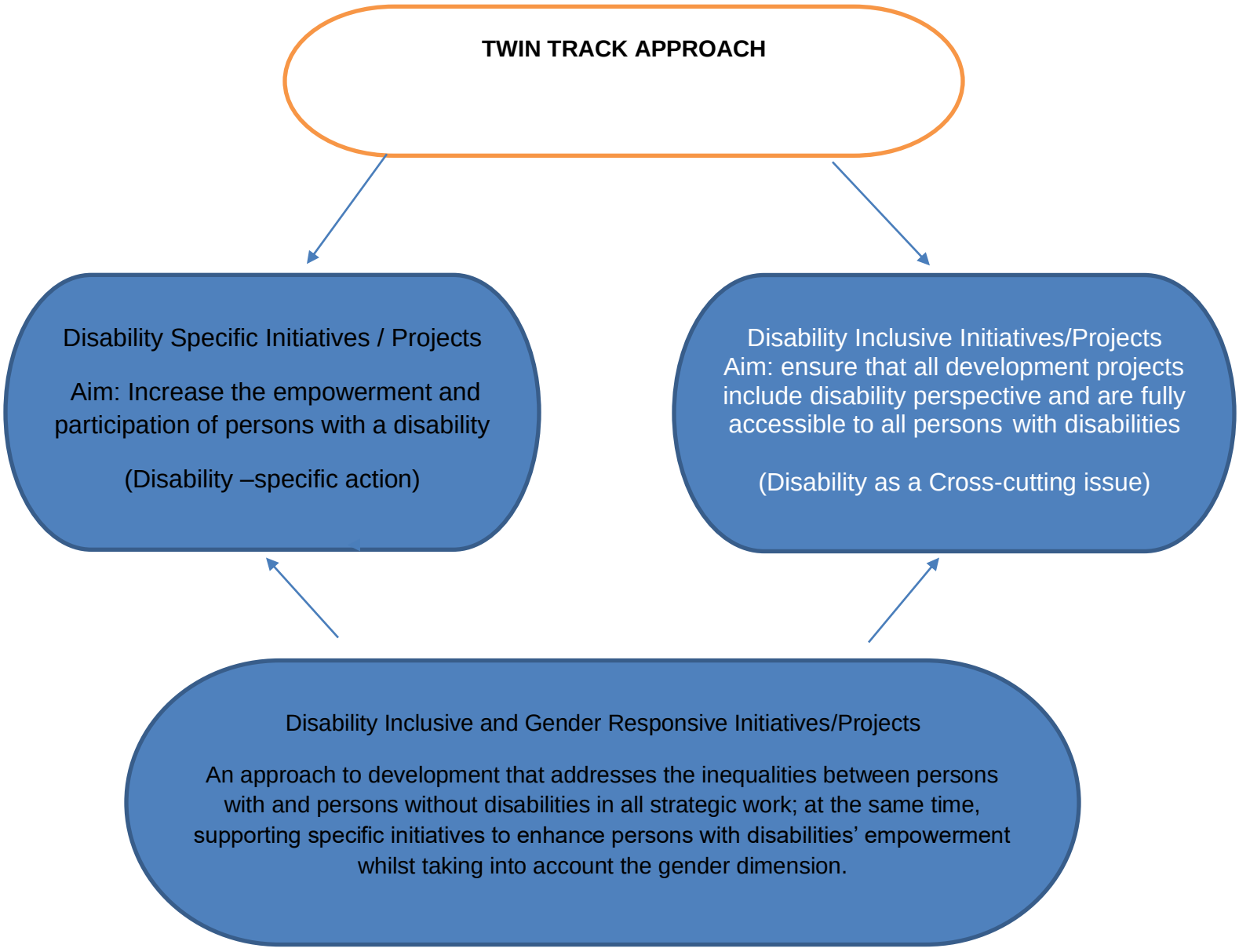
Handouts 4.2.2: Understanding Disability

Scenario	Charitable Model	Medical Model	Social Model
A girl using a wheelchair attending adolescent girls' safe space	"She can't come to our safe space. The other girls might tease her. It would be better if we had special place for her."	"She can't participate in the activities in the safe space. Once learns to walk, then she will be able to participate."	"As long as the physical environment in the safe space accessible she can participate/ we can think of other of some different activities in safe space – activities that don't require moving around. At the end the safe space is for ALL girls"
Man with an intellectual-disabilities attending sexual and reproductive health training	"It is no use inviting him as he can't learn new things, and he will never get married or have children anyway. His family should take good care of him and make sure no one abuses him."	"He needs a specialist doctor – these are the only people who can help."	"The facilitator can should use diverse methodologies like using pictures, videos and drawings to ensure everyone understands we can also ask him what he thinks of our training to get his opinion and how we can improve it."
"Mother of a child with disabilities who is isolated in her home."	"It must be very sad having a child with disabilities. we should prioritize them for material assistance to help their situation at home."	"This child needs a therapist. Maybe we can refer her to one in the capital city."	"This child has a right to be in same activities as other children. Lets discuss with her and her mother, and start exploring what activities may interest her the most including ensuring that she attends an inclusive school."

4.3 Handout 3: Gender and Disability Equality



4.4 Handout 3.1: Twin-Track Approach in Gender and Disability



4.5 Handout 4: SRHR Services for Persons with Disabilities

It is best and usually easy to mainstream health services that accommodate persons with disabilities.

The following list, while not exhaustive, contains examples of ways in which many SRH services can be made more inclusive:

Physical access Illustrative approaches to increase physical access include:

♣ ramps for wheelchair users;

♣ larger bathrooms with grab bars;

♣ lowered examination tables. Access to information and communication

Increasing access to information and communication might include the following:

♣ sign language or captioning to improve access to health-care resources and public health announcements;

♣ information presented in simple, easily understood graphic formats;

♣ materials in large print or Braille;

♣ information given by radio, cassette tape, or CD in addition to print;

♣ demonstrating activities such as condom usage rather than just describing them;

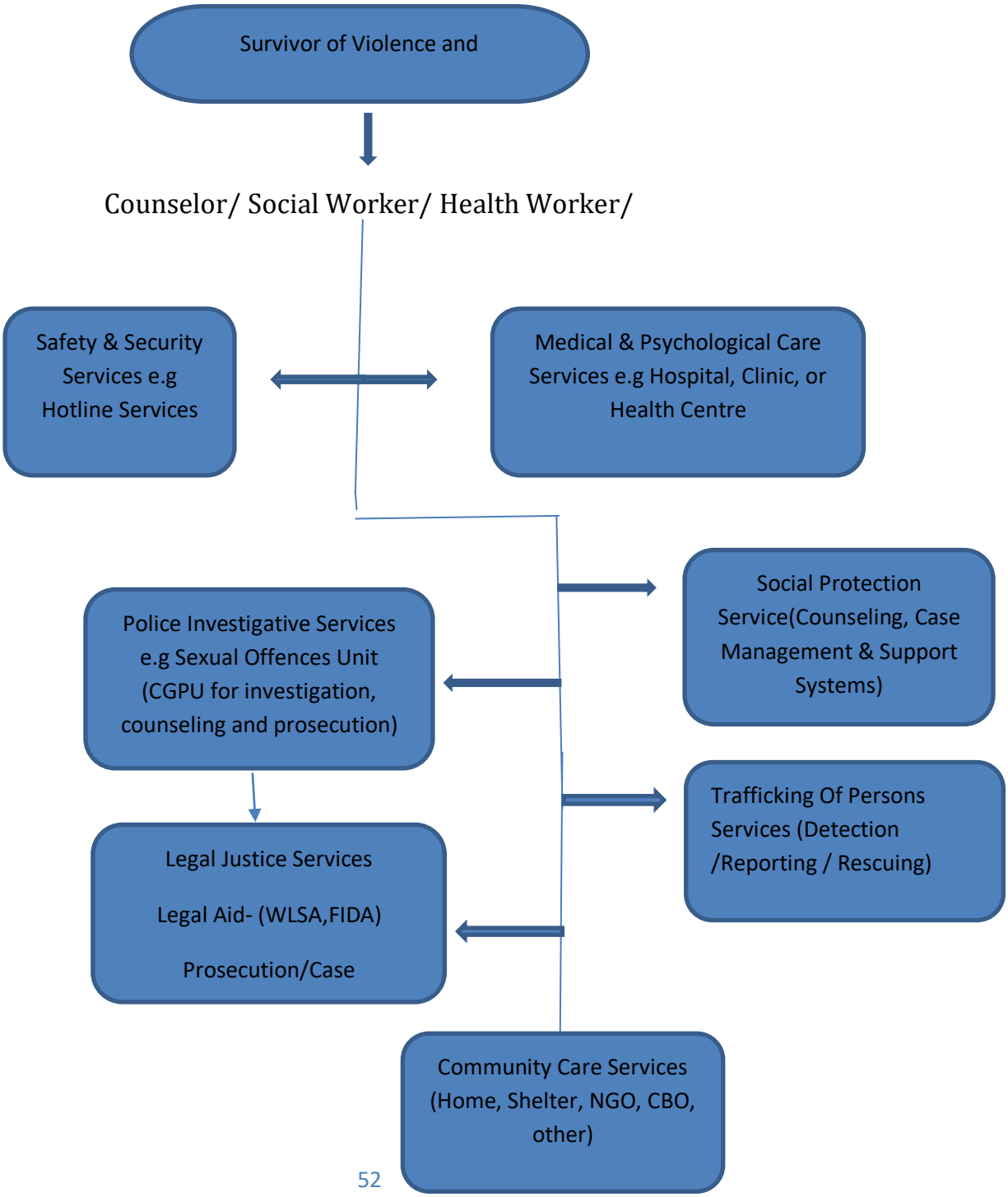
♣ giving information more slowly and stopping more often than usual to ensure comprehension by all.

A growing number of technological advances, including the availability of information via computer, have significantly improved the quality of life of persons with disabilities in industrialized countries. Such new technologies should be made accessible to all persons with disabilities, including those in developing countries.

For example, in some contexts a sexual and reproductive health NGO offers special HIV voluntary counselling and testing services for deaf persons. These services entail confidential HIV counselling and testing at clinics managed by deaf staff; mobile VCT activity and community mobilization in urban and rural deaf communities; support to deaf clients in need of referral and care; establishment of post-test support groups within deaf communities; and development of communication materials.

4.5 Handout 5: GBV Referral

Referral Pathway for Survivors of Gender-Based Violence



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