Disability Evidence Portal | Evidence Brief

What works to prevent violence among women with disabilities?

The question and the problem

Globally, 1 in 3 women experience physical and/or sexual intimate partner violence (IPV) and non-partner sexual violence in their lifetime. Women with disabilities are more likely to experience all forms of violence compared to women without disabilities and men with disabilities. Recent research from low-and middle-income countries (LMICs) suggests that in particular, women with disabilities are twice as likely to experience intimate partner violence (IPV) compared to women without a disability1. Low education, unemployment, living in poverty, exposure to violence in childhood, unequal power in intimate relationships, and attitudes and norms accepting violence and gender inequality increase the vulnerability of women with disabilities to experiencing IPV and sexual violence. Protecting girls and women with disabilities from all forms of violence and abuse is one of the four targets of the Incheon Strategy goal on ensuring gender equality and women's empowerment. Moreover, experts have emphasised that SDG Goal 5 of 'achieving gender equality and empowering women and girls', will not be met without a multisectoral focus on violence among women with disabilities as a social, economic and human rights concern.

Recommendations

- Recommendation #1: Address the wider social determinants, that put women with disabilities at high risk of experiencing any form of violence
- Recommendation #2: Create a safe and accessible system for reporting all forms of violence as well as offering protection and ongoing support.
- Recommendation #3: Invest in capacity building activities for all relevant stakeholders to promote all types of violence prevention for women with disabilities.
- Recommendation #4: Assign dedicated funding for all types of violence prevention and management strategies among women with disabilities.
- Recommendation #5: Invest in policy analysis and further research to strengthen the evidence base on all types of violence prevention and management interventions for women with disabilities.

"Donors should prioritize disability inclusive IPV prevention programs and provide funding opportunities for disability inclusive program development, costing, provider training, implementation, monitoring and evaluation"

- Stern. 2020

Challenges

Challenge #1: There are numerous drivers and stressors triggering risk of violence among women and girls.

- Women and girls with disabilities face multiple layers of discrimination resulting from gender inequalities, their disability status, and social norms, attitudes, and stereotypes that make them very prone to experiencing violence. Structural factors that can increase risk of violence for women with disabilities include patriarchal privilege (power imbalance between women and men), normalisation and acceptability of violence in social relationships, and poverty that can either individually or collectively influence men to perpetrate violence against women.
- Data from a World Health Organisation (WHO) multi-country study on domestic violence indicates that among women of reproductive age (with and without disabilities), the risk of experiencing IPV increases if they have experienced factors such as witnessing violence against their mother during childhood, their first sexual experience was unwanted or forced, or they report that their partner has behaviour issues (e.g. alcohol use, frequent fights, controlling behaviour).
- Furthermore, women with disabilities on average are less likely to have had access to secondary education compared to those without disabilities. As a result, they often have limited employment opportunities and when employed can face several barriers including discrimination. This can have a big impact on mental health, which further exposes them to sub-standard livelihoods, financial dependence on family members and risk of violence perpetrated against them.
- Unprecedented events like the current COVID pandemic can further directly or indirectly have an adverse effect on individuals and families, causing poor mental health, increased dependencies and loss of housing or livelihoods, which are additional risk factors for IPV that will also affect women with disabilities.

Challenge #2: Women with disabilities do not enjoy their rights to full and effective participation and inclusion in society on an equal basis with others.

- Despite ratifying the United Nations convention on the rights of persons with disabilities, many countries' legislative laws do not adequately recognise the multiple layers of barriers experienced by women with disabilities. As a result, women with disabilities continue to experience discriminatory attitudes and practices that may manifest in violence.
- Data from a multi-country qualitative study conducted with women and men with disabilities in the context of IPV prevention programmes in four LMICs confirmed the existence of disability-related stigma and discrimination; manifested as being blamed and devalued for having a disability, denied access to employment opportunities, and excluded from community interactions. Women with physical impairment frequently experienced stigma due to the visibility of their impairment.
- Women with disabilities experience internalised stigma and discrimination such as feeling of failure for not conforming to the gender norms and social obligations in their communities. This can introduce additional stress in the households, through care and support needs, which in turn can increase their increase of experiencing IPV..
- Stigma and discrimination can lead to underreporting of IPV, with common reasons such as: failure of law enforcement, silencing by communities, fear of repercussions from perpetrators, financial dependence on violent partners, or survivors' empathy for abusive partners. In some situations, stigma enactors in the community can include law enforcement professionals such as police and judiciary staff, meaning that perpetrators of violence escape punishments and women with disabilities' accounts are disregarded4. This further discourages women with disabilities from reporting crimes perpetrated against them.

Challenge #3: Violence is a complex event that needs a multi-sectoral and collaborative approach.

- One review reported that the prevalence of violence was highest among people with mental illness. Another multi-country study reported that although women with disabilities were at increased risk of both physical and emotional types of violence, emotional violence caused mental health issues including anxiety, depression, and suicidal thoughts. Furthermore, the study reported increased risk of IPV with increased severity of disability.
- Evaluation of a social and economic empowerment programme – 'Stepping Stones and Creating Futures,' conducted in South Africa found that the programme had led to a significant reduction in severe physical IPV among women without disabilities, but reported an increase among women with disabilities. The authors explain that women with disabilities may have found it challenging to translate the learnings and experiences from the programme into action in their home lives, particularly those around building respect and authority. This suggests that targeted programmes need to consider wider social dimensions and take a multi-system approach, to avoid further marginalising women with disabilities and adding to their vulnerability.
- In general, programmes that support women experiencing IPV do not fully accommodate the access needs of women with disabilities, further contributing to their exclusion and isolation. Future programmes should be more inclusive and consider accessibility needs related to communication channels, venues, programmes materials and activities.
- Women with disabilities experiencing sexual violence often need several multidisciplinary services such as health, social care, and legal support that may be scattered in different locations. They frequently need to retell their stories of trauma each time they engage with a different service/sector which can contribute to secondary victimisation. One review identified the following barriers to the implementation of a one-stop care model for IPV and sexual violence for women experiencing violence in LMICs: harmful staff attitudes towards women experiencing violence; mistreatment by police; lack of services on night and weekends, out-of-pocket user costs, lack of community awareness; lack of resources including financial constraints; privacy issues and maintaining confidentiality, poor data management system and lack of monitoring and evaluation mechanisms; and weak multi-sectoral networks.

Challenge #4: There are methodological problems in the way that violence data is captured and measured.

- It is recognised that the nature of victimisation and abuse experienced by women with disabilities may be distinct from that experienced by women without disabilities. A recent study reported that among the research participants almost half of the women with disability experienced sexual form of IPV compared to a quarter of the women without a disability. As a first step towards developing an effective violence prevention strategy, it is necessary to define the nature of the problem by identifying the prevalence and risk of violence among women with disabilities specifically. However, available violence data does not adequately capture and measure violence against women with disabilities. For example, prevalence data from cross-sectional studies does not routinely measure or report whether violence or disability occurred first, and large studies on violence do not regularly disaggregate outputs by disability status.
- Prevalence data on disability from household surveys can also underestimate the true prevalence of both disability and of violence. If surveys do not include institutional settings (in which women with disabilities may live), allow for proxy-report (otherwise excluding those who cannot communicate independently) or use stigmatising tools to measure disability (leading to non-disclosure), they may under-estimate disability prevalence. If they do not protect anonymity and safety, women (with and without disabilities) who are dependent on an abuser may also be unlikely to disclose violence, leading to underestimates of violence prevalence.
- Few studies used accepted and validated measurement tools for IPV like the Conflict Tactics Scale or the Women's Experience with Battering Scale. A recent study used a shortened version of the Conflict Tactics Scale (CTS). Although the CTS can capture all types of IPV including physical, sexual, and emotional type of violence it can overlook disability-specific forms of violence experienced by women with disabilities, such as withholding care or assistive devices, and forced sterilisation.
- Although Washington Group Short Set of Disability Questions (WG-SS) is a recommended questionnaire to capture functional difficulties they are limited in their ability to capture disabilities resulting from mental health conditions or chronic illness. Moreover, they do not measure the implications of social contexts and built environments on disability. It is therefore necessary to complement the WG-SS questions with additional mental health questions such as those in the Short-Set Enhanced.

Challenge #5: The evidence base on what works to prevent violence among women with disabilities is sparse.

- The evidence base around effective violence prevention interventions specifically developed for women with disabilities is very limited. One recent study compared the effectiveness of a multi-component IPV prevention intervention related to economic and social empowerment between women with and without disabilities, finding similar benefits between the groups. However, the relative change in some outcomes such as physical violence was quite small among women with disabilities suggesting high rates of violence even after receiving the intervention. The intervention was generic, but there is a need to develop and evaluate violence prevention interventions taking into consideration specific disability issues.
- Further, research participants in violence prevention interventions may not represent all women with disabilities as those with severe disabilities can face exclusion from participation due to barriers in the recruitment and intervention delivery phases. Lack of specific accommodations strategies have been cited as one of the barriers.

How did we find answers

This evidence brief was developed through a review of reviews, peer-reviewed literature, and normative guidelines on the topic of prevention of violence for women with disabilities. The recommendations are universal across all types of violence, including but not limited to IPV. Majority of the resources that focussed specifically on women with disabilities in LMICs came from the What Works to Prevent Violence Against Women and Girls Global Programme. Additionally, we referred to the recent WHO report on violence against women prevalence estimates; and the following systematic reviews – Mikton 2014 (persons with disabilities); Semahegn 2019 (gender-norms interventions against women in LMICs); Olson 2020 (One stop centre model for IPV in LMICs); and Thurston 2021 (Violence against women in disaster settings).

Evidence-informed Recommendations and Actions

Key Recommendations	Actions
Address the wider social determinants, that put women with disabilities at high risk of experiencing any form of violence, including harmful gender attitudes, beliefs, norms, and stereotypes.	*Promote gender equality and eliminate discrimination based on both gender and disability. At the macro level, strengthen national policies by ensuring they fully align with the UNCRPD framework. Ensure that the needs and perspectives of women with disabilities are taken into consideration and that the programmes are well-funded, and have clear benchmark outcome indicators.* *At the meso-level, target community- and society-level factors including harmful gender attitudes, beliefs, norms, and stereotypes that uphold male privilege and female subordinates, that justify violence against*

	women, and that stigmatise those experiencing violence through public campaigns, and community mobilisation programmes.
Create a safe and accessible system for reporting all forms of violence as well as offering protection and ongoing support.	*Support free helplines to provide information on women's rights and access to relevant services and ensure that these are fully accessible for women with different types of functional limitations. Develop relevant alternatives to telephone-based phone lines so that women with hearing or communication limitations can still access help.* *Offer confidential advice and guidance regarding access to relevant services to seek protection, and ongoing support including legal challenges.* *Put in place a system for women with disabilities to register complaints against government agencies and services providers for their inactions.*
Invest in capacity building activities for all relevant stakeholders to promote all types of violence prevention for women with disabilities, including but not limited to IPV.	*Build capacity of organisations for persons with disabilities (OPDs); agencies such as local police, and courts; and service providers (such as health centres and hospitals) to increase their understanding of the rights of women with disabilities'.* *Offer gender sensitisation courses to the wider community through community action initiatives and workshops on basic gender concepts such as gender and power in the division of labour, in communications, in accessing and controlling resources, disability issues, and gender-based violence. Aim to achieve equitable gender attitudes among men and family members through gender transformation training that challenge gender roles and practices and the acceptability of violence.* *Design programme materials and strategies in collaboration with women with disabilities and the their representative organisations. Offer disability awareness training to women with disabilities, programme staff, and service providers. Provide opportunities for women with disabilities to develop leadership qualities such as resilience, self-determination, and motivation to apply for leadership roles like community activist.*
Assign dedicated funding for violence prevention and management strategies among women with disabilities.	*Intensify commitments to promote the rights of women with disabilities as well as address the intergenerational transfer of deeply rooted cultural-norms that support male dominance and gender inequality. Dedicated funding should be allocated for actions to eliminate all forms of violence through enhancing capacity building, improving the evidence-base, and leveraging partnerships and collaborations.* *Offer effective multicomponent interventions including sexual health and social empowerment (SHSE); SHSE and Economic empowerment; and Economic and Social empowerment programmes that have been shown to be effective for reducing violence among women in LMICs.* *Use group-based participatory approaches such as role-playing, and facilitated discussions and workshops to support skill building as well as encourage engagement of the participants with intervention components. Vocational skill training needs to consider contextual factors such as social norms and accessibility, for example, occupations that can be undertaken from home such as sewing and knitting may be more acceptable to women living in a conservative community that impose travel restrictions due to social norms.* *Offer social empowerment programmes for married women comprising of couple intervention. Specific components include focussing on resolving conflict around money, trust, mutual respect, and autonomy.* *Group-based empowerment training should be offered to both women with disabilities and their care-givers/families to address the underlying expectations about inequitable gender roles and behaviour, and to support the development of communication and conflict-resolution skills. This opportunity to experience social support have been found to have a positive effect on women's mental health outcomes.*
Invest in policy analysis and further research to strengthen the evidence base on all types of violence prevention and management interventions for women with disabilities.	*Collaborate with academic researchers to undertake methodological research to identify specific accommodation needs to address barriers experienced by women with varying types of disabilities, for e.g. accessibility* *Monitor, evaluate, and disseminate the data about the inclusion and accessibility of women with disabilities in IPV programmes.*

	Use standardised outcome measurement tools on both violence (e.g. WHO Multi-country Study on Women's Health and Domestic Violence against Women) and disability (e.g. Washington Group on Disability Statistics – Short Set enhanced) to quantify the prevalence, magnitude, and forms of violence against women with disabilities. Aim to gather disability-specific information related to IPV, such as withholding care or assistive devices, and perpetrators of violence such as personal aides. Data on violence should be disaggregated by disability status and other relevant characteristics and reported using standardised outcome indicators such as the one developed by the ESCWA. *Assess the effectiveness of multicomponent interventions including sexual health and social empowerment (SHSE); SHSE and Economic empowerment; and Economic and Social empowerment programmes in women with disabilities using robust methods such as cluster-randomised controlled trials, advanced matching techniques, regression discontinuity designs, or interrupted time series to establish causality between the intervention and outcome of interest.* *Further develop guidelines for context-specific, disability-inclusive development, implementation, and evaluation of IPV prevention and response efforts. Use the RESPECT women framework for designing prevention programmes, identifying entry points and evidence-based strategies, and monitoring progress. Pay particular attention to the intersectorality aspect of gender and disability, and adopt a multisectoral and collaborative approach including women with disabilities and women's rights organisations in the development, implementation, monitoring, and evaluation of the programmes.*

Policy priorities

Policies and programmes to eliminate violence against women and girls need to adopt a multi-dimensional approach involving women with disabilities and their associated organisations, policymakers, the wider community including partners and family members, and academic researchers. Programmes should target the wider factors that affect risk of violence, including resources (e.g. self- and community awareness about women with disabilities' rights to equal opportunities in all spheres of life) and structural elements (e.g. social norms and attitudes that allow perpetrators to commit violence and /or lead to discrimination). This requires capacity building to increase the skills and knowledge of all the relevant stakeholders so that they can contribute to the design, implementation, monitoring, and evaluation of violence prevention programmes. In addition to focussing on violence prevention, there is a need to focus on programmes for women with disabilities experiencing violence. This can include among other strategies a safe system for women with disabilities to report violence as well as efficient mechanisms that ensures safety, considers the immediate health and social needs, and offers need-based social and legal protection system. Although there is some evidence of social and economic empowerment programmes, couple interventions, and target community action interventions for the reduction of violence against women, there is a need to develop further interventions that consider the specific needs and challenges experienced by women with disabilities. Alongside, further work should be undertaken to explore the impact of promising interventions for women in LMICs.

GAPS & RESEARCH NEEDS

Future research should consider twin-track programme where women with disabilities have an opportunity to participate in mainstream violence prevention programme as well as disability-specific programme or targeted components of programmes. The former can provide a platform to challenge disability-related stigma and discrimination while the latter can take into account potential risk factors specific to women with disabilities such as disability-related stigma (internalised or external), and accessibility of reporting services.

Conclusion

Women with disabilities are at greater risk of experiencing violence including intimate partner violence and sexual abuse compared with both women without disabilities and men with disabilities. However, there is lack of evidence on effective interventions to prevent violence in women with disabilities. This highlights the need to invest in further developing the evidence-base on violence prevention interventions for women with disabilities. At the same time, governments should intensify their commitment to eliminate all forms of violence against women with disabilities by increasing their funding to build capacity and adopt a multisectoral and collaborative approach to implement effective interventions such as group-based social and economic empowerment programmes.

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