

DISABILITY INCLUSION IN GENDER-BASED VIOLENCE PROGRAMMING



PROMISING PRACTICES AND INNOVATIVE APPROACHES
FROM UNFPA ASIA AND THE PACIFIC COUNTRY OFFICES



This report is a product of the United Nations Population Fund (UNFPA) Asia and the Pacific Regional Office (APRO), and was produced under the technical guidance of Sujata Tuladhar, Regional Gender-Based Violence (GBV) Adviser, and Kamma Blair, Regional Programme Specialist. Emma Pearce, GBV and Disability Inclusion Consultant, was the primary author of this publication, with thanks to Jessica Gardner, Sarah Baird, Valentina Volpe, Giorgia Airoidi and Jiwon Park from UNFPA APRO for review and input. We are also thankful to Tod Emko, UNFPA APRO Accessibility Advisor, who provided key guidance on improving the accessibility of the document.

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July 2023



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EXECUTIVE SUMMARY

The United Nations Population Fund (UNFPA) Asia and the Pacific Regional Office is committed to making sure that all efforts to address gender-based violence (GBV) are inclusive of and accessible to women and girls with disabilities, ensuring that transformative goals are met and that no one is left behind. This document presents promising practices and innovative approaches to disability inclusion in GBV programming adopted by UNFPA country offices and their GBV partners in the Asia-Pacific region. Practices were identified through consultations with UNFPA country offices and interviews with GBV partners, including organizations of persons with disabilities. The promising practices and approaches are categorized as follows:

- Adopting a twin-track approach to strengthening disability inclusion in GBV programming
- Addressing negative attitudes, beliefs and norms relating to gender and disability among persons with disabilities, community members and GBV actors
- Setting standards for disability inclusion with GBV partners and promoting action planning to address gaps identified
- Engaging with organizations of persons with disabilities appropriately, exploring their understanding of gender equality and GBV principles
- Collecting and analysing disaggregated data – quantitative or qualitative – on age, gender and disability
- Strengthening the capacity of GBV practitioners to work with survivors with disabilities

The promising practices and approaches in this document all highlight the power of partnerships between UNFPA, mainstream GBV service providers and organizations of persons with disabilities not only in addressing the needs of survivors with disabilities, but for knowledge exchange, mentoring and joint advocacy. However, there is still a critical gap in the evidence on the outcomes of disability-inclusive approaches and strategies. These outcomes include changes in the knowledge, attitudes and practices of GBV partners and service providers and in the outcomes for persons with disabilities who are accessing GBV services or activities. Gathering more information about outcomes is critical to identifying what disability-inclusive approaches and strategies work, where they work and why.

We are not just beneficiaries but also agents of change ... I hope that in future activities by UNFPA and other UN agencies – I hope you find the space for us – we can join and contribute.

– Students with Disabilities Club, Viet Nam

ABBREVIATIONS

APRO	Asia and the Pacific Regional Office
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRPD	Convention on the Rights of Persons with Disabilities
DDI	Disability Development Initiative
GBV	Gender-based violence
ICPD	International Conference on Population and Development
MAPAL	Myanmar Association of Persons Affected by Leprosy
MDCDA	Myanmar Deaf Community Development Association
MHPSS	Mental health and psychosocial support
OPD	Organization of persons with disabilities
PSEAH	Prevention of sexual exploitation, abuse and harassment
SDG	Sustainable Development Goals
SRHR	Sexual and reproductive health and rights
STEP	Special Talent Exchange Program
TLMM	The Leprosy Mission Myanmar
UNDIS	United Nations Disability Inclusion Strategy
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
WHO	World Health Organization

1. INTRODUCTION



Ending gender-based violence (GBV) and harmful practices is one of the *three transformative results* of UNFPA, and a key priority in implementing the Programme of Action of the International Conference on Population and Development (ICPD) and the 2030 Agenda for Sustainable Development.¹ In pursuit of these goals, the UNFPA Asia and the Pacific Regional Office (APRO) is supporting countries in the region to address GBV, including strengthening sexual and reproductive health services as an entry point for violence-related information, services and referrals, and developing evidence-based programmes to promote and protect women's rights.²

The United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) estimates that Asia and the Pacific is home to more than 700 million persons with disabilities, who face significant barriers to their full and effective participation in society.³ Globally, 18 per cent of the female population has a disability,⁴ and many of these women are at higher risk of GBV than those without disabilities owing to the multiple and intersecting forms of discrimination they face. Attitudinal, environmental and communication barriers result in this population's systematic exclusion from GBV programmes, services and activities – both as partners and as beneficiaries.

As ending GBV is one of UNFPA's key transformative results, UNFPA APRO is committed to making sure that all efforts to address GBV are inclusive of and accessible to women and girls with disabilities, ensuring that transformative goals are met and that no one is left behind. UNFPA has prioritized a "whole of institution approach" that focuses on accelerating the implementation of the four pillars of the *United Nations Disability Inclusion Strategy* (UNDIS). The disability inclusion approach of UNFPA is aligned with the *UNFPA Strategic Plan (2022–2025)*, which further details specific measures for promoting the rights of persons with disabilities. The work of UNFPA aims to further strengthen the capacity for high-quality collection, analysis and utilization of population data in policymaking and programming regarding population issues, gender equality and sexual and reproductive health, including in humanitarian settings.

¹ United Nations Population Fund, *The UNFPA Strategic Plan, 2022–2025* (DP/FPA/2021/8).

² UNFPA APRO, "What we do: Gender-based violence" (n.d.). Available at <https://asiapacific.unfpa.org/en/node/15204>.

³ United Nations ESCAP, *Disability-inclusive Development in Asia and the Pacific and the Path to 2030: Perspectives of Persons with Disabilities and Civil Society Organizations* (ESCAP/APDDP/2022/INF/1).

⁴ World Health Organization, *Global Report on Health Equity for Persons with Disabilities* (Geneva, 2022).

This document presents promising practices and innovative approaches to disability inclusion in GBV programming adopted by UNFPA country offices and their GBV partners in the Asia-Pacific region. It complements wider tools and resources developed by UNFPA and partners at global and regional levels. These include:

- UNFPA, *Women and Young Persons with Disabilities: Guidelines for Providing Rights-based and Gender-responsive Services to Address Gender-based Violence and Sexual and Reproductive Health and Rights* (New York, 2018)
- UN Women and Women Enabled International, *COVID-19, Gender, and Disability Checklist: Preventing and Addressing Gender-Based Violence against Women, Girls, and Gender Non-conforming Persons with Disabilities during the COVID-19 Pandemic* (New York and Washington, DC, 2021)
- UNFPA APRO, *Tip Sheet: Disability Inclusion in Gender-based Violence Programming* (2023) (see Annex I)
- UNFPA APRO, *Gender-based Violence and Disability Inclusion Assessment Tool* (2023) (see Annex II)

Background

Disability is part of human diversity, and a large proportion of the population will experience disability at some point in their lives.⁵ Disability results from the interaction of health conditions and a range of contextual factors – such as attitudinal, communication and environmental barriers – that restrict a person’s participation in society.⁶ The Convention on the Rights of Persons with Disabilities (CRPD) further describes persons with disabilities as “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”.⁷

What we know about gender-based violence and disability

Global evidence indicates that persons with disabilities are more likely than their non-disabled peers to experience violence, abuse and exploitation. The World Health Organization (WHO) estimates that one in three women will experience physical or sexual violence (which includes intimate partner violence) in their lifetime.⁸ The Asia-Pacific region has one of the highest prevalence rates of GBV in the world, with lifetime experience of intimate partner violence (physical and / or sexual violence) with countries ranging from 15 to 64 per cent. The proportion of women who have reported experiences of physical or sexual violence by an intimate partner in the past 12 months ranges from 4 per cent to 48 per cent.¹⁰ The rates are even higher among women and children with disabilities (see Figure 1 and Box 1).

Box 1: Global statistics

Globally, 18 per cent of the female population has a disability.^a

Persons with disabilities have a 1.5 times greater risk of violence than those without disabilities, and the risk is even higher among those with intellectual and psychosocial disabilities.^a

Women with disabilities are two to four times more likely to experience intimate partner violence.^b

Children with disabilities are three times more likely to experience sexual abuse.^c

a World Health Organization, *Global Report on Health Equity for Persons with Disabilities* (Geneva, 2022).

b Kirstin Dunkle and others, *Disability and Violence against Women and Girls: Emerging Evidence from the What Works to Prevent Violence against Women and Girls Programme* (London, UK Aid, Department for International Development, 2018).

c UNICEF, *The State of the World’s Children 2013: Children with Disabilities – From Exclusion to Inclusion* (New York, 2013).

⁵ World Health Organization, *Global Report on Health Equity for Persons with Disabilities* (Geneva, 2022).

⁶ World Health Organization, *Global Report on Health Equity for Persons with Disabilities* (Geneva, 2022).

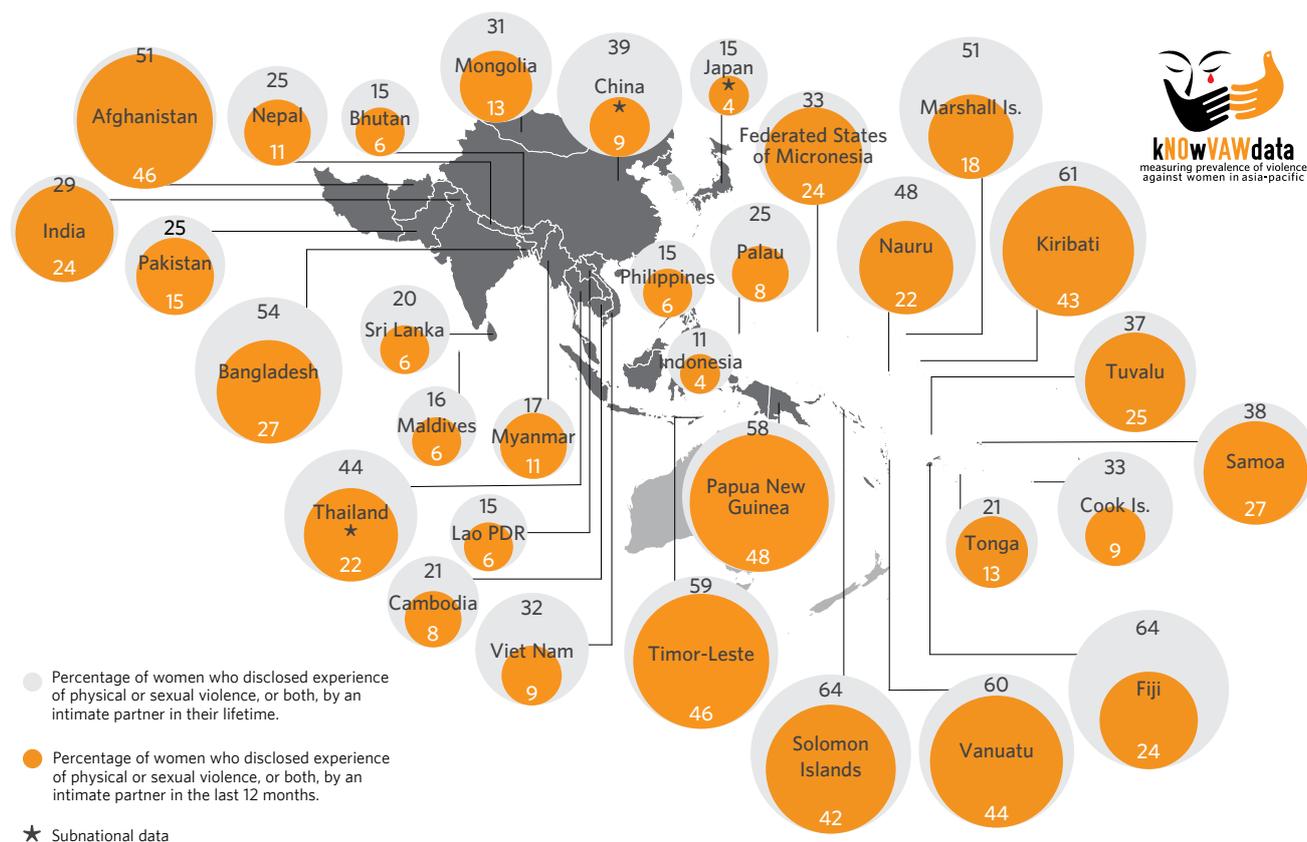
⁷ United Nations General Assembly, Convention on the Rights of Persons with Disabilities, Resolution A/RES/61/106.

⁸ World Health Organization, “Violence against women”, fact sheet (Geneva, 2021).

⁹ UNFPA, “Measuring prevalence of violence against women in Asia-Pacific” (n.d.).

¹⁰ UNFPA APRO, “Violence against women – Regional Snapshot (2022) – kNOwVAWdata”, fact sheet (Bangkok, 2022).

Figure 1: Regional snapshot of violence against women prevalence data, 2000–2022



Source: UNFPA APRO, “Violence against women – Regional Snapshot (2022) – kNOwVAWdata”, (Bangkok, 2022).

Studies from the Asia-Pacific region also demonstrate high rates of violence against women and girls with disabilities.

- A third, or 33.0 per cent, of Vietnamese women with disabilities have experienced physical husband or partner violence, compared with a quarter or 25.3 per cent of Vietnamese women without disabilities.
- One in fifteen, or 6.4 per cent, women with disabilities in Viet Nam experience childhood sexual abuse, compared to one in twenty-three, or 4.4 per cent, of women without disabilities.¹¹
- Forty per cent of women with disabilities in Australia have experienced physical violence. Also in Australia, women with disabilities are twice as likely to experience sexual violence as women without disabilities.¹²
- In a survey of 700 women with disabilities in the Indian state of Odisha, every single respondent had experienced domestic violence.¹³
- In Timor-Leste, women who experience intimate partner violence are twice as likely to have a disability, including depression and other mental health conditions.¹⁴

It is important to note that disability and violence are inextricably linked, with disability adding to the risk of violence and while experience of violence may also cause/increase disability.

¹¹ Ministry of Labour, Invalids and Social Affairs, General Statistics Office and UNFPA, *Summary Report: Results of the National Study on Violence against Women in Viet Nam 2019 – Journey for Change* (Ha Noi, 2020).

¹² Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, “Alarming rates of family, domestic and sexual violence of women and girls with disability to be examined in hearing”, 12 October 2021.

¹³ United Nations ESCAP, *Disability in Asia and the Pacific: The Facts* (Bangkok, 2016).

¹⁴ The Asia Foundation, *Understanding Violence against Women and Children in Timor-Leste: Findings from the Nabilan Baseline Study – Main Report* (Dili, 2016).

Characteristics of gender-based violence experienced by persons with disabilities

Women and girls with disabilities experience all the same forms of GBV as other women and girls. However, there are some features of the violence they experience that are also closely linked to their disabilities. For example, women and girls with disabilities may be more dependent on perpetrators of violence, who can threaten to withhold medication and assistive devices, or deny food, water and assistance that these women need to meet basic needs. Emotional abuse can also include a disability element. For example, perpetrators of intimate partner violence may tell women with disabilities that they are undesirable as sexual partners, wives and mothers because of their disabilities.

Women and girls with disabilities may be subject to a range of medical treatments without their consent, including forced, coerced and otherwise involuntary sterilization. These practices may be undertaken by medical professionals, who may claim that they are “in the best interests” of the individual and their caregivers. For example, forced, coerced and otherwise involuntary sterilization may be undertaken because of prejudiced beliefs that persons with disabilities cannot or should not have and raise children, and to avoid pregnancy among women and girls with disabilities who are raped, given the “perceived inevitable sexual abuse that persons with disabilities are expected to experience”.¹⁵

The root causes of GBV against women and girls are discriminatory beliefs and attitudes relating to gender, which perpetuate inequality and reduce women’s and girls’ power in relationships, households and communities. However, women and girls do not experience structural inequalities and unequal power due to gender alone; other factors, such as ableism, ageism and racism (to name but a few), can add to the discrimination experienced by women and girls with disabilities and by their caregivers – a role disproportionately assumed by other women and girls.¹⁶

In addition, persons with disabilities who have diverse sexual orientations, gender identities and/or expressions and sex characteristics have been described as a “minority within a minority”.¹⁷ They face multiple and complex intersections of discrimination based on all the systems already described, and also transphobia, homophobia and heteronormativity, which add to their experience of isolation, marginalization and oppression in many contexts.¹⁸

A range of factors contributes to the risk of violence faced by women and girls with disabilities. These include poverty, a lack of education and livelihoods, and barriers in accessing GBV information and services. For example, information about the different forms of GBV and where to access support and services may not be available in accessible formats (e.g. through Braille, sign language and captions), or may not be shared in a way that those with intellectual disabilities can understand (e.g. in easy-read or pictorial formats). Women and girls with disabilities are often excluded from women’s groups, activities and meeting places where this information is commonly disseminated. Transportation has also been identified as a substantial barrier preventing women and girls with disabilities from reaching a range of services and support: they may need assistance to use public transport or need money to hire a private vehicle. Furthermore, even if these women and girls do reach a safe space or a facility where they can get help, then environmental barriers, such as stairs or inaccessible toilets, may adversely affect their experience.

¹⁵ UNFPA, *Women and Young Persons with Disabilities: Guidelines for Providing Rights-based and Gender-responsive Services to Address*

Gender-based Violence and Sexual and Reproductive Health and Rights (New York, 2018).

¹⁶ Women’s Refugee Commission and International Rescue Committee, *“I See That It Is Possible”: Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings* (New York, 2015).

¹⁷ Santinele Martino, A. Crippling sexualities: An analytic review of theoretical and empirical writing on the intersection of disabilities and sexualities. *Sociology Compass*, [s. l.], v. 11, n. 5, p. n/a-N.PAG, 2017. DOI 10.1111/soc4.12471.

¹⁸ Jen Blyth, Karen Alexander and Lana Woolf, *Out of the Margins: An Intersectional Analysis of Disability and Diverse Sexual Orientation, Gender Identity, Expression & Sex Characteristics in Humanitarian and Development Contexts* (CBM Australia, Edge Effect and Nossal Institute, 2020).

Finally, and perhaps most importantly, the negative attitudes and harmful stereotypes of disability held by family members, communities and even service providers are a significant barrier. Some assume that women with disabilities, particularly intellectual disabilities, are asexual, not capable of having consensual sexual relationships, and, as a result, do not have sexual and reproductive health needs. GBV service providers may also assume that women and girls with disabilities cannot participate in the same activities as other women and girls, and that they should go to separate services. This leads to discrimination and further exclusion in society (see [Box 2](#)).

Box 2: A Note about Ableism

The Office of the United Nations High Commissioner of Human Rights described Ableism as:

“[A]bleism’ is commonly described as the belief system that underlies the negative attitudes, stereotypes and stigma that devalue persons with disabilities on the basis of their actual or perceived impairments. Ableism considers persons with disabilities as being less worthy of respect and consideration, less able to contribute and participate, and of less inherent value than others.”^a

As with racism, sexism and ageism, ableism is embedded in our institutions, systems and broader society, and these beliefs may be adopted consciously or unconsciously. Ultimately, ableism limits the opportunities of persons with disabilities, and contributes to their exclusion in all spheres of life.^a

^a Office of the United Nations High Commissioner of Human Rights, Awareness-raising under Article 8 of the Convention on the Rights of Persons with Disabilities: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/43/27).

Contextual factors also influence the risk of violence faced by women and girls with disabilities. For example, persons with disabilities, and their caregivers, who are refugees and asylum-seekers experience multiple, intersecting and sometimes mutually reinforcing forms of discrimination and oppression, adding to their risk of violence, including GBV. In displacement contexts, the loss of protective family and community networks means that women and girls with disabilities have less access to informal information networks and have fewer persons they trust to support them in accessing services. This also adds to the demands on women caregivers in the household, who may in turn experience exclusion and discrimination (see [Figure 2](#)).

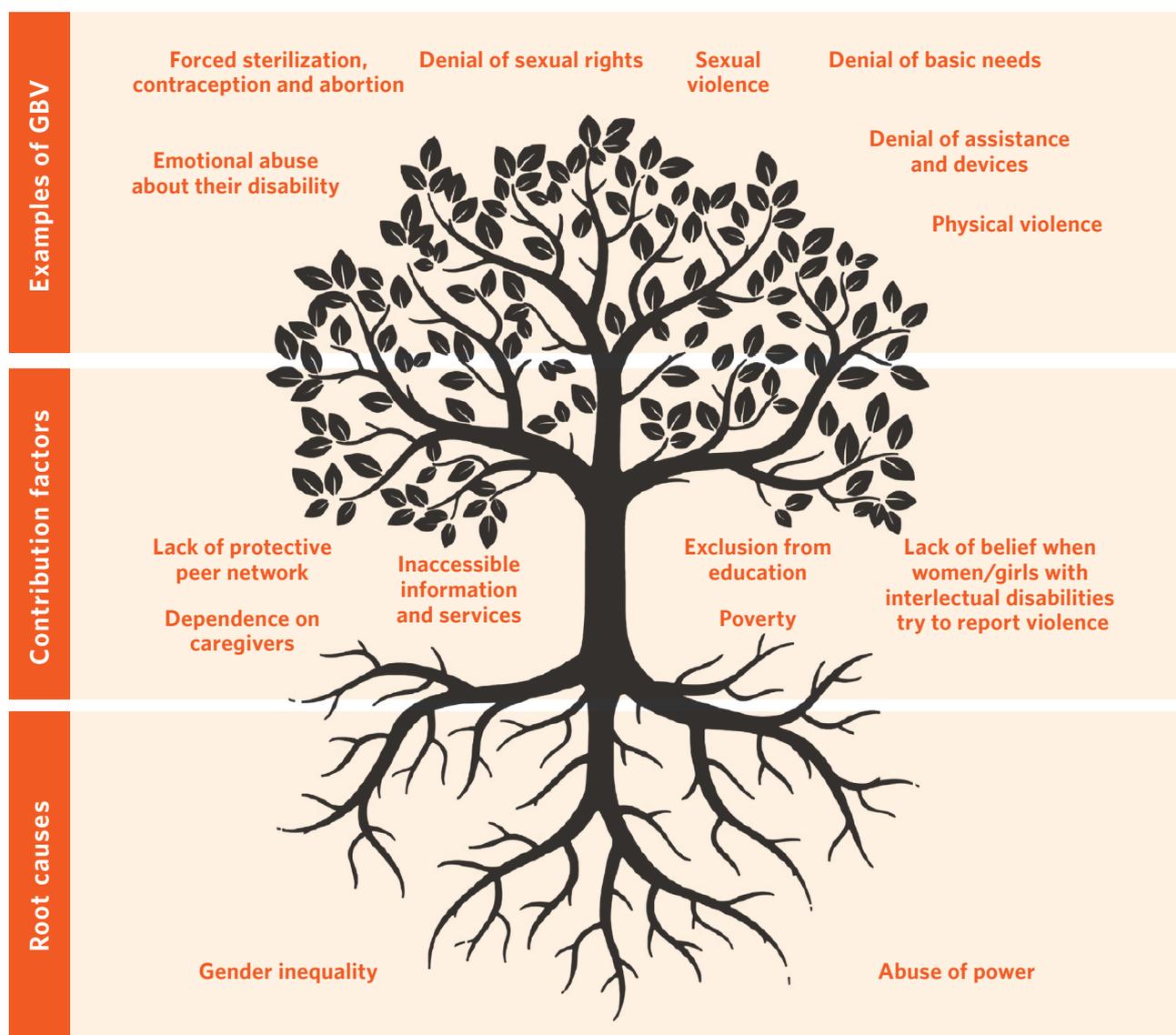


¹⁹ Women’s Refugee Commission and International Rescue Committee, “I See That It Is Possible”: Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings (New York, 2015).

The coronavirus disease 2019 (COVID-19) pandemic has added to our knowledge about the challenges faced by GBV survivors with disabilities. Most notably, studies demonstrate that women and girls with disabilities are at greater risk of GBV when separated from their usual caregivers, support staff and assistance.²⁰ Women and girls with disabilities are already more likely than the rest of the population to live in poverty, and the socioeconomic impact of the COVID-19 crisis has only added to their financial instability. In addition, it is important to note that women and girls with disabilities may not have the same digital access, resources or literacy levels as others, meaning that they may be unable to access GBV information and support provided online.²¹

Approaching GBV through an intersectional analysis helps us to better understand the multiple identities of women and girls, including those with disabilities, which may uniquely shape the way they experience GBV, and can in turn be used to improve service provision, advocacy and programme priorities.

Figure 2: GBV tree and persons with disabilities



Note: Not all types of GBV and factors contributing to GBV have been included in this tree.

²⁰ UNFPA and Women Enabled International, *The Impact of COVID-19 on Women and Girls with Disabilities: A Global Assessment and Case Studies on Sexual and Reproductive Health and Rights, Gender-based Violence, and Related Rights* (New York, UNFPA, and Washington, DC, Women Enabled International, 2021).

²¹ Emma Pearce, *GBV AOR Helpdesk Research Query: Disability Considerations in GBV Programming during the COVID-19 Pandemic* (2020). Available at <https://gbvaor.net/sites/default/files/2020-10/GBV%20AoR%20HD%20-%20COVID-19%20GBV%20Disability%20Updated%2028.09.2020.pdf>.

International frameworks and commitments

Countries have an obligation under international human rights law, and many domestic legal frameworks, to act against the multiple and intersecting forms of discrimination faced by women and girls with disabilities, including by protecting this group from violence, abuse and exploitation. Commitments to address violence against women and girls in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979), the Convention on the Rights of the Child (1989), the Programme of Action of the International Conference on Population and Development (1994) and the Beijing Platform for Action (1995) all apply to those with disabilities. The CRPD (2006) goes further: among many other commitments, it requires state parties to ensure that all protection services, including GBV services, are disability sensitive (see Box 3).

Box 3: CRPD Article 16: Freedom from exploitation, violence and abuse

“States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.”

Source: United Nations General Assembly, Convention on the Rights of Persons with Disabilities, Resolution A/RES/61/106.

The Sustainable Development Goals (SDGs) commit to empowering marginalized groups, including those with disabilities.²² Progress towards the SDG 5 targets for gender equality and women’s empowerment will be achieved only if those with disabilities – 18 per cent of the female population – are meaningfully included in these efforts. This is made clear in the *Incheon Strategy to “Make the Right Real” for Persons with Disabilities in Asia and the Pacific*, adopted by ESCAP members in 2012, which establishes goals, targets and indicators to integrate disability into wider SDG efforts.²³

Finally, UNDIS provides the foundation for sustainable and transformative progress on disability inclusion across the United Nations system. It calls for the adoption of human rights-based and intersectional approaches across organizational operations, and technical and programmatic areas of work. United Nations entities are also required to report on an annual basis against the UNDIS accountability framework, which includes 15 indicators covering all strategic focus areas.²⁴

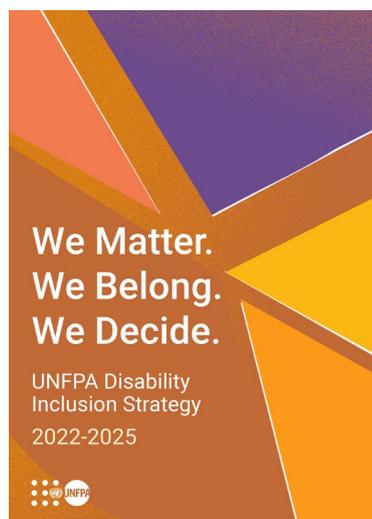


²² United Nations, *Transforming Our World: The 2030 Agenda For Sustainable Development* (A/RES/70/1).

²³ United Nations ESCAP, *Incheon Strategy to “Make the Right Real” for Persons with Disabilities in Asia and the Pacific* (Bangkok, 2012).

²⁴ United Nations, *United Nations Disability Inclusion Strategy* (New York, 2019).

United Nations Population Fund Disability Inclusion Strategy: We Matter. We Belong. We Decide.



The UNFPA Disability Inclusion Strategy 2022-2025 provides a “whole-of-institution” framework for the agency to advocate the implementation of the ICPD and meet the organization’s UNDIS commitments and advance the rights of persons with disabilities through its work globally. The strategy adopts a twin-track approach to achieve its goals and attain results, with disability matters being systematically included in all UNFPA programmes and activities, and disability-specific initiatives to address situations and conditions of marginalization faced by persons with disabilities. It also promotes efforts to address intersectional discrimination, recognizing that persons with disabilities can experience rights violations based on multiple factors, including gender, age, economic status, ethnicity, sexual orientation, religion, indigeneity, migration status, race and nationality. Coordination, collaboration and partnership with civil society, including organizations of persons with disabilities (OPDs), is also a central principle promoted across global programming. Finally, the strategy sets forth the

key areas of concern for UNFPA programming as promoting the sexual and reproductive health rights of women and youth with disabilities, including through GBV programming, and supporting persons with disabilities who are affected by emergencies.²⁵

Gender-based violence standards and guidelines

Following these global commitments to addressing violence against women and girls with disabilities, a growing body of GBV standards and guidelines include explicit references to disability inclusion. The *Essential Services Package for Women and Girls Subject to Violence* (UNFPA, UN Women, WHO, UNDP, UNODC) requires service providers to consider the needs of women and girls who experience multiple forms of discrimination, including discrimination based on disability,²⁶ and the *Gender-based Violence Quality Assurance Tool for health facilities* also explicitly mentions disability in two standards.²⁷ More substantial guidance is now in place in the humanitarian sector, with disability integrated into the Inter-agency Minimum Standards for Gender-based Violence in Emergencies Programming²⁸ and the Inter-Agency Standing Committee *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*.²⁹

In addition the *Inter-Agency Gender-based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-based Violence Survivors in Humanitarian Settings*,³⁰ as well as Inter-Agency Standing Committee guideline *Inclusion of Persons with Disabilities in Humanitarian Action* include specific mention of considerations for supporting persons with disabilities. These show that disability inclusion should not be seen as something new or additional to the core business as GBV actors – it is an established component of safe and effective GBV service delivery.

²⁵ UNFPA, *We Matter. We Belong. We Decide: UNFPA Disability Inclusion Strategy 2022-2025* (New York, 2021).

²⁶ UN Women, UNFPA, UNDP, WHO, UNODC, *Essential Services Package for Women and Girls Subject to Violence* (New York, 2015).

²⁷ Jhpiego and others, *Gender-based Violence: Quality Assurance Tool – Standards for the Provision of High Quality Post-violence Care in Health Facilities* (Baltimore, Maryland, USA, 2018).

²⁸ Gender-based Violence Area of Responsibility, *The Inter-agency Minimum Standards for Gender-Based Violence in Emergencies Programming* (New York, UNFPA, 2019).

²⁹ Inter-Agency Standing Committee, *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery* (Geneva, 2015).

³⁰ Gender-based Violence Information Management System (GBVIMS) Steering Committee

³¹ Interagency Gender-based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-based Violence Survivors in Humanitarian Settings, 1st ed. (2017).

UNFPA APRO's work on disability inclusion in GBV programming

In pursuit of this goal of disability inclusion, UNFPA APRO is committed to making sure that all efforts to address GBV are inclusive of and accessible to women and girls with disabilities, ensuring that transformative goals are met and that no one is left behind. Throughout 2021 and 2022, UNFPA APRO provided technical support on disability inclusion to UNFPA country offices in their advocacy and technical GBV programming. This technical support has included the development of complementary tools and resources to strengthen GBV programming for survivors with disabilities. In addition, UNFPA APRO organized a range of virtual capacity-building sessions, including webinars/learning sessions, bi-monthly country office check-in calls, and ad-hoc bilateral support, and organized a sharing workshop with GBV and disability country office focal points to enhance cross-country learning and exchanges.



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2. PROMISING PRACTICES OR APPROACHES TO DISABILITY INCLUSION IN GENDER-BASED VIOLENCE PROGRAMMING



While there are now a range of toolkits and guidelines to support GBV practitioners to strengthen disability inclusion, there are still few documented examples of changes to address gaps in GBV programmes and services and to enable women and girls with disabilities to overcome the barriers to accessing such programmes and services. This section documents promising practices and approaches to disability inclusion in GBV programming that UNFPA country offices in the Asia-Pacific region and their partners have undertaken.

The promising practices and approaches documented included:

1. **Adopting a twin-track approach to strengthening disability inclusion in GBV programming**
2. **Addressing negative attitudes, beliefs and norms relating to gender and disability among persons with disabilities, community members and GBV staff**
3. **Setting standards for disability inclusion with GBV partners and promoting action planning to address gaps identified**
4. **Engaging with OPDs appropriately, exploring their understanding of gender equality and GBV principles**
5. **Collecting and analysing disaggregated data - quantitative or qualitative - on age, gender and disability**
6. **Strengthening the capacity of GBV practitioners to work with persons with disabilities**

Methodology

The identification of promising practices was conducted in close consultation with UNFPA Country Offices. In doing so, UNFPA APRO reviewed relevant documents, and interviewed UNFPA country office staff and representatives of a selection of partners, including OPDs. These interviews were conducted online, with local language and sign language interpretation as required. Draft case studies were then shared with country offices and the partners interviewed for verification of accuracy of information and validation of the key lessons learned.

Limitations

It is important to note that the longer-term outcomes of these practices – whether women and girls with disabilities have increased access to and inclusion in GBV programmes – was not assessed owing to standards for safe and confidential data collection, and limitations in time and capacity. See *Lessons learned and recommendations* for more information.

2.1 Adopting a twin-track approach to strengthening disability inclusion in gender-based violence programming

As highlighted in the UNDIS, the UNFPA Disability Inclusion Strategy and a range of disability-inclusive development guidelines, the twin-track approach is critical to systematic and sustainable change. In the GBV sector, the twin-track approach means considering disability in all GBV programme activities, while also implementing targeted actions for persons with disabilities. Successful outcomes for persons with disabilities will happen only if these two tracks complement and balance each other.³²



Promising practice example:

The twin-track approach to disability inclusion in the gender-based violence sector in Pakistan

UNFPA has taken a twin-track approach to strengthening disability inclusion across wider GBV prevention and response efforts in Pakistan under the multi-year AAWAZ II: Inclusion, Accountability and Reducing Modern Slavery programme. This joint programme aims to strengthen the institutional response to GBV survivors through support/assistance to government institutions, evidence generation, legislative reform/implementation, policy advocacy and system strengthening (including capacity-building, coordination, monitoring and evaluation).³³ The GBV strategy for this joint programme focuses on improving the lives of women, adolescent girls and marginalized groups in the provinces of Khyber Pakhtunkhwa and Punjab by building and strengthening institutional capacity to coordinate GBV prevention and response; influencing and reviewing policy and legal instruments, and supporting implementation; guiding inclusive policy and programmes through safe and standardized data collection and knowledge management to make “uncounted people visible”; supporting referral and engagement at community level; and empowering women.³⁴

Actions undertaken to strengthen disability inclusion in this GBV programme include:

- Introducing targeted interventions to support the empowerment of persons with disabilities through:
 - Developing OPDs’ technical capacity to deliver GBV awareness-raising and provide information on services, through psychosocial support activities for women with disabilities
 - Developing the organizational capacity of OPDs, including on financial process, monitoring and evaluation, and the establishment of policies on the prevention of sexual exploitation, abuse and harassment (PSEAH)

³² CBM Global, *Disability Inclusive Development Toolkit* (Bensheim, Germany, 2017).

³³ AAWAZ II, *Gender Based Violence Strategy: AAWAZ II – Inclusion, Accountability, and Reducing Modern Slavery (2019–2024)* (UNFPA Pakistan).

³⁴ AAWAZ II, *Gender Based Violence Strategy: AAWAZ II – Inclusion, Accountability, and Reducing Modern Slavery (2019–2024)* (UNFPA Pakistan).

"We were sitting together; they [UNFPA] were giving us so much time because we weren't as familiar with the language that these organizations use ... The most important change for the organization is probably preventing sexual exploitation, abuse and harassment – we were not following that and now our staff have training – not only our project staff, but all our staff have training – and they are very well aware of systems and approaches for this. These were the areas that we had the feeling it was a bit challenging, but then with time, with discussion and with all those learning opportunities, we came up with strong activities."

- Special Talent Exchange Program (STEP), Pakistan

- Integrating disability in the design, implementation, monitoring and evaluation of wider GBV programming through:
 - Setting disability inclusion milestones and targets in the revised AAWAZ II logframe (see Box 4)
 - Collecting and reporting disability-disaggregated data through GBV service providers
 - Incorporating disability inclusion in GBV case management capacity building
 - Ensuring that women with disabilities are represented in campaigns to change social norms and beliefs relating to gender and violence (see Box 5)

Box 4: Example of disability milestones and targets integrated into GBV programme logframe

Outputs. Strengthened government institutions with effective policies and action plans for the protection of women's and girls' rights, prevention and response to GBV, and ending child marriage.

Indicator. Available evidence on GBV and child marriage.

Milestones. Disability audit/assessment of GBV services conducted, and tracker made available to relevant government departments for monitoring disability-inclusive services provided to GBV survivors.

Target. Improved evidence and monitoring mechanisms available in the provinces of Khyber Pakhtunkhwa and Punjab for policy and programming towards inclusive and gender-sensitive prevention and response to GBV.

Box 5: Example of mainstreaming disability in communications materials



UNFPA, "Insaan Hoon Mein" video, 7 March 2022

UNFPA produced a folk song called "Insaan Hoon Mein", which promotes the message that "women's rights are human rights". The song celebrates the power of women and their contributions to the society and economy, and the video represents women in all their diversity, including those with disabilities.

Screenshot from the video "Insaan Hoon Mein" - A woman sits in a wheelchair with a computer on her lap. The captions says: "If roads are tough, so are my dreams".

2.2 Addressing negative attitudes, beliefs and norms relating to gender and disability among persons with disabilities, community members and GBV staff

The underlying causes of GBV against persons with disabilities are discriminatory attitudes, beliefs, norms and structures that promote and/or condone discrimination based on gender and disability, and lead to persons with disabilities having reduced power and status in relationships, households and communities.³⁵ Gender-transformative programming, GBV prevention and women's empowerment efforts should explore the intersection with disability, and include persons with disabilities and their caregivers.

Discriminatory attitudes, beliefs, norms and structures affect all levels of society – including GBV service providers and partners. For example, there are reports of health professionals sterilizing women and girls with disabilities without their consent because of beliefs that they cannot make their own decisions and would not be fit parents – and sometimes in response to or as a precaution against pregnancy caused by rape.³⁶

Therefore, promising practices and approaches to disability inclusion in GBV programming should consider and address how societal norms and ableism increase the risk of violence against persons with disabilities and consider and address this group's access to essential GBV services for survivors.



Promising practice example:

Change in mindset among gender-based violence actors in Pakistan

In Pakistan, GBV service providers report that the most important change seen as a result of disability inclusion efforts has been a shift in mindset within their organizations. For Rozan, a national non-governmental organization providing GBV psychosocial support to survivors, this shift included challenging assumptions that their staff “don't work with” persons with disabilities and critically reflecting on how this might hinder its commitments to the core value of inclusiveness. Rozan also reports addressing the issue at multiple levels within the organization – which included sensitization of all staff, and explicit references to disability inclusion in core values and strategic plans.

Furthermore, focusing on what GBV actors can do – rather than what they cannot do – for persons with disabilities was a feature of Rozan's shift in mindset. Recognising the critical role of the counselling helpline in delivering psychosocial support to women and girls with disabilities, they extended their support to survivors with disabilities. Rather than excluding women and girls with disabilities based on assumptions that Rozan's spaces and services cannot meet all their needs, the organization now talks to women and girls with disabilities to identify a solution together.

“We thought that there would be a whole lot of new skills and approaches that we would need. But we also realized that we can't ignore it, and we can start integrating it into our work. So that over time we can say that we are working with them.”

- Rozan, Pakistan

³⁵ Women's Refugee Commission and International Rescue Committee, “I See That It Is Possible”: Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings (New York, 2015).

³⁶ UNFPA, Women and Young Persons with Disabilities: Guidelines for Providing Rights-based and Gender-responsive Services to Address Gender-based Violence and Sexual and Reproductive Health and Rights (New York, 2018).

2.3 Setting standards and fostering action planning for disability inclusion with partners

The *Essential Services Package for Women and Girls Subject to Violence* establishes that GBV services must respond appropriately to women and girls who face multiple forms of discrimination, including women and girls with disabilities. Non-discrimination is one of the key elements in a survivor-centred approach. As such, GBV service providers have a responsibility to take appropriate steps to ensure that they provide safe and effective services to GBV survivors with disabilities. This includes integrating disability inclusion into GBV programme development, monitoring, quality assurance and partner development processes.



Tools and resources:

Setting standards for disability inclusion in gender-based violence service provision

The GBV and Disability Inclusion Assessment Tool (UNFPA APRO, 2022) provides a list of questions for service providers on the accessibility and inclusiveness of their services. The questions are aligned with the common characteristics of high-quality essential health services outlined in the *Essential Services Package for Women and Girls Subject to Violence*, including:

- Physical, communication and economic accessibility;
- Availability;
- Adaptability;
- Appropriateness;
- Prioritizing safety;
- Informed consent and confidentiality;
- Effective communication and participation by stakeholders;
- Data collection and information management;
- Linking with other sectors and agencies through coordination.

It is recommended that service providers integrate this assessment into regular service monitoring, development and planning processes, allowing them to collect relevant information, to reflect on strengths and weaknesses and to implement appropriate actions with their staff and partners to address gaps identified.



Promising practice example:

Translating assessment findings into action plans for disability inclusion

UNFPA country offices and their partners piloted the GBV and Disability Inclusion Assessment Tool in three countries: Viet Nam, Bangladesh and Indonesia. UNFPA country offices adapted and translated the assessment tool, and orientated GBV partners through bilateral meetings and service provider workshops. A total of nine GBV partners (including one-stop crisis centres, GBV helplines, police help desks, women and girls' safe spaces, and integrated multisectoral response GBV services) used the tool to help them identify strengths and weaknesses relating to disability inclusion in GBV programming. Some of the common gaps identified by partners in different countries included the following.

- Gaps in the dissemination of information to women and girls with disabilities, as very few OPDs participate in community activities conducted by GBV partners.
- Small numbers of survivors with disabilities approached GBV service providers.
- The tool raised awareness about which groups of persons with disabilities are still not being reached by partner's GBV activities, most notably those with intellectual disabilities.
- Inadequate facilities and lack of staff with the knowledge and capacity to support survivors with disabilities were also reported.

UNFPA country office staff played a critical role in supporting GBV partners to then prioritize filling these gaps and to develop appropriate action plans in consultation with local OPDs. Examples of the proposed actions to address priority gaps include:

- Revising procedures for community activities to ensure that community mobilizers invite women and girls with disabilities to activities, an action that would also apply to other interventions, such as training and workshops, aiming to ensure the participation of women and girls with disabilities
- Building a relationship with local OPDs to disseminate information about available services, and ensure they are aware of existing GBV services and will refer survivors
- Working with existing women's support networks to provide peer support to women with disabilities
- Developing a basic sign language and Braille training module for staff working on GBV help desks/ service desks
- Designing GBV information materials, such as leaflets and posters that reflect the needs, skills and capacities of persons with disabilities, and using different formats for these
- Strengthening the capacity of GBV service providers for supporting women and girls with disabilities
- Improving the physical accessibility of GBV services to ensure that they are accessible to women and girls with disabilities

2.4 Engaging with organizations of persons with disabilities appropriately

GBV service providers can consult with OPDs – ideally organizations of women and girls with disabilities – when identifying and addressing barriers that women and girls with disabilities face when accessing services and activities. The providers can also collaborate with these groups to share information about available GBV services and activities with persons with disabilities in communities.

Promising practices and approaches to disability inclusion in GBV programming should include actions to engage OPDs in conducting disability sensitization with GBV service providers, discussions about barriers to access and potential strategies to improve services, and sharing information about available GBV services and activities with persons with disabilities in communities.

These actions should be accompanied by appropriate capacity development regarding GBV, so that representatives understand their role, and can provide psychological first aid and safe referrals to GBV specialist services for survivors. It may also be important to support OPDs to reflect on gender equality, promoting women with disabilities into decision-making roles. Where appropriate, UNFPA can also link OPDs to other civil society partners, fostering a more inclusive women's rights movement in countries.



Tools and resources:

Disability inclusion in gender-based violence programming – tip sheet

This tip sheet (*see Annex I*) provides guidance for UNFPA country office staff on the entry points to and appropriate strategies for integrating disability into GBV programme planning. This includes making GBV coordination and referral mechanisms inclusive by identifying and inviting women-led OPDs to participate in coordination meetings, providing appropriate capacity-building on survivor-centred approaches, and defining the roles and responsibilities of different stakeholders in supporting survivors with disabilities (*see Table 1*).

Table 1: The roles and responsibilities of groups involved in GBV programming

GBV coordination bodies	GBV service providers (e.g. health, justice and policing, social services)	Disability service providers (e.g. rehabilitation, sign language interpretation services)	Community groups (e.g. women's rights organizations, OPDs)
Set and monitor standards on access and inclusion for GBV service providers	Provide services to survivors with disabilities on an equal basis with others survivors	Safely refer survivors and those at risk of violence to GBV service providers	Participate in consultations with GBV service providers who are assessing and addressing barriers
Map and develop appropriate linkages with disability service providers and community groups	Regularly assess and improve the accessibility and inclusion of services in line with appropriate standards	Provide rehabilitation, aids and devices, and/or confidential interpretation services, if requested by GBV survivors	Sensitize GBV service providers on disability
Train stakeholders on safely receiving disclosures and on referring survivors with disabilities	Consult with OPDs on barriers and strategies to improve access to services		Share information about available GBV services/ activities with persons with disabilities
	Ensure staff have the knowledge, attitudes and skills to support survivors with disabilities		



Promising practice example:

Engaging organizations of persons with disabilities in gender-based violence coordination in Myanmar

Women and girls with disabilities are often excluded from GBV information and awareness-raising activities. Isolation and exclusion mean that they may not participate in the same activities as other women and girls in their community. However, many women and girls with disabilities are connected to their local OPD or disability organization – therefore, these organizations provide a valuable entry point for providing women and girls with disabilities with information about GBV and the services available.

UNFPA Myanmar Country Office is working to strengthen the role of OPDs in GBV coordination and service provision at national and subnational levels. This role includes:

- Raising community awareness of sexual and reproductive health rights, including GBV prevention and response
- Safely referring GBV survivors with disabilities and those at risk of violence to GBV service providers, and helping them to access these services
- Providing economic empowerment, aids and assistive devices, and/or confidential interpretation services to survivors with disabilities and those at risk of violence

Actions that have been taken to support OPDs in this role include

- Adding criteria for the inclusion of persons with disabilities as one of the prioritized target populations in the call for expression of interest for grants to civil society organizations, and disseminating the call through a range of disability networks, which led to OPDs applying for and receiving this grant

- Developing the operational capacity of OPDs through training and technical support on proposal writing, results-based management and monitoring and evaluation, including strengthening OPDs' capacity to ensure that they met the standards and requirements for becoming UNFPA implementing partners
- Developing OPDs' technical capacity through providing training on GBV and mental health and psychosocial support (MHPSS) to OPD staff and community partners, which strengthened their capacity to understand and apply survivor-centred principles and approaches in their work

UNFPA Myanmar supports six disability organizations (four OPDs and two non-governmental organizations) that collaborate with OPD networks at national and subnational levels. Through these partnerships, 56 OPD staff/members have received training on GBV and 46 have received training on MHPSS, supporting the safe and effective implementation of activities with women and girls with disabilities in target communities.

"In the community, many persons with disabilities never get this type of awareness on GBV – even DDI [Disability Development Initiative] we never conducted this – maybe other CSOs [civil society organizations] do this awareness-raising, but persons with disabilities don't get access to these activities. So, in the villages and the group, we invite them to participate in this programme – people with different types of disabilities, both genders – and that is how we raise awareness on the concept of power, GBV and different understanding of gender."

- DDI, Myanmar

OPDs engaged in GBV programming report having a better understanding of their role in supporting survivors and a wider network of GBV actors that they can coordinate and collaborate with in the future.

"Before, when violence happened, I just wanted to grab them and go and do something. But now I have learned the importance of power in the family and also how to connect the survivor to other important services. Not only what to do by myself, but what we can do with others ... To provide the services, we must be aware of our own power knowing when and how to refer."

- DDI, Myanmar

Beyond information dissemination, actions undertaken have also expanded protective peer networks among women and girls with disabilities, with those trained using their new skills and knowledge in their everyday life with friends and neighbours.

"In the UNFPA project, we also conduct awareness raising in the community. Apart from this project, I am also using this information personally with my friends ... I now understand better, especially different forms of violence – how words can even be violence – so I am helping to encourage and comfort those that have experienced violence."

- DDI, Myanmar

In addition to sharing information with women and girls with disabilities in their communities, OPDs are increasingly playing a role in the multisectoral response to GBV in Myanmar. Some survivors with disabilities may require adaptations to the way GBV services are provided to address barriers relating to access and communication. Most notably, the Myanmar Deaf Community Development Association (MDCDA)³⁷ provides sign language interpretation for those seeking services through the helpline, including health, legal and social services (see Box A2).

³⁷ The organization referred to as Myanmar Deaf Community Development Association (MDCDA) in this report changed its official name to KDN General Services Co. from 1 January.

2.5 Disaggregating gender-based violence data for collection and analysis

Violence prevalence surveys should integrate the Washington Group Short Set on Functioning³⁸ into the introductory or demographic section of their questionnaires. This will allow for disaggregated analysis of data on violence, including identifying where women, men, girls and boys with disabilities may experience higher rates of various types of violence and/or access essential services at lower rates than their non-disabled peers. Similarly, these same questions can be asked when a survivor attends a service, and can be integrated into data collection and analysis of service usage (in line with standards for safe and confidential data collection). It is important that findings that demonstrate greater risk of GBV or reduced access to services for survivors with disabilities be responded to through appropriate actions in GBV programmes. This may include collecting more qualitative information on the barriers and recommended strategies from women and girls with disabilities.



Tools and resources: Disaggregating data by disability

The *Washington Group Short Set on Functioning* consists of six questions, which have been developed and tested for integration in censuses and surveys. The questions draw on the World Health Organization's International Classification of Functioning, Disability and Health as a conceptual framework. Any individual respondent who answers "a lot of difficulty" or "cannot do at all" to at least one of the six short set questions should be considered a person with a disability for data disaggregation purposes.



Promising practice example: Collecting prevalence data on violence against women with disabilities

The Australian Department of Foreign Affairs and Trade, UNFPA and the University of Melbourne are partnering in an initiative to support and strengthen regional and national capacities to measure violence against women in the Asia-Pacific region in a programme called kNOwVAWdata. In 2017, national, regional and global experts were brought together to discuss what approaches should be taken to ensure that women with disabilities are better represented in national prevalence studies on violence against women. Efforts are now being taken to integrate the Washington Group Short Set on Functioning into national surveys on violence against women (most commonly using the methodology from the *WHO Multi-country Study on Women's Health and Domestic Violence*, or the domestic violence module of the Demographic and Health Survey). One such effort from Viet Nam found that a third (33.0 per cent) of women with disabilities had experienced physical violence perpetrated by their husband/partner, compared with a quarter (25.3 per cent) of women without disabilities. In addition, more women with disabilities had experienced childhood sexual abuse (6.4 per cent compared with 4.4 per cent).³⁹

The UNFPA Viet Nam country office is now supporting GBV partners to assess and meet standards for accessibility and inclusion. See *Setting standards and fostering action planning for disability inclusion with partners*. Furthermore, the national study on GBV in Mongolia engaged the Mongolian National Federation of Organizations of Disabled People in the advisory panel for the study.⁴⁰ This study went beyond the disaggregation of quantitative data by disability by also collecting qualitative data from women and girls with disabilities, providing more information about the characteristics of violence experienced by this group.

³⁸ Washington Group on Disability Statistics, *The Washington Group Short Set on Functioning (WG-SS)* (Hyattsville, MD, 2022).

³⁹ Ministry of Labour, Invalids and Social Affairs, General Statistics Office and UNFPA, *Summary Report: Results of the National Study on Violence against Women in Viet Nam 2019 – Journey for Change* (Ha Noi, 2020).

⁴⁰ National Statistics Office of Mongolia and UNFPA Mongolia, *Breaking the Silence for Equality: 2017 National Study on Gender-based Violence in Mongolia* (Ulaanbaatar, 2018).

“In the end, my husband started telling me he could not live any longer with an invalid. In 2008, he started an affair with another woman. He would slander me by saying I was having sex with another man and lying about it and would say he was not abandoning the other woman. He would talk to her over the phone in my presence and tell her “I am getting sick and tired of my wife”. He told our children that he was going away because their mother was an exploiter.”

- Woman with disabilities⁴¹

2.6 Strengthening the capacity of gender-based violence practitioners to work with survivors with disabilities

Ensuring that staff have the appropriate knowledge, attitudes and skills relating to disability inclusion is the responsibility of GBV actors, including service providers. Practices and approaches in disability inclusion in GBV programming should integrate disability into the development or review of GBV curricula and training. UNFPA country office staff should discuss with partners the importance of reflecting women and girls with disabilities in GBV training content, activities and case studies. While it may be appropriate to seek advice on the content from disability experts and organizations, it is critical for sustainability that GBV service providers deliver this training directly to their own staff. This also sends a message that supporting survivors with disabilities is part of the core business of GBV service providers. To ensure that GBV service providers and staff have the essential basic knowledge on the topic, a good practice would be to include technical knowledge on GBV and disability inclusion as a desirable skill within terms of reference and job descriptions.



Tools and resources: Training materials

- Women’s Refugee Commission and International Rescue Committee, *Tool 4: A Training Module for GBV Practitioners in Humanitarian Settings* (New York, 2015)
- WHO, *Caring For Women Subjected to Violence: A WHO Training Curriculum for Health Care Providers* (Revised Edition, 2021)



Promising practice example: Integrating disability into gender-based violence training for health service providers

Several UNFPA offices in the Asia-Pacific region are strengthening the capacity of the health sector to respond to GBV through the implementation of the World Health Organization’s training curriculum for health-care providers on caring for women subjected to violence. While disability considerations are limited in the global training package, UNFPA staff and partners in Timor-Leste and Papua New Guinea have adapted case studies, shared tip sheets and added information to reflect the diverse needs of women and girls with disabilities who may present to health-care facilities because they have experienced violence. This includes drawing on published guidance for GBV case managers on supporting survivors with disabilities, safely engaging with caregivers and ensuring processes for informed consent.

In Timor-Leste, during GBV training targeting health-care service providers and managers, local OPDs were consulted on terminology used in the country to refer to persons with disabilities and the importance of using more positive terminology; accessibility in terms of infrastructure, information and how to overcome key challenges; how to communicate with persons with disabilities and understand each other; and the main barriers that survivors face when the need to access health-care services.

⁴¹ National Statistics Office of Mongolia and UNFPA Mongolia, *Breaking the Silence for Equality: 2017 National Study on Gender-based Violence in Mongolia* (Ulaanbaatar, 2018).

3. LESSONS LEARNED AND RECOMMENDATIONS



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The power of partnerships

The promising practices and approaches in this document all highlight the power of partnerships between UNFPA, mainstream GBV service providers and OPDs, not only in addressing the needs of survivors with disabilities, but for knowledge exchange, mentoring and joint advocacy (see Figure 3).

“We don’t have the particular skills to respond to GBV cases with disabilities – for example, our staff are not trained in sign language. So, we have expanded our referral network to get help from other organizations. By working with STEP and capacity-building them on case management, we were also helped on the issues of working with women with disabilities.”

- Rozan

For OPDs, collaborating with UNFPA and their GBV partners strengthens not only their organizational and technical capacity, but also their capacity to influence service providers, policymakers and others. The OPDs build new relationships with GBV service providers through disability assessments, action planning and training, and have the opportunity to raise the issue of inclusion of women and girls with disabilities in a far wider range of development forums and human rights mechanisms.

“The government sees us in a very different way – they used to think OPDs are charity and delivering wheelchairs. Now they are looking at us more strategically – thinking about us in relation to CEDAW and the SDGs, as well as the CRPD. The level of conversations and everything has really changed now that they know that we are working with UNFPA. It puts OPDs in a very strong position to talk about disability rights.”

- STEP, Pakistan

Reaching women and girls with disabilities through psychosocial support and organizations that they trust

Building rapport and trust is essential to engaging with persons with disabilities on sensitive topics. In many contexts, OPDs have established networks and trust with persons with disabilities – they know how to find and engage with persons with disabilities. As such, with appropriate training, OPDs may be in a better position than other organizations to discuss sensitive topics such as GBV with individuals and their families.

“It is better to talk about GBV with people who are familiar with each other – so persons with disabilities talking to other persons with disabilities will be easier to help them to understand.”

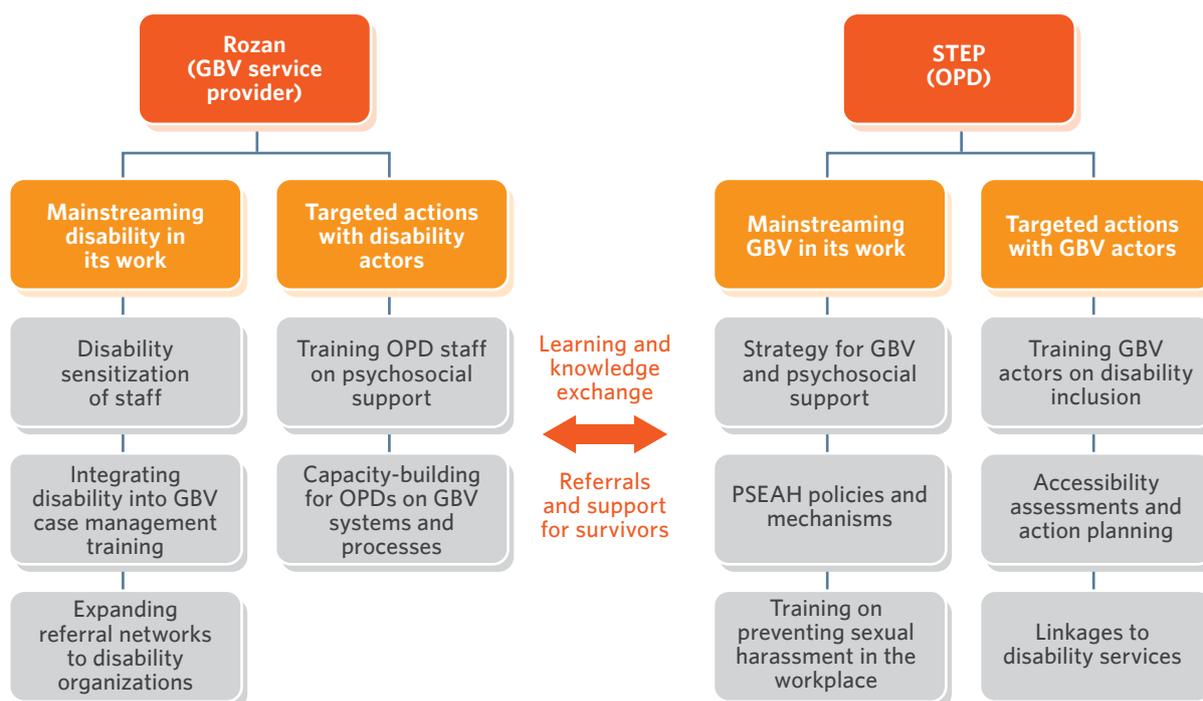
- DDI, Myanmar

Many women and girls with disabilities will have mental health concerns and psychosocial needs as a result of the stigma and discrimination they experience in everyday life. They may seek psychosocial support for these needs, and do not always recognize all the types of violence to which they have been subjected, including GBV. Hence, addressing the wider psychosocial support needs of persons with disabilities can be a critical entry point for building trust, sharing GBV information and supporting survivors of violence, who will have a range of needs. Although those who have experienced violence may not want to access all GBV-related essential services, psychosocial counselling can be an opportunity to determine what social support mechanisms are available among their families or communities.

“Women with disabilities are highly dependent on caregivers, so sometimes they can't disclose violence. The counselling helpline and psychosocial support area is one way we can help because they do contact the helpline ... The first step is always to provide psychosocial support, we identify what are their specific needs, what are the support mechanisms where they are living – family members, friends – and then for those services that we can't provide, we refer to another organization.”

- Rozan, Pakistan

Figure 3: Example of partnerships between GBV service providers and OPDs in Pakistan



Pushing past misconceptions: a key to effective mainstreaming

OPDs can play a critical role in not only sharing information with persons with disabilities about GBV, but also advising GBV service providers on how to make their services more inclusive and accessible. This is essential because OPDs do not have the capacity or skills to provide specialized GBV services, such as case management and health care, to survivors with disabilities. OPDs are also rarely able to reach all persons with disabilities in all regions of a country.

“Together with us and OPDs, UNFPA needs to advocate to mainstream organizations who reach out to the wider population to comprehensively include disability and leprosy in their GBV and sexual and reproductive health rights work. A country like Myanmar – it is very wide and big – it needs everyone to bring on board disability inclusion. It will take a lot of working together, sharing knowledge, coaching – identifying people with disabilities and people with leprosy will only happen when it is everyone’s mandate, and they are committed to it – this is the only way that access to sexual and reproductive health [and GBV] services will happen.”

- The Leprosy Mission Myanmar (TLMM), Myanmar

A key lesson from UNFPA and its partners’ work on disability inclusion in GBV programming is the importance of first addressing the attitudes of GBV actors in order to foster culture change. There is a need to push past misconceptions that GBV service providers “don’t work with” persons with disabilities. Donors and United Nations agencies can play an important role in this process by challenging partners on how they put principles such as inclusion and non-discrimination into practice. Linking GBV service providers and OPDs (with appropriate capacity-building) has led to valuable knowledge exchange and mentoring, providing positive examples of persons with disabilities as partners, not just beneficiaries. In some organizations, sensitization of staff – by simply introducing them to persons with disabilities – has fostered change

“Be open minded – and just learn. People have so many boundaries – discrimination and stigma about people who are different. Include the services for everybody. Of course, it is easier to talk than do. But firstly, if we think about the diverse population, and intersectionality of GBV – this is a good starting point for all organizations ... I believe that in any relationship – it is about getting to know people. You can’t just start with theory in the book or on paper – everything starts with people and communication.”

- Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents, Viet Nam

Integrating gender-based violence prevention and risk mitigation into the work of organizations of persons with disabilities

OPD partners explained that their community awareness-raising on GBV currently engages only with women with disabilities, not the wider community, and reported that, in some contexts, they may be met with hostility from men and male partners. OPD partners expressed an interest in greater collaboration with GBV organizations that can provide advice on how to contextualize GBV messages, engage with men and boys, and reduce the risk of negative outcomes. UNFPA Myanmar is currently considering a pilot of an integrated model for GBV prevention that would bring together women’s economic empowerment, trauma-informed care, engagement of men and boys, and GBV awareness-raising. In Pakistan, UNFPA has also supported organizations such as STEP to develop their PSEAH mechanisms and approaches, with all staff receiving appropriate training and capacity development.

“And we need male participation. In many awareness sessions, most participants are women. In some households, the GBV awareness has led to increased anger among husbands. Sometimes when you introduce something new, you can feel the resistance and it is important to contextualize.”

- TLMM, Myanmar

At the same time, the partnership between GBV actors and OPDs should also focus on ensuring that OPDs prioritize confidentiality and safety within internal administrative processes and data collection practices any time GBV and disability may intersect, thereby ensuring that the survivor is placed at the centre of every process.

Disability inclusion in gender-based violence programming: a journey, not a one-time event

The promising practices and approaches documented highlight how advancing disability inclusion needs to go beyond a single training session or activity. Disability inclusion needs to be more systematically integrated into organizational standards, quality assurance assessments and GBV curricula.

Similarly, OPDs are also on a journey when it comes to including GBV in their prevention work. Women with disabilities may have less pre-existing knowledge of GBV because of their long-standing exclusion from all discussions about rights, sex, violence and relationships. As a result, they can find some of the GBV training concepts and topics more challenging than other participants, and may request more time for training.

Women with disabilities also recommend that GBV training materials be designed with input from persons with disabilities, to ensure accessibility and usability, and that women and girls with disabilities are represented more in the materials developed.

There are still challenges related to reaching persons with disabilities in all their diversity. Persons with disabilities may have a range of different types of impairments, including vision, hearing, physical, psychosocial and intellectual impairments, which need to be considered in GBV capacity-building. For example, GBV awareness-raising also needs to be accessible to those with intellectual disabilities, and, for some groups, engagement of families and caregivers will be critical. Persons with disabilities from ethnic minorities, indigenous groups and rural areas also face a range of unique barriers to accessing GBV services and activities, and it remains a challenge to fully address these barriers.

Building the evidence base on effective practices

The mapping of disability inclusion in GBV initiatives demonstrates that, although many national programmes are already taking steps to strengthen disability inclusion in GBV programming, this is not yet systematic across all countries or in all GBV programmes. Furthermore, there is still a gap in the evidence on the outcomes of these disability-inclusive approaches and strategies. These outcomes include changes in the knowledge, attitudes and practices of GBV partners and service providers, and outcomes for persons with disabilities. Gathering more information about outcomes is critical to identifying what disability-inclusive approaches and strategies work, where they work and why.

ANNEX I: TIP SHEET: DISABILITY INCLUSION IN GENDER-BASED VIOLENCE PROGRAMMING

Introduction

Ending gender-based violence (GBV) and harmful practices is one of the three transformative results of the United Nations Population Fund (UNFPA), and a key priority in implementing the Programme of Action of the International Conference on Population and Development and the 2030 Agenda for Sustainable Development. In pursuit of these goals, the UNFPA Asia and the Pacific Regional Office (APRO) is supporting countries in the region to address GBV, including strengthening sexual and reproductive health services as an entry point for violence-related information, services and referrals, and developing evidence-based programmes to promote and protect women's rights.⁴²

Box A1: Some statistics on GBV and disability

Globally, 18 per cent of the female population has a disability.^a

Persons with disabilities have a 1.5 times greater risk of violence than those without disabilities, and the risk is even higher among those with intellectual and psychosocial disabilities.^a

Women with disabilities are two to four times more likely to experience intimate partner violence.^b

Children with disabilities are three times more likely to experience sexual abuse.^c

a World Health Organization, *Global Report on Health Equity for Persons with Disabilities* (Geneva, 2022).

b Kirstin Dunkle and others, *Disability and Violence against Women and Girls: Emerging Evidence from the What Works to Prevent Violence against Women and Girls Programme* (London, UK Aid, Department for International Development, 2018).

c UNICEF, *The State of the World's Children 2013: Children with Disabilities – From Exclusion to Inclusion* (New York, 2013).

Globally, 18 per cent of the female population has a disability (see Box A.1),⁴³ and many of these women are at higher risk of GBV than those without disabilities owing to the multiple and intersecting forms of discrimination they face. Attitudinal, environmental and communication barriers result in this population's systematic exclusion from GBV programmes, services, and activities – both as partners and beneficiaries. For this reason, all UNFPA efforts to address GBV must be inclusive of and accessible to women and girls with disabilities, ensuring that transformative goals are met and that no one is left behind.

This tip sheet provides guidance for UNFPA country office staff on the entry points to and appropriate strategies for integrating disability into GBV programme planning. Links to additional tools and resources on the implementation of the proposed strategies and approaches are provided throughout. The tip sheet links to and complements wider toolkits and checklists on disability inclusion in GBV programming developed by UNFPA and its partners, as outlined in *Figure A.1*, *Figure A.2* provides an overview of the entry points.

⁴² UNFPA APRO, "What we do: Gender-based violence" (n.d.). Available at <https://asiapacific.unfpa.org/en/node/15204>.

⁴³ World Health Organization, *Global Report on Health Equity for Persons with Disabilities* (Geneva, 2022).

Figure A1: GBV and disability tools developed by UNFPA APRO

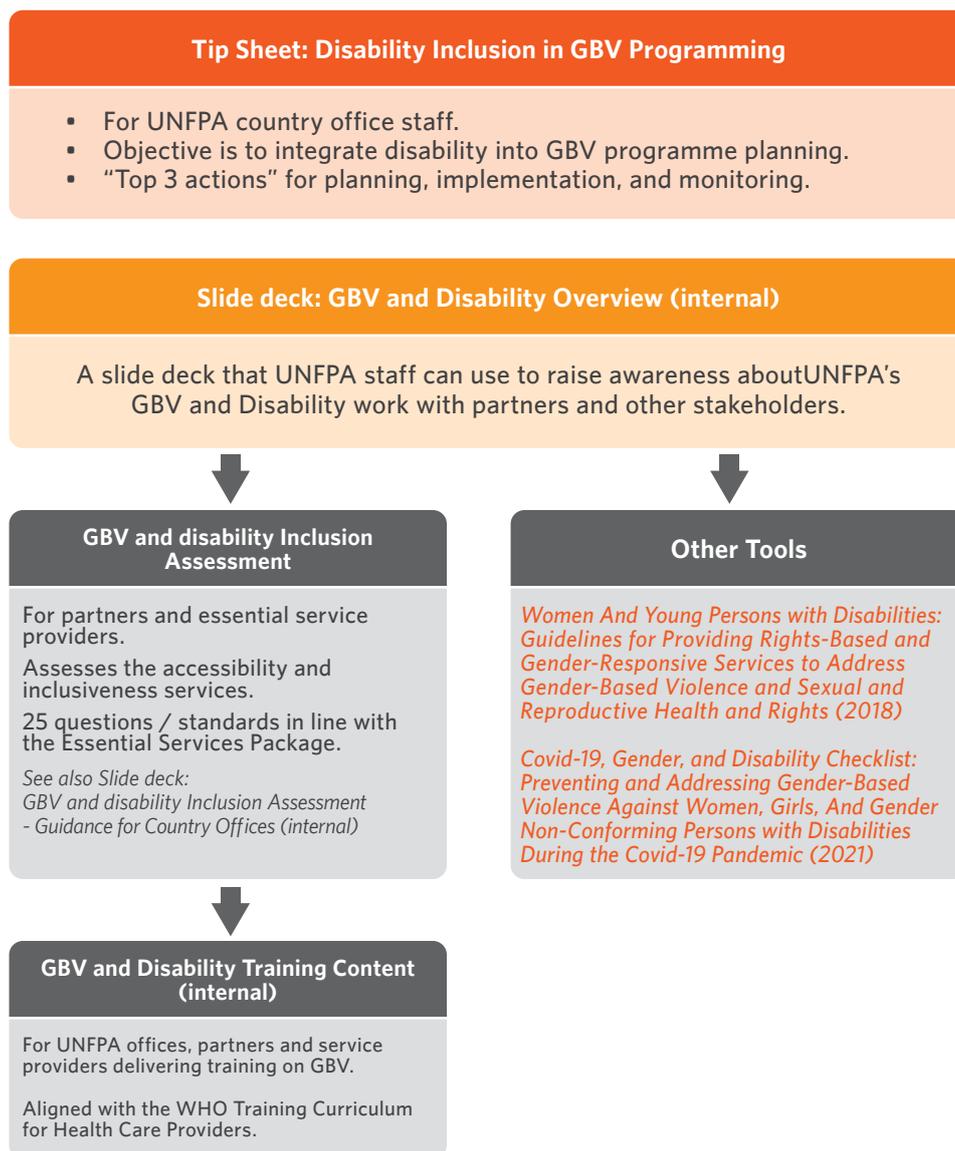
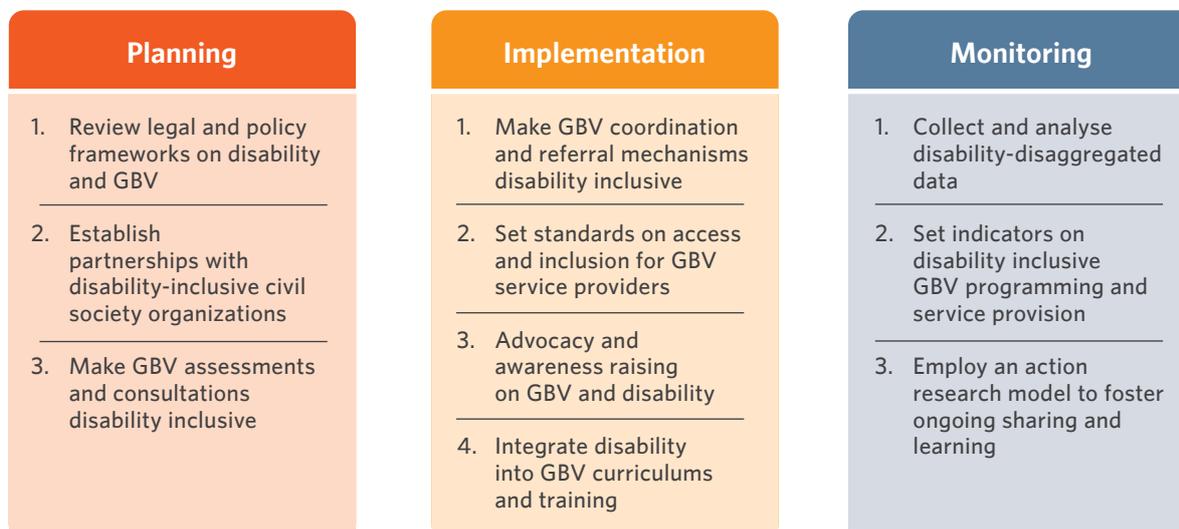


Figure A2: Overview of entry points for disability inclusion in GBV Programming



Disability inclusion in gender-based violence programme planning processes

To meaningfully address the rights of women and girls with disabilities, it is essential to mainstream disability inclusion in GBV planning processes, including in contextual analysis, community assessments and consultation. UNFPA Country Office staff can take the following top three actions during the planning phases to mainstream disability inclusion in their GBV programmes.

1) Review legal and policy frameworks on disability and gender-based violence

- Review existing laws and policies relating to disability to identify good practices that can be built on and gaps that need to be addressed to ensure the rights of women and girls with disabilities are protected in GBV programmes. Key questions to ask in this review are the following.
 - Are women and girls with disabilities referenced in the national strategy and/or action plan on GBV? Furthermore, is GBV referenced in any national strategies and/or action plans on disability? If appropriate, can these strategies and action plans be developed or revised to ensure the protection and empowerment of women and girls with disabilities?
 - How do existing laws and policies create barriers to women and girls with disabilities accessing GBV services? For example, do national laws protect legal capacity/recognize women and girls “with disabilities as equal before the law? Is the informed consent of women and girls with disabilities legally required for all GBV services? Are service animals legally permitted in all public buildings and private facilities?
 - Does the country have an independent and effective accountability mechanism for reporting, monitoring and redressing violations against women and girls with disabilities? To the extent that this mechanism exists, are remedies responsive to and appropriate for the violations experienced by women and girls with disabilities, including GBV?⁴⁴ If this mechanism exists, is it in line with survivor-centred principles (e.g. does it respect the confidentiality, safety, self-determination and non-discrimination principles)?

For more information, please see UNFPA, “Chapter 2: Foundational guidelines for action for providing rights-based GBV and SRHR services for women and young persons with disabilities - Section 2.2: Law and policies” in *Women And Young Persons with Disabilities: Guidelines for Providing Rights-based and Gender-responsive Services to Address Gender-based Violence and Sexual and Reproductive Health and Rights* (New York, 2018).

⁴⁴ Adapted from UNFPA Regional Office for Eastern Europe and Central Asia and East European Institute for Reproductive Health, *Multi-sectoral Response to Gender-Based Violence: A Resource Package* (Istanbul, UNFPA Regional Office for Eastern Europe and Central Asia, 2020).

2) Establish partnerships with inclusive civil society organizations

- Identify how current civil society partners include women and girls with disabilities. Women's rights organizations may not always have members with disabilities or involve persons with disabilities in their consultations and activities. The organizations may lack an understanding of the needs of this group and the barriers they face, barriers that should be considered in GBV programme planning.
- Expand partnerships to include women-led organizations of persons with disabilities (OPDs). OPDs are “non-governmental organizations led, directed and governed by persons with disabilities, who should compose a clear majority of their membership”.⁴⁵ Women-led OPDs can provide information on effective strategies to ensure that GBV policies, strategies and programmes address barriers and promote inclusion.
- Link civil society partners to women-led OPDs during GBV programme planning activities. Invite women-led OPDs to planning workshops and meetings so that common priorities and interests can be identified and integrated into GBV programmes.

For more information, please see the checklists for different types of consultations in United Nations, “Section 3: Consultation in practice” in *Consulting with Persons with Disabilities: Indicator 5*, UNDIS guideline (New York, 2021).

3) Make gender-based violence assessments and consultations disability inclusive

- Set targets with partners for the number of persons with disabilities and their caregivers to be included in community consultations on GBV. Ideally, one or two participants with disabilities should be invited to age- and gender-appropriate focus group discussions (16 per cent of the wider community members consulted).
- Add questions on disability to GBV assessments and consultations with partners, communities and service providers.

For more information, please see Women's Refugee Commission and International Rescue Committee, *Tool 1: Guidance on Including Persons with Disabilities and Caregivers in GBV Assessments*; Women's Refugee Commission and International Rescue Committee, *Tool 2: Group Discussion Guide*; Women's Refugee Commission and International Rescue Committee, *Tool 3: Individual Interview Tool*; and Women's Refugee Commission and ChildFund International, “Part 3: Participatory assessment tools for children and youth” and “Communication toolbox” in *Gender-Based Violence Against Children and Youth with Disabilities: A Toolkit for Child Protection Actors* (New York, Women's Refugee Commission, and Richmond, Virginia, USA, ChildFund International, 2016).

⁴⁵ United Nations, *Consulting with Persons with Disabilities: Indicator 5, UNDIS guidelines* (New York, 2021).

Disability inclusion in gender-based violence programme activities

When developing and planning programmes with partners, there are four types of GBV activities where disability inclusion is critical: 1. when setting standards for GBV service providers (in line with the *Essential Services Package for Women and Girls Subject to Violence*); 2. establishing or revising GBV referral and coordination mechanisms; 3. supporting joint advocacy and awareness-raising campaigns; and 4. developing and implementing curricula and training for GBV actors.

1) Set standards on access and inclusion for gender-based violence service providers

- Identify and address barriers to access and inclusion when strengthening essential services for GBV survivors, including specific barriers to access to information on GBV services. The Gender-based Violence and Disability Inclusion Assessment Tool is designed for partners and essential service providers to use to collect information about how their service is meeting standards on access and inclusion of women and girls with disabilities. It can be used to inform future service development and track improvements over time. It is structured according to the common characteristics of all essential services, and thus is relevant for all sectors engaged in GBV service provision and response.

For more information, please see UNFPA APRO, *Gender-based Violence and Disability Inclusion Assessment Tool* (2023).

2) Make gender-based violence coordination and referral mechanisms inclusive

- Identify and invite women-led OPDs to participate in coordination meetings. They can provide information on some of the gaps and appropriate strategies needed to strengthen essential service delivery to persons with disabilities.

For more information, please see the checklists for different types of consultations in United Nations, "Section 3: Consultation in practice" in *Consulting with Persons with Disabilities: Indicator 5*, UNDIS guideline (New York, 2021).

- Define the roles and responsibilities of different stakeholders in supporting persons with disabilities who have experienced violence and ensure referral processes and standard operating procedures are aligned accordingly (see *Table A1*).

Table A1: Roles of groups involved in GBV programming

GBV coordination bodies	GBV service providers (e.g. health, justice and policing, social services)	Disability service providers (e.g. rehabilitation, sign-language interpretation services)	Community groups (e.g. women's rights organizations, OPDs)
Set and monitor standards on access and inclusion for GBV service providers (see point 2 below)	Provide services to survivors with disabilities on an equal basis with others who have experienced GBV	Safely refer those who have experienced GBV and those at risk of violence to GBV service providers	Participate in consultations by GBV service providers who are assessing and addressing barriers
Map and develop appropriate linkages with disability service providers and community groups	Regularly assess and improve the accessibility and inclusion of services in line with appropriate standards (see point 2 below)	Provide rehabilitation, aids and devices, and/or confidential interpretation services, if requested by persons with disabilities who have experienced GBV	Sensitize GBV service providers on disability
Train stakeholders on safely receiving disclosures and on referring persons with disabilities who have experienced GBV	Consult with OPDs on barriers and strategies to improve access to services		Share information about available GBV services/ activities with persons with disabilities
	Ensure staff have the knowledge, attitudes and skills to support persons with disabilities who have experienced GBV (see point 4 below)		

Box A2: UNFPA Myanmar - Engaging the Myanmar deaf community development association in GBV helpline coordination

UNFPA Myanmar is currently providing financial and technical support (e.g. training on GBV basics and case management, helpline operations, and the development of GBV helpline standard operating practices) to the Deaf Community Development Association (MDCDA), which delivers one of the few helplines targeting persons with disabilities. MDCDA operates two helplines: the Mingalar Call Center and the A Pyone Pan Helpline. The Mingalar Call Center mainly targets persons with hearing impairments and provides callers with COVID-19-related information through sign language applications. The A Pyone Pan Helpline, which has been in operation since February 2021, provides legal aid services and referral support to women and girls with disabilities, especially those with hearing impairments, who are affected by GBV. UNFPA Myanmar recognized the opportunity to reach women and girls with disabilities through these existing networks, but also the need to ensure the safety and quality of services for survivors. Therefore, it provided tailored training specific to MDCDA and its role, including advice on the use of sign language interpreters. MDCDA is also a valuable resource for other GBV service providers, and offers sign- language support to these providers.

3) Conduct joint advocacy and awareness raising on gender-based violence and disability

- Make efforts to raise awareness, mobilize advocacy and foster collaborative action to combat all forms of GBV inclusive of the needs and contributions of women and girls with disabilities. This can be achieved by engaging OPDs in these initiatives and ensuring that women and girls with disabilities are represented in campaign materials and at events. Key messages on disability can also be integrated into advocacy conducted with government partners and other stakeholders. The engagement of OPDs in co-designing and implementing advocacy and awareness-raising campaigns is also key to ensuring that women and girls with disabilities are reached through modalities that are inclusive of and responsive to their specific disability-related needs.

4) Integrate disability into gender-based violence curricula and training

- Ensure that staff have the appropriate knowledge, attitudes and skills relating to disability inclusion. This is the responsibility of GBV service providers. When planning the development or review of GBV curricula and training, discuss with partners the importance of reflecting women and girls with disabilities in the content, activities and case studies. While it may be appropriate to seek advice on the content from disability experts and organizations, it is critical for sustainability that GBV service providers deliver this training directly to their own staff. This also sends a message that supporting survivors with disabilities is part of the core business of GBV service providers. Key GBV topics for the integration of disability content, examples and case studies are:
 - Understanding risk and vulnerability to GBV
 - Community awareness-raising on GBV
 - Ensuring survivor-centred approaches
 - Effective communication with GBV survivors

For more information, please see Women's Refugee Commission and International Rescue Committee, *Tool 4: A Training Module for GBV Practitioners in Humanitarian Settings* (2015); and Women's Refugee Commission and ChildFund International, "Part 2: Capacity development tools for staff" in *Gender-Based Violence against Children and Youth with Disabilities: A Toolkit for Child Protection Actors* (New York, Women's Refugee Commission, and Richmond, Virginia, USA, ChildFund International, 2016).

Box A3 provides an example of integrating disability into this type of activity.

Box A3: UNFPA Pakistan – Integrating disability into GBV case management training

It is essential that case workers recognize and use their skills to support survivors with all types of disabilities. Therefore, it is recommended that training on case management incorporate examples of how to deal with survivors with a range of different communication skills and preferences and include case studies of people with different types of disability. It should also give examples of how to deal with those who might be accompanied by family members or caregivers. The following is an example of reflective listening practice applied to an example of a survivor with disabilities attending case management with her mother.

The mother of a survivor with disabilities says to you

“She needs to go somewhere else to live – it is not safe here.” The daughter starts to cry and yells *“no”*.

Core message: the mother is scared, and the daughter does not agree with her.

Core feelings: fear, helplessness, disagreement.

Your possible response: to the mother, *“You are worried for you daughter’s safety”*;
to the daughter, *“And my understanding is that you want to make your own decisions – you don’t want to live somewhere else?”*^a

^a Rozan Counselling Helpline, *Case Management Module on Gender Based Violence*.

Disability inclusion in gender-based violence programme monitoring

The following top three actions can be integrated into GBV programme monitoring and evaluation. Information about the gaps in and opportunities for greater disability inclusion should be addressed in work plans, new projects or phases of action with partners

1) Collect and analyse disability-disaggregated data in violence prevalence surveys and gender-based violence service usage databases

- Integrate the Washington Group Short Set on Functioning into the introductory or demographic section of violence prevalence survey questionnaires. This will allow disaggregated analysis of data on violence, including identifying the circumstances in which women, men, girls and boys with disabilities may experience higher rates of various types of violence and/or be less likely to access essential services than their peers without disabilities. Where GBV services are collecting demographic information, such as sex and age, the Washington Group questions can also be added to appropriate forms (in line with standards for safe and confidential data collection) to identify if persons with disabilities are accessing these services on an equal basis with others. It is important that findings that demonstrate greater risk of GBV or reduced access to services for survivors with disabilities be responded to through appropriate actions in GBV programmes. This may include collecting more qualitative information on the barriers and recommended strategies from women and girls with disabilities. An example of integrating the Washington Group Short Set on Functioning is provided in [Box A.4](#).

For more information, please see Washington Group on Disability Statistics, *The Washington Group Short Set on Functioning (WG-SS)* (Hyattsville, Maryland, 2022).

Box A4: Integrating disability into national violence against women surveys

With support from the Australian Department of Foreign Affairs and Trade, UNFPA Asia Pacific Regional Office, in partnership with the University of Melbourne have created the kNOwVAWdata initiative to support and strengthen regional and national capacities to measure violence against women in the Asia-Pacific region. In 2017, national, regional and global experts were brought together to discuss what approaches should be taken to ensure that women with disabilities are better represented in national prevalence studies on violence against women. Efforts are now being taken to integrate the Washington Group Short Set on Functioning into national surveys on violence against women (most commonly using the methodology from the WHO Multi-country Study on Women's Health and Domestic Violence, or the domestic violence module of the Demographic and Health Survey). One such effort from Viet Nam found that a third (33.0 per cent) of women with disabilities had experienced physical violence perpetrated by their husband/partner, compared with a quarter (25.3 per cent) of women without disabilities. In addition, more women with disabilities had experienced childhood sexual abuse (6.4 per cent compared with 4.4 per cent).^a

^a Ministry of Labour, Invalids and Social Affairs, General Statistics Office and UNFPA, *Summary Report: Results of the National Study on Violence against Women in Viet Nam 2019 – Journey for Change* (Ha Noi, 2020).

2) Set indicators on disability-inclusive gender-based violence programming and service provision

- Track whether GBV programme activities are reaching and benefiting persons with disabilities equally by disaggregating beneficiary data collection and analysis by disability and/or including indicators relating to disability inclusion in your logframes and results frameworks. Sample indicators include:
 - Percentage (not number) of survivors accessing GBV services who report having a disability
 - Percentage (not number) of service users who report being satisfied with the service provided, disaggregated by sex, age and disability
 - Number and type of GBV curriculums or training packages that integrate disability
 - Percentage of GBV service provider staff who have received training on the Essential Services Package for Women and Girls Subject to Violence and other international standards through inclusive curricula and training packages
 - Number and type of GBV services that meet set standards on access and inclusion.

For more information, please see UNFPA APRO, *Gender-based Violence and Disability Inclusion Assessment Tool* (2023).

3) Employ an action research model to foster ongoing sharing and learning

- Use a participatory action research model. This means putting women and girls with disabilities at the centre of programming processes – from the identification of gaps and barriers, to development of pilot actions, and, ultimately, to the decision on what change matters the most.
- Try using “stories of change”. These have proved to be an effective way of engaging women and girls with disabilities, who would otherwise be considered merely “beneficiaries” of GBV programming, in identifying effective strategies and approaches to inclusion, current gaps and recommendations for stakeholders. Providing women and girls with different options on how to document and share their own stories – verbally, in written form or through photography, and individually or with persons they trust – and valuing the diversity of contributions brought forth can also contribute to empowerment processes.

For more information, please see Women's Refugee Commission and International Rescue Committee, *Tool 12: Documenting “Stories of Change”* (New York, 2015).

- Encourage GBV service providers to reflect on changes in knowledge, attitudes and practices relating to disability inclusion, highlighting successes and informing future capacity development goals.

For more information, please see Women's Refugee Commission & International Rescue Committee, *Tool 11: Reflection Tool for GBV Practitioners*.

- Finally, document positive practices and approaches to share with APRO colleagues and the wider GBV community.

ANNEX II: GENDER-BASED VIOLENCE AND DISABILITY INCLUSION ASSESSMENT TOOL

Introduction

In line with the *Essential Services Package for Women and Girls Subject to Violence*, gender-based violence (GBV) services must respond appropriately to women and girls who face multiple forms of discrimination, such as women and girls with disabilities. Furthermore, the Convention on the Rights of Persons with Disabilities requires provision of gender- and age-sensitive assistance and support for persons with disabilities who have experienced violence, and their families and caregivers.⁴⁶ Yet women and girls with disabilities face a range of attitudinal, communication and environmental barriers when accessing essential health, justice and policing, or social support services. They may also be excluded from community consultation and engagement mechanisms, including from women's rights organizations and other civil society organizations. Essential services coordination mechanisms may fail to take into account the diversity of experiences and needs of women and girls who experience violence in the design and monitoring of responses.

This GBV and disability inclusion assessment tool is designed for GBV essential service providers to use to collect information about how their service is meeting standards on access and inclusion of women and girls with disabilities. It can be used to inform future service development and track improvements over time. It is structured according to the common characteristics of all essential services, and thus is relevant for all sectors engaged in GBV service provision and response, including health, mental health and psychosocial support, justice and policing, and social service providers (which covers those delivering safe shelter and financial support to GBV survivors).

How to use this tool: who to involve and how to conduct consultations

Table A.2 provides a list of questions for service providers on the accessibility and inclusiveness of their services. The questions are aligned with the common characteristics of high-quality essential health services outlined in the *Essential Services Package for Women and Girls Subject to Violence*.

There are 25 standards in total, each of which corresponds to one of the 25 questions. Service providers should answer "yes" or "no" to each standard/question. All standards/questions will be relevant to most service providers. Only if the service provider believes that a standard/question is "not appropriate", "not applicable" or "not relevant" should they mark "N/A"; they should then provide information about why this is the case in the "Comments" section of the form. At the end of the form, notes with additional information about some standards/questions are provided.

The table also includes guidance on how to answer each of the questions. For example, it may suggest involving women and girls with disabilities in age- and gender-appropriate community group discussions and adding questions relating to disability to community consultations; conducting an accessibility audit (the table provides links to appropriate materials and tools); or collating and reviewing service provider policies and procedures.

⁴⁶ United Nations General Assembly, Convention on the Rights of Persons with Disabilities, Resolution A/RES/61/106.

Service providers should engage organizations of persons with disabilities in the assessment process, as these organizations can provide perspectives on the accessibility and inclusiveness of the service, as well as recommendations of ways to improve the service for women and girls with disabilities. For more information on consulting with persons with disabilities, please see the checklists for different types of consultations in United Nations, "Section 3: Consultation in practice" in *Consulting with Persons with Disabilities: Indicator 5*, UNDIS guideline (New York, 2021).

It is recommended that service providers integrate this assessment into regular service monitoring, development and planning processes, allowing them to collect relevant information. They can then complete the form in consultation with senior staff and partners. For example, the questions below can be contextualized and added as an additional standard on disability inclusion to the *Gender-based Violence: Quality Assurance Tool for health facilities*, or selected questions can be integrated as verification criteria under each of the standards (see *Table A.4*).

Service providers are encouraged to reflect on and share their lessons learned with each other and with UNFPA offices, documenting positive practices and improvements in access and inclusion over time. Please contact your UNFPA focal point if you have any questions about this tool or require additional advice to complete the process.

Table A2: GBV and disability inclusion assessment tool

Accessibility					
"Accessibility requires services to be accessible to all women and girls without discrimination. They must be physically accessible (services are within safe physical reach for all women and girls), economically accessible (affordability) and linguistically accessible (information is provided in various formats)." ^a					
Physical accessibility					
Standard/question ^b		N/A	Yes	No	How to answer this question
1.	Has an accessibility audit been conducted of service facilities?				Ask facility managers and supervisors. For more information, see <i>Note 1</i> .
2.	Does the service provider have an accessibility action plan to address gaps identified in the accessibility audit?				Cross-check service provider's work plans and action plans against the accessibility audit.
3.	Does the service provide transport options to support persons with disabilities to reach the service (e.g. organize a pick-up and drop-off service, or an established client				Review service provider's policies and procedures.
Comments:					

Communication (linguistic) accessibility

Standard/question ^b	N/A	Yes	No	How to answer this question
4. Is information about the service available in multiple formats (e.g. large print, Braille, sign-language interpretations, simplified for persons with intellectual disability)?				Review a random sample of service provider's information, education and communication materials.
5. Are persons with communication difficulties requiring assistance able to access support and/or interpreters?				Review service provider's policies and procedures.
6. Do information, education and communication materials feature positive representations of persons with disabilities as part of the general community?				Review a random sample of service provider's information, education and communication materials. For more information, see Note 2 .

Comments:

Economic accessibility

Standard/question ^b	N/A	Yes	No	How to answer this question
7. Has the service consulted with women and girls with disabilities and their families about any additional costs in accessing the service (e.g. cost of transportation, accessible shelter, loss of income when supporting survivor to access services)?				Involve women and girls with disabilities and their family members in age- and gender-appropriate community group discussions. Add this question to community group discussions.
8. Are persons with disabilities entitled to a concession/discount/rebate due to their disability?				Review government policies and entitlements for persons with disabilities and/or consult with organizations of persons with disabilities. For more information, see Note 3 .
9. If so, are service providers aware of this, and is it being promoted?				Integrate this question into staff group discussions and interviews.

Comments:

Availability

"Essential health care, social services, justice, and policing services must be available in sufficient quantity and quality to all victims and survivors of violence regardless of her place of residence, nationality, ethnicity, caste, class, migrant or refugee status, indigenous status, age, religion, language and level of literacy, sexual orientation, marital status, disabilities or any other characteristic not considered."^a

Standard/question	N/A	Yes	No	How to answer this question
10. Does the budget for the service include adaptations or adjustments for women and girls with disabilities and other disability-inclusive actions (e.g. training staff, producing information in alternative communication formats, providing transportation and assistance costs)?				Review service provider budgets and reports. For more information, see <i>Note 4</i> .
11. Are actions to ensure access and inclusion for women and girls with disabilities integrated into the service provider's development plans?				Review service provider's budgets and reports.

Comments:

Adaptability

"Essential services must recognize the differential impacts of violence on different groups of women and communities. They must respond to the needs of victims and survivors in ways that integrate human rights and culturally sensitive principles."^a

Standard/question	N/A	Yes	No	How to answer this question
12. Are organizations of persons with disabilities actively involved in raising awareness of disability among service provider staff?				Review staff awareness-raising and training activities.
13. Have staff at the service (including health-care workers and other staff, such as security and administrative staff) undergone training on disability and disability inclusion, and are they aware of the rights of persons with disabilities and their GBV needs?				Review staff awareness-raising and training activities.

Comments:

Appropriateness

"Appropriate essential services for women and girls are those which are delivered in a way that is agreeable to her; respects her dignity; guarantees her confidentiality; is sensitive to her needs and perspectives; and minimizes secondary victimization."^a

Standard/question	N/A	Yes	No	How to answer this question
14. Do women and girls with disabilities report the same levels of service satisfaction as those without disabilities?				Add the <i>Washington Group Short Set on Functioning</i> to existing service user satisfaction questionnaires, and then disaggregate data analysis. It does not need to be a separate form. For more information, <i>see Note 5</i> .
15. Do women and girls with disabilities know how to provide feedback and/or make a complaint to service providers?				Add this question to community focus group discussions. It does not need to be a separate group discussion. For more information, <i>see Note 5</i> .
16. Are these feedback and complaints mechanisms accessible to women and girls with disabilities?				Add this question to community focus group discussions. It does not need to be a separate group discussion. For more information, <i>see Note 5</i> .

Comments:

Prioritize safety

"Women and girls face many risks to their immediate and ongoing safety. These risks will be specific to the individual circumstances of each woman and girl. Risk assessment and management can reduce the level of risk. Best practice risk assessment and management includes consistent and coordinated approaches within and between social, health and police and justice sectors."^a

Standard/question	N/A	Yes	No	How to answer this question
17. Are disability considerations (e.g. access to medicines, mobility aids, interpreters and support persons) included in safety planning and risk management tools?				Review existing safety planning and risk management tools. For more information, <i>see Note 5</i> .
18. Are women and girls with disabilities receiving a strength-based, individualized plan that includes strategies for risk management?				Review random selection of case management plans for survivors with disabilities.

Comments:

Informed consent and confidentiality

"All essential services must be delivered in a way that protects the woman or girl's privacy, guarantees her confidentiality, and discloses information only with her informed consent, to the extent possible. Information about the woman's experience of violence can be extremely sensitive. Sharing this information inappropriately can have serious and potentially life threatening consequences for the women or girls and for the people providing assistance to her."^a

Standard/question	N/A	Yes	No	How to answer this question
19. Does guidance on confidentiality explicitly reference only sharing information with trusted support persons and/or interpreters chosen by a survivor with disabilities?				Review service provider's policies and procedures. For more information, <i>see Note 5</i> .
20. Are staff trained on informed consent/assent and strategies to support women and girls with disabilities to make their own decisions?				Review staff awareness-raising and training activities. For more information, <i>see Note 5</i> .

Comments:

Effective communication and participation by stakeholders in design, implementation, and assessment of services.

"Women and girls need to know that she is being listened to and that her needs are being understood and addressed. Information and the way it is communicated can empower her to seek essential services. All communication with women and girls must promote and be respectful of them."^a

Standard/question	N/A	Yes	No	How to answer this question
21. Are staff trained on strategies to communicate effectively with persons with different types of impairments?				Review staff awareness-raising and training activities. For more information, <i>see Note 5</i> .
22. Are women and girls with disabilities included in community consultation and engagement in the design, implementation and assessment of services?				Review community consultation records - ideally 15 per cent of community members consulted will be persons with disabilities. For more information, <i>see Note 5</i> .

Comments:

Data collection and information management

"The consistent and accurate collection of data about the services provided to women and girls is important in supporting the continuous improvement of services. Services must have clear and documented processes for the accurate recording and confidential, secure storage of information about women and girls, and the services provided to them."^a

Standard/question	N/A	Yes	No	How to answer this question
23. Has the Washington Group Short Set on Functioning been integrated into service user data collection and violence prevalence surveys, as appropriate? See Note 6 .				Review service user, survey and other assessment tools.
24. Is data analysis disaggregated by sex, age and disability (where possible)?				Review service user monitoring, survey and other assessment reports.

Comments:

Linking with other sectors and agencies through coordinations.

"Linking with other sectors and agencies through coordination, such as referral pathways, assist women and girls receive timely and appropriate services. Referral processes must incorporate standards for informed consent. To ensure the smooth navigation of the different essential services for victims and survivors, protocols and agreements about the referral process with relevant social, health and justice services, including clear responsibilities of each service, need to be in place."

Standard/question	N/A	Yes	No	How to answer this question
25. Are the roles and responsibilities of different stakeholders supporting a survivor with disabilities – including disability service providers and organizations of persons with disabilities – defined in existing referral pathways?				Review service provider's policies and procedures. For more information, see Note 5 .

Comments:

Subtotals

Total number of relevant standards (maximum 25)				
Total number of standards met (maximum 25)				
Percentage of relevant standards met				

^a UN Women and others, *Essential Services Package for Women and Girls Subject to Violence* (New York, 2015).

^b Adapted from World Health Organization, Regional Office for the Western Pacific, *Disability-inclusive Health Services Toolkit: A Resource for Health Facilities in the Western Pacific Region* (Manila, 2020).

Note 1: Accessibility audits

An accessibility audit involves moving through different sections of the facility that a survivor may need to access (e.g. from transport access points, to reception, consultation rooms and toilets) to identify physical barriers that need to be addressed. Ideally, an accessibility audit is undertaken with a member of the local organization of persons with disabilities and a member of the service provider leadership team. Where possible, persons with different types of impairments (for example, a person with a mobility impairment and a person with visual impairment) should also be involved. Some local organizations of persons with disabilities will have their own accessibility audit tool that has been developed and tested in the given context. If this does not already exist, the physical accessibility audit in the *Disability-inclusive Health Services Toolkit: A Resource for Health Facilities in the Western Pacific Region* (pages 47–49) can be used for all essential services – health, justice and policing, and social support services.

Note 2: Representing persons with disabilities in communication materials

Inclusive and accessible communications reduce bias and discrimination, and promote inclusion and participation. The *United Nations Disability-inclusive Communication Guidelines* provide practical information on how to make communications materials accessible and respectfully represent persons with disabilities in such communications. *Tool 7: Accessible Information, Education and Communication Materials* (from the Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings: A Toolkit for GBV Practitioners series) outlines five key questions to ask when developing materials to ensure they are disability-inclusive, and provides a practical example from a GBV programme in Ethiopia.

Note 3: Financial assistance

In many countries, persons with disabilities may be eligible to access additional financial assistance programmes established by the government. Accessing these programmes can support GBV survivors to have greater independence and autonomy, and improve their access to a range of support, including reaching facilities where essential services are delivered, and accessing safe shelter, food and other basic needs. Therefore, it is important for GBV essential service providers to be aware of the financial assistance available and to support survivors with disabilities to access this assistance. Local organizations of persons with disabilities and the ministry responsible for disability (usually the social welfare ministry) can provide more country-specific information.

Note 4: Disability-inclusive budgeting

All GBV service providers should allocate funds to addressing some of the barriers faced by survivors with disabilities when accessing their services. This funding could be used to train staff on disability inclusion, to produce information in alternative formats, or to cover the transportation and assistance costs incurred by GBV survivors when they access services. To meet the physical accessibility requirements of persons with disabilities (for example, when constructing buildings or facilities), it is estimated that between 0.5 per cent and 1 per cent should be added to budgets.⁴⁷ *Figure A.1* provides some low-cost adaptations that can be made to existing facilities to remove physical barriers and improve accessibility.

⁴⁷ Inter-Agency Standing Committee, *Inclusion of Persons with Disabilities in Humanitarian Action* (Geneva, 2019).

Figure A3: Examples of low-cost strategies to remove physical barriers



Source: World Health Organization, Regional Office for the Western Pacific, *Disability-inclusive Health Services Toolkit: A Resource for Health Facilities in the Western Pacific Region* (Manila, 2020).

Note about “alternative models of service delivery”: Home visits are often unsafe in situations of GBV. GBV service providers should use this option only if no others exist, and only with a safety protocol in place for the visit.

Note 5: Integrating disability into existing service process, tools and forms

Many of these standards/questions can be achieved/answered by adapting existing service processes, tools and forms. It is not appropriate to develop separate processes, tools and forms for persons with disabilities. Instead, the following can be done.

- The Washington Group questions can be included in the demographic information of service user’s exit/satisfaction forms used with all survivors.
- The content of communication and consent should be integrated into GBV training packages – there is no need for separate training.
- Women and girls with disabilities can be included in the same groups discussions as other community members (with appropriate communication support and interpretation).
- Questions about access to medicines, mobility aids, interpreters and support persons can be included in safety planning tools used with all survivors (with the specification that disability-related questions should only be asked to survivors with disabilities).
- Existing referral mechanisms can be adapted to include stakeholders and adaptations required by persons with disabilities. It does not need to be a separate referral mechanism.

Note 6: Disability-disaggregated data collection

The Washington Group questions may not be appropriate in settings where other detailed information about the service user is not collected (e.g. in safe spaces in humanitarian settings). Furthermore, it is not necessary for all these questions be answered during the first appointment with a service user: this information can be collected at later points in users’ engagement with the service.

Disability inclusion action plan

Service providers and partners should develop a plan to prioritize and address the gaps identified through the assessment. It is recommended that service providers continue to engage organizations of persons with disabilities in this step, as these organizations can provide feedback on priorities and recommendations of ways to improve the service for women and girls with disabilities. The matrix in [Table A.3](#) can be used to develop a disability inclusion action plan. Please note that this can be adapted to align with specific service development plans or work plans.

Table A3: Action plan matrix

Our strengths: What areas are we doing well in? What factors contribute to these successes?					
Example	Adaptability (standards 12 and 13) Our staff are aware of disability rights and the importance of providing our services to women and girls with disabilities. This is because staff have received training from the local organization of persons with disabilities. We also have a system to ensure that new staff receive this training – it is not a “one-off”, but rather a required part of the onboarding process.				
1.					
2.					
3.					
Our gaps: What areas do we need to improve in? List in order of importance to address. What factors do you think are contributing to these gaps?	Actions to address these gaps	Roles and responsibilities	Potential partners	Timeline	
Example	Effective communication and participation (standard 22) Community consultation records demonstrate lack of feedback from women and girls with disabilities when designing new awareness-raising materials. No information available about whether these materials are suitable for women and girls with disabilities or if they know how to access our service.	Revise community consultation protocols to require that one or two persons with disabilities are included in all age- and gender- appropriate group discussions.	Supervisor to review the community consultation protocols and share with community workers in their next in-service training/ supervision meeting.	The local organization of persons with disabilities can identify focal points for community workers to engage with during community consultations.	Over the next month.
		Conduct a targeted consultation with women and girls with disabilities in the community to get their feedback on the new awareness-raising materials.	Designer of the awareness-raising materials to conduct this consultation in partnership with the organization of persons with disabilities. Finance department to provide a budget for women and girls with disabilities who need transportation, an interpreter or assistant to attend the consultation. Logistics manager to identify an accessible venue for the consultation.	The local organization of persons with disabilities can identify a group of women and girls with disabilities for the consultation. Disability service providers may be able to advise on suitable options for venues, interpreters and transport.	Over the next three months
1.					
2.					
3.					

Table A4: Example of integrating disability inclusion assessment questions into the Gender-based Violence: Quality Assurance Tool

Quality assurance standards	Verification criteria	Means of verification	Yes	No	Comments
2. Facility has GBV information, education and communication materials	2.1 Does the facility have visible information materials for patients (e.g. posters and/or pamphlets on what to do in the case of GBV, GBV laws and rights, and available services) in high-traffic areas (lobby, waiting areas, consultation rooms, rest rooms, etc.)?	Direct observation Review documents	<input type="checkbox"/>	<input type="checkbox"/>	
	2.2 Does the facility have a list of referral services or an information pamphlet in the patient's language to take home (only if the patient thinks it is safe to do so)?	Direct observation Review documents	<input type="checkbox"/>	<input type="checkbox"/>	
	2.3 Does the facility have job aids to support appropriate GBV response (e.g. steps in first-line support, referral directory with contact details of services)?	Direct observation Review documents	<input type="checkbox"/>	<input type="checkbox"/>	
	2.4 Is information about services for GBV survivors at the facility available in multiple formats (e.g. large print, Braille, simplified for persons with intellectual disability)?	Direct observation Review documents	<input type="checkbox"/>	<input type="checkbox"/>	
Scoring Standard 2	Number of criteria in standard <input type="checkbox"/>	Number of criteria met <input type="checkbox"/>	Standard achieved? (Y/N) <input type="checkbox"/>		

Source: Adapted from Jhpiego and others, Gender-based Violence: Quality Assurance Tool – Standards for the Provision of High Quality Post-violence Care in Health Facilities (Baltimore, MD, USA, 2018)

Sources/evidence

Documents reviewed:

- UNFPA, Women and Girls First Programme Phase II Narrative
- Draft Disability Inclusion Strategy and Action Plan 2021–2022: Mainstreaming Disability and Inclusion into the “Women and Girls First” Programme
- Humanity & Inclusion, Inception Workshop Report: Capacity Building and Assessment on Needs and Gaps for Girls and Women with Disabilities in Accessing SRHR, MHPSS and GBV services (Yangon, Women and Girls First Programme, UNFPA Myanmar, 2021)
- Analysis of Inclusiveness of GBV CWG Membership, GBV Coordination Working Group Meeting, 18 June 2021
- Myanmar GBV Sub-Cluster, 2022 Action Plan on Inclusiveness and Localization Efforts
- Consultation with Organizations of Persons with Disabilities, Conducted on 29 September 2021
- Brief on the Myanmar Deaf Community Development Association (MDCDA) & A Pyone Pan Helpline
- Disabled People’s Development Organisation, Project Summary: Enabling Women and Girls with Disabilities in Kayin and Kachin States to Receive Essential Health Resources and Psychosocial Support
- DDI, Project Summary: Enabling Persons with Disabilities and IDPs in Sagaing Region to Access GBV and Health Related Resources and Psychosocial Support
- Myanmar Independent Living Initiative, Project Summary: Lifting the Quality of Life of Persons with Disabilities (LQLP)
- TLMM and MAPAL, Project Summary: Empowering Persons Affected by Leprosy and Their Community for Accessing SRHR Information and Services
- Myanmar Independent Living Initiative, Project Summary: Increasing the Benefits and Inclusion for Persons with Disabilities in Humanitarian and Crisis Response Sector (PIPHC)
- COVID-19 Emergency Response Committee, Project Summary: COVID-19 Emergency Response Committee for Persons with Disabilities

Interviews conducted with:

- UNFPA Myanmar GBV colleagues, interviewed on the process of civil society grant-making and capacity development of OPDs
- MDCDA, interviewed on its role in GBV coordination mechanisms

Representatives of OPDs who have received training, interviewed on how they have used this training

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