What Works Evidence Review:
Preventing violence against women and girls with disabilities in lower- and middle-income countries (LMICs)
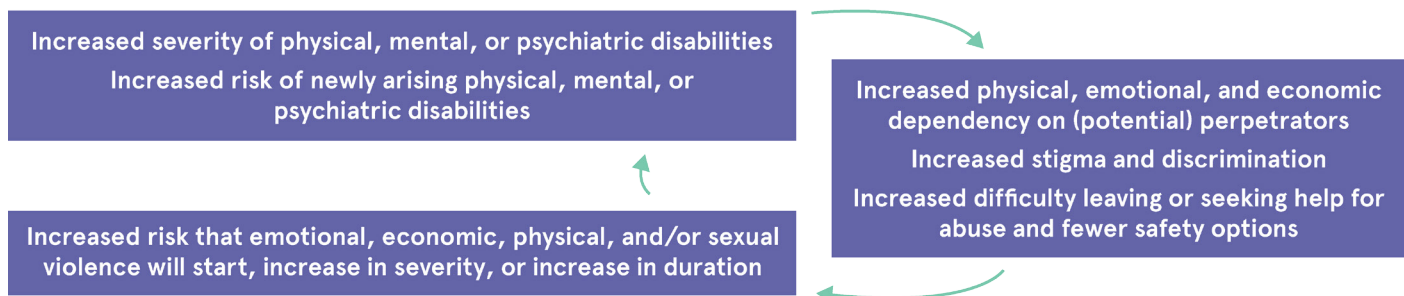
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Introduction

Women and girls with disabilities are at increased risk of violence, abuse, neglect, maltreatment, and exploitation both because of their gender and their disabilities. **Women with disabilities are at least twice as likely as nondisabled women to be victims of rape, sexual abuse and intimate partner violence (IPV)**[1,2]. While all children with disabilities are at a higher risk for various forms of violence when compared to children without disabilities[3,4] – including sexual violence, bullying, and physical violence – **girls with disabilities are more likely to experience physical and sexual violence than boys with disabilities**[5]. Meanwhile, experiences of violence by all women and girls can have significant, long-term impact on both their physical and mental health. Thus, **the relationship between disability and violence is reciprocal as disability enhances the risk of violence, while violence itself can lead to** (or increase the severity of) **disabilities** (Figure 1).

Figure 1: Cycle of violence and disability

> Increased severity of physical, mental, or psychiatric disabilities
> Increased risk of newly arising physical, mental, or psychiatric disabilities

> Increased physical, emotional, and economic dependency on (potential) perpetrators
> Increased stigma and discrimination
> Increased difficulty leaving or seeking help for abuse and fewer safety options

> Increased risk that emotional, economic, physical, and/or sexual violence will start, increase in severity, or increase in duration

Globally, 80% of women and girls with disabilities live in low-middle income countries (LMICs), where they are more likely to be poorer, less educated, and at a greater societal disadvantage than men with disabilities or their non-disabled peers[6]. Those in conflict areas or humanitarian crises face significant barriers in fleeing to safety and finding accessible accommodation and health services, placing them at higher risk for experiencing violence[7]. In many settings, women and girls with disabilities face additional pressures because they are regarded as unable to meet the social roles and expectations on women and girls to, for example, attract men, marry, bear children, or care for families. This can result in further social exclusion, which may contribute to development of depression or other mental illness, in addition to increasing physical and economic vulnerabilities.

The importance of social context for understanding disability and vulnerability to violence

While disability originates from functional impairments in a person's body or mental health, the defining characteristic of disability is the way society and culture treat these differences in a person's functioning. In other words, **disability arises from the interactions of a person's physical and mental health with the social context within which they live and the resources they can access and use.** These factors together either enable or restrict their full participation in society. For women and girls with disabilities, there are a range of common contextual factors that contribute to making the structural and social contexts in which they live disabling, by both increasing their vulnerability to violence, and also by preventing them from effectively seeking help, care or redress from the health, justice, or other sectors.

Box 1: Multi-Country Qualitative Research on Disability and Violence in the What Works Global Programme

The What Works to Prevent Violence against Women and Girls Global Programme is conducting qualitative research with participants with disabilities in five intervention programmes in South Africa, Rwanda, Ghana, Tajikistan, and Pakistan – including women, men, and youth with a range of disabilities – to better understand how age, gender, and types of impairment shape their context-specific experiences of violence. By better understanding the causes and consequences of violence in their lives, and exploring the factors that serve as barriers and enablers to accessing support and interventions to prevent violence, we will be able to develop guidelines for future violence prevention programmes – both for including people with disabilities in general purpose programmes and in developing targeted programmes specific to people with certain kinds of disabilities.

Barriers in built and structural environments

Because of impairments or illness, women and girls with disabilities may not be able to access safe and secure housing, transportation, ablutions, recreational areas, or other public spaces. Education, health, justice, or other social services may be inaccessible because of stairs, travel distance, or other physical barriers. Women and girls with disabilities may be unable to use communication tools requiring vision or hearing, and often lack access to appropriate assistive technology that would help them access information on how best to prevent or respond to violence.

## Discrimination, dependence, and social barriers

Because of impairments or illness, women and girls with disabilities may be dismissed, stereotyped, treated with contempt, or viewed as too difficult to accommodate in a wide range of social settings. They are often excluded from events, activities, education, and employment opportunities because of stigma and (legal or illegal) discrimination. This reduced access to education and employment can make them dependent on potential perpetrators of violence for support. In addition, women and girls with disabilities are often stereotyped as either asexual or undesirable, and thus often fail to receive appropriate education or services related to sexual and reproductive health, as well as being excluded from programmes or services intended to prevent or respond to intimate partner violence or non-partner sexual violence. Their reports of violence may be dismissed as lacking credibility when they attempt to seek help or justice. Women and girls with mental health conditions or invisible chronic illnesses may also be stigmatised as crazy, lazy, or suffering other personal failings which make them undeserving of services or social support. Finally, women and girls with disabilities may in many settings be dismissed as too difficult to work with by educators or service providers who lack appropriate skills or resources.

Box 2

In the What Works Help the Afghan Children evaluation in Afghanistan, 18% of children self-reported some level of functional impairment. Factors associated with self-reporting disability included experiences of corporal punishment and peer victimisation, with boys more likely to report corporal punishment than girls. Among girls, food insecurity and depression were also strongly linked to reporting disability.

Figure 2: Adverse experiences linked to self-reported disability among girls and boys participating in the What Works Help the Afghan Children Project
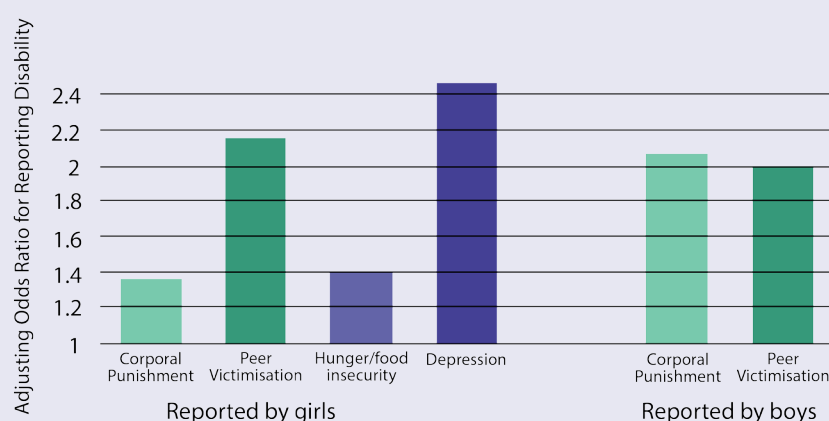
Intersections of disability, gender and violence

While women and girls with disabilities experience the same forms of violence that all women and girls experience, when gender and disability intersect, violence has additional perpetrators, unique forms, unique settings, and more severe consequences that need additional attention in programming. Women and girls with disabilities are exposed to a **wider range of potential perpetrators** than their non-disabled peers[8].

These include people on whom they may be physically, economically, or socially dependent. Additionally, they are at risk for **disability-specific forms of violence** such as verbal or emotional abuse targeting their disability; denial of psychological or psychiatric care; being prevented from using essential assistive devices such as wheelchairs; being denied essential medication or being over-medicated; being physically neglected or refused help; and being economically exploited through misuse of social welfare grants by household members or others[9].

Women and girls with disabilities also face an increased risk of violence in a wider range of settings than non-disabled peers, such as institutions or group-homes and specialised health care settings. They are more likely to stay in abusive situations for longer periods of time and have fewer options for seeking safety due to barriers in their physical and social environments[10].

Depending on the nature of their disability, they may have difficulty recognising, defining, or describing abuse, and are often less likely than their peers without disabilities to be aware of or able to access services, or to be believed when they do make reports[11-14]. This increased difficulty in seeking help increases their risk of sustaining severe injuries from unalleviated violence. Violence can also exacerbate a pre-existing disability or lead to a new impairment – this is especially the case for mental health conditions such as anxiety, depression, and post-traumatic stress disorders, all of which are common consequences of experiencing violence. Barriers in help seeking and accessing health care exaggerate the consequences of violence against women and girls with disabilities[15].

Intimate partner violence

Research consistently suggests that intimate partners are the most common perpetrators of violence against women both with and without disabilities[8]. To date, research on IPV among people with disabilities has been limited. Research in the United States and Germany shows that women with disabilities are at increased risk for experiencing IPV compared to men with disabilities, as well as being at higher risk than non-disabled women[2,15-18].

Most existing research on IPV and disability comes from developed countries. One of the most important contributions from the What Works Global Programme is expanding the evidence base around connections between disability and IPV in LMICs. All the What Works quantitative impact evaluations include the Washington Group Short Set of Questions on Disability [19]. Emerging findings from the baseline assessments for What Works projects in Ghana, South Africa, and Nepal all confirm the greatly increased prevalence of IPV among women self-reporting higher levels of functional impairments.

In the COMBAT intervention in Ghana and the Stepping Stones and Creating Futures trial in South Africa, women reporting more severe functional impairments also reported significantly more experiences of IPV in the last 12 months than women who report none (Figures 3 and 4). In Ghana, there is a clear and significant relationship between more severe impairments and increased frequency of IPV (Figure 3).

Figure 3: Experience of IPV in the past 12m among disabled and nondisabled women participating in the What Works COMBAT Ghana Project
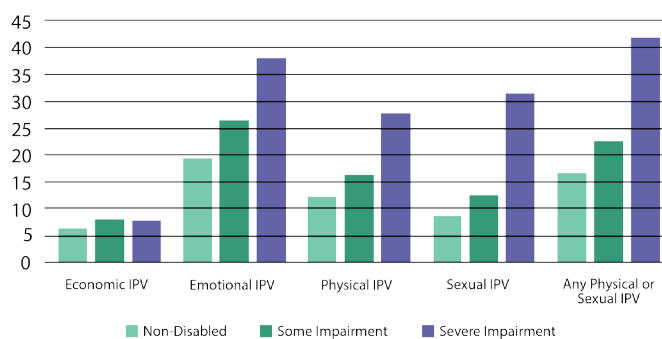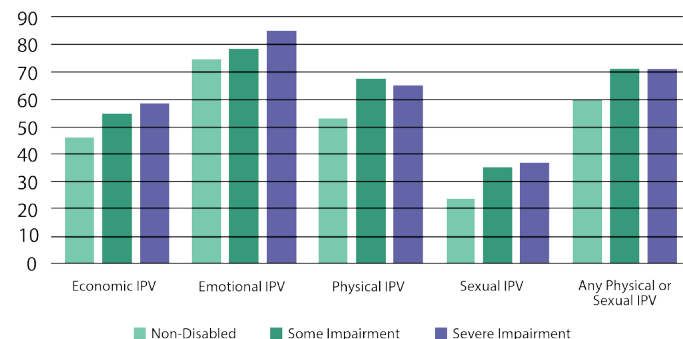

Figure 4: Experience of IPV in the past 12m among disabled and nondisabled women participating in the What Works Stepping Stones Creating Futures Project in South Africa

A similar pattern is observed among women participating in the Change Starts at Home intervention in Nepal, with the addition of increased odds of reporting violence from in-laws in the last 12 months (Figure 5)[20-22]. Because these baseline data are cross-sectional, we do not yet know the extent to which impairments and associated disability increase the risk of IPV, versus IPV increasing the risk of disability, but this is something What Works will examine in depth as the programme continues and additional waves of data are collected.

Figure 5: Experience of IPV and violence from in-laws in the past 12 m among disabled and nondisabled women participating in the What Works Change Starts at Home project in Nepal
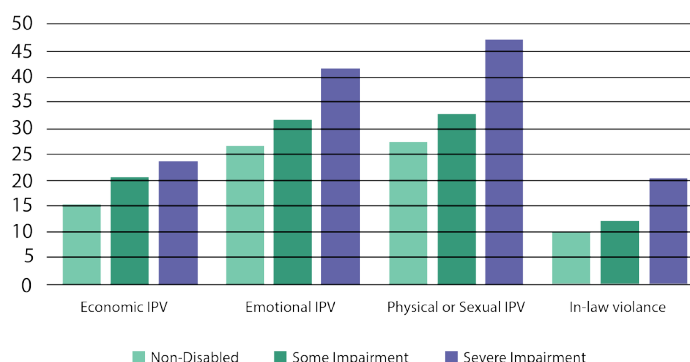
Expanding the evidence base on preventing violence against women and girls with disabilities in LMICs

While our knowledge on how to effectively prevent and respond to violence against women and girls in many different settings is rapidly expanding, we know very little about how to effectively prevent or address such violence against women and girls with disabilities in LMICs [23]. In 2014, a systematic review of global evidence on preventing violence against people with disabilities found only 10 existing evaluations[24]. While the review included a range of interventions with service providers, families of children with disabilities, and adults with intellectual disabilities, none of the evaluations reviewed demonstrated a significant ability to reduce or prevent violence, and all suffered weak quality of evidence. In addition, only one study was based in a LMIC: the Sexual Assault Victims Empowerment (SAVE) programme

in South Africa, which is a criminal justice intervention for intellectually impaired survivors of sexual assault and their families[25]. In Uganda, the Good Schools Toolkit, which worked across mainstream primary schools to reduce violence among primary school children was shown to reduce violence against children[26]. In a secondary analysis of this data they showed that it also reduced violence against children with disabilities, although the evaluation did not look at whether the programme was equally effective for children with and without disabilities[5].

Recommendations for disability inclusive research, evaluations, and violence prevention programmes

While the evidence base on the best strategies to prevent violence against women and girls with disabilities in LMICs is only now starting to emerge, we can make some recommendations based on what we know today, from our knowledge of the broader field of violence against women and girls, and specific work on women and girls with disabilities.

· **Use an intersectional approach:** Research and programmes need to **employ a gender lens** and explicitly seek to understand the intersectional (or multiple, compounding) oppressions faced by women and girls with disabilities compared to men with disabilities, and **employ a disability lens** in VAWG programmes to understand women's double oppression of gender and disability.

· **Foster partnerships:** VAWG actors need to **work together with disabled people's organisations** to identify context-specific and disability-specific risks and needs of women and girls living with disabilities in any given setting to make programming most relevant for them. Such partnerships can help ensure that strategies for preventing violence against women and girls with disabilities are **flexible and responsive**

to a broad spectrum of functional impairments among participants in different types of disabling environments.

· **Value accessibility:** Programmes can readily explore ways in which existing violence prevention research, evaluations and interventions for the general population can be **made available to women and girls with disabilities,** for example by requiring venues to be accessible to those with mobility impairments.

· **Monitor participation:** Violence prevention programmes should actively **monitor the participation of people with disabilities in programmes activities, and actively partner with participants with disabilities and local disability service organisations to improve accessibility.**

Generating new knowledge to help prevent violence against women and girls with disabilities in LMICs

Our knowledge about the lives of women and girls with disabilities is largely based on research from the Global North; the lives of women and girls with disabilities in the Global South need more attention. The inclusion of disability questions in What Works evaluation tools, combined with planned qualitative research, will enable us to:

• Track the **participation** of people with disabilities in our interventions.

• Assess the **barriers and enablers to full participation** for participants with disabilities, as well as their experiences of the extent to which the programmes are relevant to their lives.

• Use our follow-up data to explore the **bi-directional linkages between violence and disability** among

intervention participants, i.e. the extent to which disability increases risk of violence and vice versa.

• Compare the **impact** of the programmes between women, men, and youth with disabilities and non-disabled peers.

In these ways, we hope to contribute to the evidence on the optimal balance on mainstreamed versus targeted prevention programmes for preventing violence against women and girls with disabilities, as well as describing which violence prevention strategies are most effective for people with disabilities.

The What Works to Prevent Violence against Women and Girls Programme is a flagship programme from the UK Department for International Development, which is investing an unprecedented £25 million over five years to the prevention of violence against women and girls. It supports primary prevention efforts across Africa and Asia that seek to understand and address the underlying causes of violence, and to stop it from occurring. Through three complementary components, the programme focuses on generating

evidence from rigorous primary research and evaluations of existing interventions to understanding what works to prevent violence against women and girls generally, and in fragile and conflict areas. Additionally the programme estimates social and economic costs of violence against women and girls, developing the economic case for investing in prevention.

WhatWorks
TO PREVENT VIOLENCE
A Global Programme To Prevent
Violence Against Women and Girls

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TO PREVENT VIOLENCE
Violence Against Women and Girls
in Conflict and Humanitarian Crises

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Economic and Social Costs of
Violence Against Women and Girls

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