Disability Evidence Portal |
Evidence Brief

How do we support women and girls with disabilities to overcome stigma against them?

The question and the problem

Stigma refers to the labelling of an individual or group of people in a way that ultimately denies them full social acceptance and equality of opportunity, and is often the root cause of discrimination and exclusion experienced by people with disabilities. The negative implications of stigma are far-reaching and profound, including limiting opportunities for accessing health care, education or livelihoods; affecting quality of life and wellbeing, and increasing the risk of violence and abuse. Stigma is intersectional, meaning that women and girls with disabilities often experience several layers of discrimination, on account of both their disability and their gender. Reducing stigma experienced by women and girls with disabilities is therefore critical to supporting their full inclusion in society on an equal basis as others.

Recommendations

- Recommendation #1: Engage directly with women and girls with disabilities and civil society to establish key drivers of stigma across all levels and sources
- Recommendation #2: Prioritise interventions that empower women and girls with disabilities, decrease internalised stigma and support self-, family and community advocacy
- Recommendation #3: Develop partnerships with research organisations to document what works in reducing stigma against women and girls with disabilities
- Recommendation #4: Take ownership for the removal of structural stigma that excludes women and girls with disabilities and jeopardises implementation of the UNCRPD, through developing an evidence-based and well-resourced strategy

"Even the most vigorous attempts at implementing the CRPD are likely to be significantly muted when they run up against the spectre of disability stigma."

Mostert, 2016

Challenge #1: Stigma is a complicated phenomenon

- Stigma can be experienced at an individual, interpersonal, organisational, community or structural level, and can be internalised (e.g. sense of shame, guilt), anticipated (e.g. expected), or enacted (e.g. discrimination). Sources of stigma include people's behaviours, negative attitudes or prejudices, and excluding processes, structures, policies or laws. The drivers of stigma may be diverse and interconnected, and vary from one setting to another.
- Several conceptual frameworks have been developed to help understand and overcome stigma, many of which are linked to specific stigmatised health conditions, such as HIV and leprosy. The Health Stigma and Discrimination Framework draws on the literature across multiple health conditions, and can be used to help unpack and understand the impacts of stigma in LMICs.

Challenge #2. There are many intersectional drivers of stigma against people with disabilities generally

- A recent review of stigma experienced by people with disabilities in LMICs identified a number of key drivers, including a lack of understanding of the cause of impairments, and misconceptions based on cultural or religious beliefs that disability is a source of shame and fear. The review identified additional layers of stigma, related to type or severity of impairment, how and when impairments were acquired, individuals' socio-economic status, or their ability to participate in important community and cultural events.
- Compared with men and boys, women and girls with disabilities have often been found to experience greater barriers to inclusion - including lower access to work, education or social participation. Drivers of stigma may be further reinforced by perceptions of womanhood – for example the societal value placed on being a wife and mother. Evidence from across LMICs shows how misconceptions that women and girls with disabilities are not capable of fulfilling these roles further marginalises them, heightening the risk of violence against them and limiting their access to sexual reproductive health and other important services.
- There is limited robust evidence on differences in stigma experienced by women and girls with disabilities compared with men and boys, but evidence from numerous specific health conditions (Leprosy, Epilepsy, Mental Health and Obesity) all describe higher levels of stigma experienced by women compared with men.

Challenge #3. Existing stigma reduction interventions are too narrow in focus, often targeting a single level or source of stigma

- No systematic reviews of stigma reduction strategies for women and girls with disabilities were identified, but several reviews synthesised evidence for people with disabilities generally, or with specific health conditions, or among children with disabilities.
- Successful interventions for adults with disabilities at an intrapersonal or family level included self-help, advocacy and support groups. Education (e.g. challenging stereotypes and misinformation) was found to have mixed efficacy at the family or community level, but to have greater results when combined with contact interventions – for example encouraging positive interactions between people with disabilities and their peers.
- Involvement of community leaders, and adapting interventions to the cultural values and structures of different settings was found to support stigma reduction, provided that community leaders were themselves knowledgeable and non-stereotyping in their own perspectives about disability.
- Specifically related to children with disabilities, one review found that most studies were low quality (poorly defined tools, lack of control groups and high risk of bias) but that broadly, attempts to educate teachers and students about disability, and contact interventions, appeared to reduce negative attitudes and improve knowledge. Differences in outcomes for girls versus boys with disabilities were not described.
- Few interventions were identified in the literature aimed at reducing structural stigma (e.g. in government legislation or policy), and several reviews emphasised the relatively low quality and high risk of bias in available studies, limiting generalisability of findings. Frequently, reviews identified increased efficacy of multifaceted interventions that tackled different components or sources of stigma together – such as ignorance stemming from lack of education or awareness, prejudice stemming from incorrect beliefs or negative attitudes, and discriminatory behaviour, stemming from drivers identified above.

Challenge #4. Empowerment, stigma reduction and implementing the UNCRPD are interlinked

- A number of reviews highlighted the importance of empowerment in reducing stigma, particularly internalised stigma. For example one Bangladeshi study focused on vocational training for people with disabilities, which led to increased likelihood of voting, and membership both of Organisations of People with Disabilities (OPDs) and village councils following the intervention.
- Separate studies showed how empowering people with disabilities to be leaders and self-advocates helped others with disabilities overcome their own internalised stigma, and changed the negative perceptions members of the community felt towards them. Study outcomes were not disaggregated by gender.

- Empowerment of women with disabilities can facilitate challenging stigma perpetrated against them at all levels, including challenging denial of their rights. Empowerment alone is insufficient to advocate for the removal of structural stigmas and elimination of social stigma. However, increasing participation of women and girls with disabilities in developing interventions and initiatives to tackle structural stigma is fundamental to implement the UNCRPD. Legislation to tackle discrimination, functional systems to report and act on abuse and progressive, inclusive policies are all ways in which structural stigma can be addressed. Moreover, attainment of the Sustainable Development Goals also relies on overcoming stigma that excludes women with disabilities and leaves them behind in development progress.
- In spite of this, multiple systematic reviews criticised the lack of stigma reduction interventions designed or tested to overcome structural stigma and support upholding rights, and lack of evidence on what works.

Challenge #5. There is no evidence on what works to reduce stigma experienced specifically by women and girls with disabilities in LMICs

- Despite strong evidence that women and girls with disabilities often experience multiple layers of stigma, and moderate evidence that stigma is both more common and more isolating in women with disabilities compared with men, there is no evidence of interventions specifically designed to reduce stigma experienced by women and girls with disabilities. This includes a lack of primary research on which to build systematic reviews. Moreover, while we can gain some insight from the limited research base that exists on stigma reduction for all adults or children with disabilities, outcomes for these interventions are rarely disaggregated by gender, preventing any comparison or interpretation of gender differences.
- This evidence gap is reflective of a wider issue in disability inclusive development research, whereby process and outcome evaluations of interventions are infrequently completed or poorly executed, and where large geographical gaps in disability research remain. More, and better, research is needed to build the evidence base on what works to reduce stigma experienced specifically by women and girls with disabilities in LMICs.

How did we find answers

This evidence brief is based on evidence synthesised across two scoping reviews, two systematic reviews, two reviews of systematic reviews and several primary research articles. All literature was specific to LMICs. The evidence reviewed was widened to include stigma reduction strategies for specific health conditions such as mental health, HIV and leprosy, on account of the limited findings related to women and girls with disabilities specifically.

Evidence-informed Recommendations and Actions

Key Recommendations	Actions
Engage directly with women and girls with disabilities and civil society to establish key drivers of stigma across all levels and sources	*Use a conceptual model such as the Health, Stigma and Discrimination Framework to understand how stigma manifests in your setting at different levels and by different sources. Stigma experienced at different levels means stigma at the individual, interpersonal, organisational, community and structural levels. Sources refer to people's behaviours, attitudes or prejudices, and discriminatory or excluding processes, structures, policies and laws. Engage directly with women and girls with disabilities to apply conceptual models to your setting and understand the intersectionality of stigma, and the role of other attributes such as their age, or impairment type, in stigma they experience. This is a crucial first step to developing effective, targeted stigma reduction interventions that will support inclusion of women with disabilities in a given setting.*

Prioritise interventions that empower women and girls with disabilities, decrease internalised stigma and support self-, family and community advocacy	*Pilot test and evaluate interventions that focus on self-advocacy and vocational training, to support women with disabilities in overcoming internalised stigma they feel about themselves, and advocating for their rights and inclusion. Through interventions that support self-advocacy, women with disability can be empowered to challenge discriminatory practices and policies that exclude them and violate their rights, and become active in mitigating stigma perpetrated against them. Develop interventions focused on family and community advocacy, particularly combined with contact interventions and education that encourages positive interactions, increases knowledge and decrease negative attitudes.*
Develop partnerships with research organisations to document what works in reducing stigma against women and girls with disabilities	*Champion participatory research led by women and girls with disabilities, that builds an evidence base on what works. Review interventions from other settings that have shown promising results, and adapt those to your context. Collaborate with researchers to ensure interventions can be robustly evaluated, and resource this adequately to ensure the evidence is valid.*
Take ownership for the removal of structural stigma that excludes women and girls with disabilities and jeopardises implementation of the UNCRPD through developing an evidence-based and well-resourced strategy.	*Establish mechanisms for input from national and regional OPDs, include women-led and youth-led OPDs, civil society and international organisations (UNCRPD Secretariat, UNESCO, WHO) into refinement of legislation to ensure the rights of women with disabilities enshrined in the UNCRPD are met. Establish an evidence-based and well-resourced (including well-budgeted and well-implemented) strategy for the removal of structural stigma experienced by women and girls with disabilities, including developing functional, systems for the reporting and management of discrimination or abuse.*

Policy priorities

A critical recommendation in the literature is the need to invest in stigma reduction against women and men with disabilities, so as to be able to effectively implement the UNCRPD. Investment in establishing the drivers and facilitators of stigma experienced by women with disabilities at all levels and by all sources is required, to challenge and overcome these. Pilot-testing appropriate interventions based on this knowledge, and development of evidence-based policies and scaled-up programmes should be prioritised, particularly to reduce structural stigma.

Conclusion

Despite clear evidence that women and girls with disabilities experience multiple layers of discrimination across LMICs that affect their participation in society, wellbeing and quality of life, there is no evidence on effective strategies to overcome this. Promising interventions are available either from the literature on people with disabilities overall or specific health conditions that can be associated with disability, but much more context-specific primary research is needed to establish and scale up interventions that work for women and girls with disabilities specifically.

Acknowledgements

Included sources

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GAPS & RESEARCH NEEDS

There is a fundamental gap in evidence in this area, requiring further research on intersectional stigma reduction strategies at each level and by different sources. While some intervention types (such as contact and education) show promise across settings, the complex drivers of stigma vary by country and require context-specific solutions and evaluation. A gender lens is required to establish the nuanced intersectionality of stigma experienced by women and girls with disabilities.