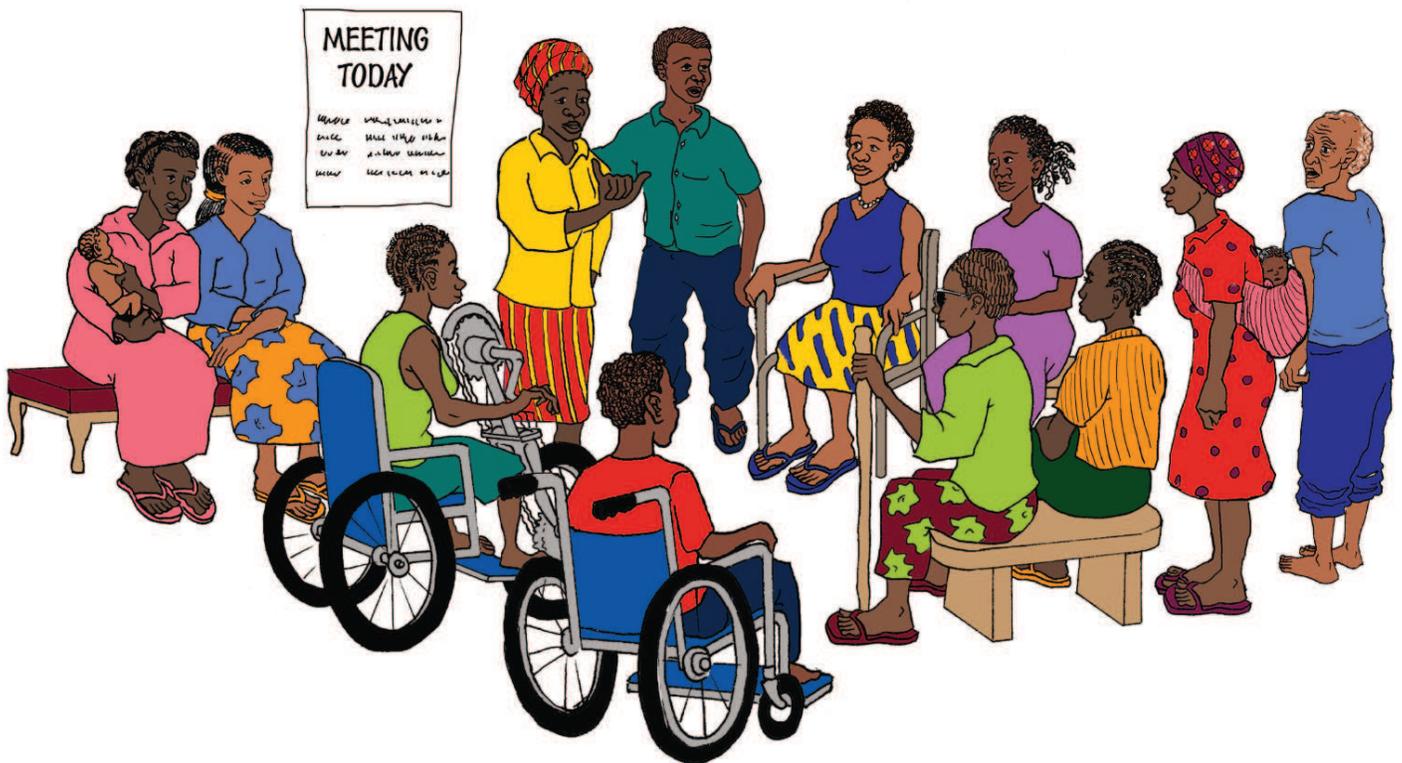


Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

A Toolkit for GBV Practitioners



Acknowledgements

The Women's Refugee Commission (WRC) works to improve the lives and protect the rights of women, children and youth displaced by conflict and crisis. WRC researches their needs, identifies solutions and advocates for programs and policies to strengthen their resilience and drive change in humanitarian practice.

The International Rescue Committee (IRC) helps people whose lives and livelihoods are shattered by conflict and disaster to survive, recover and gain control of their future. IRC teams provide health care, infrastructure, learning and economic support to people in 40 countries, with special programs designed for women and children.

The GBV and Disability Toolkit was developed by the Women's Refugee Commission (WRC) and International Rescue Committee (IRC). It is one of the outputs of a two-year project entitled *Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings*. The project was conducted in humanitarian settings in four countries – Ethiopia, Burundi, Jordan and the Northern Caucasus in the Russian Federation – with the goal of identifying barriers and piloting approaches to disability inclusion in GBV programming in humanitarian settings. (For more information about the project, including related publications, visit: http://wrc.ms/disability_GBV)

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Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

A Toolkit for GBV Practitioners

Overview

Introduction

Approximately 15 percent of any community may be persons with disabilities.¹ These rates may be higher in communities that have fled conflict or disaster, as during crisis people may acquire new impairments and have limited access to medical treatment.

Persons with disabilities are among the most vulnerable and socially excluded groups in any crisis-affected community. They may have difficulty accessing humanitarian assistance programs due to a variety of societal, environmental and communication barriers,² increasing their protection risks, including to gender-based violence (GBV).³ For women and girls with disabilities, the intersection of gender inequality and disability makes them especially vulnerable to GBV. In addition, social norms often designate women and girls to be caregivers of people with disabilities, which can reinforce their isolation and further limit their access to social, economic and material support, increasing their vulnerability to violence and exploitation.

There has been a tremendous amount of advocacy to make GBV programs and services integral to humanitarian response from the earliest stages of an emergency. Yet, where these exist, persons with disabilities and their caregivers face particular barriers to accessing those services. They may be isolated in their homes, overlooked during needs assessments and not consulted in the design of programs. Persons with disabilities and caregivers, particularly women and girls in recognition of their increased exposure to violence, have a right to protection in situations of humanitarian crisis, and should be able to access services and participate in GBV programs on an equal basis with others.⁴

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This toolkit was created with the input and participation of persons with disabilities, as well as GBV practitioners, over the course of the project. It is intended to support GBV staff to build disability inclusion into their work, and to strengthen the capacity of GBV practitioners to use a survivor-centered approach when providing services to survivors with disabilities. The tools are designed to complement existing guidelines, protocols and tools for GBV prevention and response, and should not be used in isolation from these. GBV practitioners are encouraged to adapt the tools to their individual programs and contexts, and to integrate pieces into standard GBV tools and resources.

Contents of the Toolkit

Section 1: Disability inclusion in GBV program planning. These tools can help GBV practitioners to consult with persons with disabilities and their caregivers in the design of programs and services.

Tool 1: Guidance on including persons with disabilities and caregivers in GBV assessments

This guidance note describes the general principles and approaches to conducting assessments with persons with disabilities and their caregivers in humanitarian settings.

Tool 2: Group discussion guide

This tool describes participatory activities and questions to be used in group discussions with persons with disabilities and caregivers.

Tool 3: Individual interview tool

This tool provides an alternative to group sessions. It can be used for one-on-one interviews with persons with disabilities and caregivers who are isolated in their homes, and with people who may prefer one-on-one communication in a familiar environment.

Section 2: Disability inclusion in GBV program implementation. The tools in this section focus on building the capacity of GBV program staff to work with people with disabilities and their caregivers.

Tool 4: Gender-based violence and disability: A training module for GBV practitioners in humanitarian settings

This training module is designed to support GBV practitioners to understand the intersections between disability, gender, and violence in the communities where they work, and to develop strategies to improve the inclusion of persons with disabilities in GBV prevention and response programming.

Tool 5: Pre- and post-training test for the GBV and disability training module

This test can be used with GBV practitioners to identify changes in their knowledge and attitudes relating to disability inclusion, and is accompanied by an answer key for scoring the tests. It should be used in conjunction with the GBV and disability training module.

Tool 6: Guidance on communicating with people with disabilities

This tool provides simple tips and advice for GBV practitioners on interacting and communicating with persons with different types of impairments.

Tool 7: Accessible information, education and communication (IEC) materials

This tool provides five key questions to ask when developing IEC materials to ensure they are disability-inclusive, with a practical example from a refugee setting.

Tool 8: Guidance for GBV caseworkers: Applying the guiding principles when working with survivors of disabilities

This tool has been developed to support GBV practitioners in adapting a survivor-centred approach to working with survivors with disabilities.

Tool 9: Guidance for GBV service providers: Informed consent process with adult survivors with disabilities

This tool outlines general principles and steps for obtaining informed consent with adult survivors with disabilities.

Tool 10: Working with caregivers of survivors with disabilities

This tool offers guidance on how to approach working with caregivers of survivors with disabilities to ensure all needs are met and positive relationships are strengthened.

Section 3: Monitoring and evaluating disability inclusion in GBV programs. These tools have been developed to help GBV staff monitor their progress with disability inclusion.

Tool 11: Reflection tool for GBV practitioners

This participatory activity supports GBV practitioners to reflect on changes in their attitudes, knowledge and practices relating to disability inclusion, as well as to identify successes and set goals for further capacity development.

Tool 12: Documenting “stories of change”

“Stories of change” help identify what activities have been most important to women, men, girls, and boys with disabilities and their caregivers, the facilitators and barriers to their inclusion, and their suggestions for change.

Additional Tool: Identifying skills and capacities of persons with disabilities

This tool has been developed by the WRC to support GBV practitioners to identify the skills and capacities of persons with disabilities that may be useful in both case management with survivors and supporting participation in empowerment activities.

What to keep in mind when using the Toolkit

- **These tools are intended to complement, not replace, existing resources for GBV program design, implementation, and monitoring and evaluation.** For example, *Researching Violence Against Women: A Practical Guide for Researchers and Activists* (http://www.path.org/publications/files/GBV_rvw_complete.pdf) provides extensive guidance on conducting focus groups and one-on-one interviews, as well as on how to analyze and utilize data.
- This Toolkit provides general guidance on working with people with different types of disabilities. Every individual, however, will have different needs. These resources should thus be seen as a starting point in supporting GBV practitioners to consult with persons with disabilities and their caregivers, and to consider their needs when designing and carrying out programs.
- As with any global resource, these tools should be adapted to fit the local context. The experience and expertise of the local population should be the starting point for implementing any of these resources.

Notes:

1. World Health Organization & The World Bank (2011). *World report on disability*. Geneva: WHO.
2. Women’s Refugee Commission (2008). *Disabilities among refugees and conflict-affected populations*.
3. Women’s Refugee Commission (2014). *Disability inclusion: Translating policy into practice in humanitarian action*.
4. United Nations (2006). Convention on the Rights of Persons with Disabilities.

To download the complete *Toolkit for GBV Practitioners*, the report “*I See That It Is Possible*”: *Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings*, and *Stories of Change*, visit http://wrc.ms/disability_GBv

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 1: Guidance on including persons with disabilities and caregivers in GBV assessments

Purpose of this guidance note

This document provides an overview of the process and tools to use when conducting an assessment with persons with disabilities, particularly women and girls with disabilities, and their caregivers about the risks of GBV in their communities, potential barriers to accessing response services and participating in programs and activities, and their suggestions for improving GBV programs. The guidance note should be read before implementing [Tool 2: Group discussion guide](#) and [Tool 3: Individual interview guide](#). This assessment process and tools are designed to complement other GBV assessments conducted in humanitarian contexts. Examples of standard tools for GBV emergency assessments in crisis-affected communities are available from the GBV Responders' Network at: <http://gbvresponders.org/>

Who do we want to consult?

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

- those with difficulty moving and walking (since birth or due to an impairment acquired later in life);
- those with difficulty seeing, even when wearing glasses;
- those with difficulty hearing, even when using hearing aids;
- those with intellectual disabilities who may have difficulty understanding, learning and remembering new things;
- those with mental disabilities and mental health conditions;
- those with multiple disabilities, who are often confined to their homes and who may need assistance with personal care.¹

In GBV program assessments, it is particularly important to consult with women and girls, including those with disabilities and those who are caregivers, to understand their needs, perspectives and priorities. Women and girls often take on the role of caregiver for family members with disabilities, in addition to their other roles and responsibilities. Women and girls may have been caregivers prior to becoming displaced, or could find themselves in this new role when a family member acquires a new disability during a humanitarian emergency. Caregivers may be isolated and at greater risk of violence, both inside and outside the home. They are important to include in consultations so that their perspective and needs are taken into account.

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

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

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

Before carrying out your assessment:

- Read and become familiar with the WHO *Guidelines on Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*.² Ensure that all staff understand the principles of this document and are able to incorporate them into the assessment process.
- Identify and mitigate risks that may arise from your consultations. Before recruiting participants, meet with community leaders and/or local government representatives to explain the purpose of the assessment. Where possible, link with leaders of local women's groups and leaders of groups for persons with disabilities — both formal and informal — during participant mobilization. Careful consideration should be taken when talking with caregivers, as they may be perpetrators of violence, which will limit the participation of survivors being consulted while their caregiver is present, or may expose survivors to further risk.
- Emphasize that participation is voluntary. Persons with disabilities and caregivers can choose not to participate or can withdraw at any point during the consultations. Watch for signs that persons with communication difficulties are not comfortable participating in an activity (e.g., becoming distressed or agitated or start crying), particularly when you are talking with their caregiver.
- Get consent for participation. As with all activities, GBV staff should obtain consent from individuals before they participate in the assessment. Persons with disabilities and caregivers should be briefed on why you are undertaking these consultations. They should also know how you will use or share the information they provide. If participants do not wish to participate or to continue with the consultation once it has started, it should not affect the services they are already receiving or their opportunity to seek GBV services in the future. For interested participants under the

Tool 1: Guidance on including persons with disabilities and caregivers in GBV assessments

age of 18 years (e.g., adolescents with disabilities and their siblings), consent should also be sought from their parent or guardians. Processes of seeking consent should follow the principles and guidance in the WHO Guidelines, in accordance with age and developmental levels. Some adults with intellectual disabilities may choose to have a trusted caregiver, family member or friend participate with them in the consent process and/or the consultation. They should be asked in private and in advance if this is the case.

- Be clear and up front with participants about the purpose of the consultation and what services your organization can and cannot provide. Participants should understand that the purpose of the consultation is to better understand how persons with disabilities and their caregivers can be included in *existing* GBV activities and how survivors can access *existing* services. The consultation not will lead to the creation of *new* services.
- It may take time for persons with disabilities, particularly women and girls, to share their perspectives with you. They may have never participated in an activity like this before, and may not be used to people asking for their opinions. It may also take them time to feel safe and comfortable. If this is the case, try talking with them through a series of meetings, using different approaches, such as participatory activities, group discussions or more private interviews (see *Tools 2* and *3* for related guidance). Start discussions with general topics and move towards more sensitive topics as the participants become more comfortable. Guide group discussions towards general, rather than personal conversation, so people do not feel pressure to disclose their own experiences of violence.
- Be sure another trained staff member is available to speak privately with participants who require additional psychosocial/emotional support and/or referrals to other services. The staff member should have experience working with survivors of GBV.
- Be flexible about when and where consultations take place. The assessment team should try as much as possible to accommodate persons with disabilities by holding consultations as near to their homes as possible – always prioritizing the safety of the participants.
- Make sure that caregivers are included in the assessment. They should be consulted separately about their own experiences and needs.

Group discussions

Group discussions are best conducted with 8-10 participants and should not be longer than 90 minutes. If groups take longer than this to complete all activities in the Group Discussion Guide (see [Tool 2](#)), you may wish to conduct Parts A and B on one day, and Parts C and D another day, if participants are willing and able to return.

Group discussions should be conducted separately with men and women to gather in-depth information about their specific and varied needs. Women should lead the discussions with other women to ensure the space is comfortable and safe and that participants feel free to express themselves, including to talk about the violence they are exposed to, in line with WHO Guidelines on assessments related to violence.

Persons with different types of disabilities can participate in the same group discussion, according

Tool 1: Guidance on including persons with disabilities and caregivers in GBV assessments

to their communication skills and abilities. Separate and/or specific groups may be necessary to facilitate effective participation of the following groups:

- adolescent girls and young women with disabilities;
- people who are deaf and use sign language to communicate;
- persons with intellectual disabilities who might prefer to use drawing, stories or photos to stimulate discussion. In such cases, smaller groups (4-6 participants) may be necessary.

In some settings, it might be most effective to have a separate group for people with new disabilities (e.g., acquired through war injuries) to explore their specific concerns. It may also be helpful to run separate, parallel discussions or activities with caregivers and persons with disabilities, in the same or a nearby venue. This can create a safe space for each group to explore their different concerns, may decrease the demands on caregivers who now would not need to come on multiple days, and increase the participation of people who are not used to being separated from their caregivers.

See [Tool 2: Group discussion guide](#)

One-on-one semi-structured interviews

One-on-one semi-structured interviews may be used for persons with disabilities and their caregivers who are isolated in their homes, and those with mental disabilities who prefer one-on-one communication in a familiar environment. Wherever possible, interviews should be conducted directly with individuals with disabilities, but they can also choose to have others present to support their participation. In some cases, where no method of communication can be established, information can be collected from caregivers. Risks need to be weighed according to the principles laid out in the WHO Guidelines, and the interview may need to be reconsidered. The *Individual interview guide* (see [Tool 3](#)) will help you to identify other information that might be helpful in program design and implementation.

See [Tool 3: Individual interview guide](#)

Notes:

1. Adapted from the Washington Group Questions on Disability. http://www.cdc.gov/nchs/washington_group/wg_questions.htm
2. <http://www.who.int/reproductivehealth/publications/violence/9789241595681/en/>

To download the complete *Toolkit for GBV Practitioners*, the report “*I See That It Is Possible*”: *Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings* and *Stories of Change*, visit http://wrc.ms/disability_GBV

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 2: Group discussion guide

Purpose of this guidance note

This tool provides guidance on conducting group discussions and includes a set of discussion questions.

Composition of groups

Group discussions should be conducted with men and women separately to gather in-depth information about their specific and varied needs. Women should lead the discussions with other women to ensure the space is comfortable and that participants feel free to express themselves, and to ensure that women are safe to talk about the violence they are exposed to, in line with the WHO *Guidelines on Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*.¹ Persons with different types of disabilities can participate in the same group discussion, according to their communication skills and abilities. Separate and/or specific groups may be necessary to facilitate effective participation of the following groups:

- adolescent girls and young women with disabilities;
- people who are deaf and use sign language to communicate;
- persons with intellectual disabilities who might prefer to use drawing, stories or photos to stimulate discussion. In such cases, smaller groups (4-6 participants) may be necessary.

In some settings, it might be most effective to have a separate group for people with new disabilities (e.g., acquired through war injuries) to explore their specific concerns. It may also be helpful to run separate, parallel discussions or activities with caregivers and persons with disabilities in the same or a nearby venue. This can create a safe space for each group to explore their different concerns, may decrease the demands on caregivers who now would not need to come on multiple days and increase the participation of people who are not used to being separated from their caregivers.

Timing of groups

Group discussions are best conducted with 8-10 participants and should not last longer than 90 minutes. If groups take longer than this to complete all activities in the Group Discussion Guide (see below), you may wish to conduct Parts A and B on one day, and Parts C and D another day, if participants are willing and able to return.

Tool 2: Group discussion guide

Facilitation

Facilitation of groups will require at least one person to lead the discussion and one person to take notes. As much as possible, group discussions with women and girls should be facilitated by women (this includes the person leading the discussion, the note-taker and the translator) and group discussions with men and boys should be facilitated by men. The question guide should be shared with translators in advance so they are familiar with the questions that will be asked and, if possible, should be back-translated so that you are sure their understanding of the questions is accurate.

It is important that everyone in the group have the opportunity to speak. This may mean that the facilitator interrupts or redirects the discussion and encourages participation to make sure everyone has the chance to say what they want.

At the end of the Discussion Group Guide, there is a Group Documentation Form, which should be completed for every group. It includes a place to record the composition of the group and the date, and space for the note-taker to document the discussion.

GROUP DISCUSSION GUIDE

Instructions

- Introduce all facilitators and translators.
- Present the purpose of the discussion:
 - » Give general information about your organization.
 - » Explain that the purpose of the meeting is to understand the safety and security concerns of persons with disabilities and their caregivers, and the particular risks of women and girls. This information is important to improve their participation and access services in the community.
 - » Explain what you will do with this information and make sure that you do not raise false expectations.
- Remind participants that:
 - » Participation is voluntary.
 - » No one is obligated to respond to any questions if they do not wish.
 - » Participants can leave the discussion at any time.
 - » It is not essential that participants share personal experiences if they do not wish.
- Explain confidentiality. It is important that participants understand how the information they provide will be kept confidential. All participants in the group should understand the following:
 - » Names or personal information that will identify individuals should not be shared in the group.
 - » The details of what participants in the discussion have said should not be shared with others in the community.
 - » Remind participants that the reason we want to keep these conversations confidential is so everyone feels safe in the discussion space and will be safe when they leave.
- Explain that someone will be taking notes to ensure the information provided is accurately documented. All participants in the group should understand the following:
 - » The identity of participants will not be documented or shared.
 - » The purpose of the notes is to ensure that the information collected is not misrepresented and important points are not missed.
 - » If they do not want something to be written down, they should let the facilitator know.

Tool 2: Group discussion guide

Questions and participatory activities

The discussion guide is broken down into four parts, representing key assessment areas. Each part comprises several questions that can be answered through activities or discussion.

Part A: The intersection of disability and gender (30 minutes)

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

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

Facilitation:

- Ask everyone to draw a picture representing the different types of disabilities they know exist in the community. Stick these on the wall or draw them in the sand. Alternatively, you can use your own pictures of persons with different types of disabilities and ask people to identify which ones are most common in their community.
- Ask the group to talk about persons who are isolated in their homes, or those with more “hidden” disabilities, like intellectual or mental disabilities.
- Ask the group: Do women and girls have disabilities that are different from men and boys?

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

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

Facilitation:

You can use pictures of women and men with disabilities undertaking different roles in the community to stimulate the discussion. See pictures in [Tool 4: GBV and disability: A training module for GBV practitioners in humanitarian settings](#).

- Begin by asking the group:
 - » What tasks or roles are women with disabilities expected to undertake in the community? What about men?
 - » Is it expected that women with disabilities will also undertake the tasks expected of women without disabilities? Why or why not?
 - » Is it expected that men with disabilities will also undertake the tasks expected of men without disabilities?
 - » How might the spouse or family treat a woman with disabilities if they are unable to undertake these roles? How might the community treat women with disabilities if they are unable to undertake these roles? How would they treat men with disabilities if they are unable to undertake these roles?

Part B: Safety and security of women and girls with disabilities (30 minutes)

Facilitation:

- Begin by explaining that “we would now like to ask you a few questions about the safety and security of women and girls with disabilities in the community.”
 - **Use pictures of places in the community or ask participants to draw a map of the general area, camp or site.** Maps can be created on paper with colored pens or in the dirt/sand using natural materials such as sticks and pebbles. Make sure that they include common places where women and girls spend time throughout the day or gather for social reasons (e.g., home, school, market or community spaces).²
1. Ask the group to select the places where women go to meet each other. Ask the group to select the places where girls go to meet each other.
 2. Ask the group “Do women and girls with disabilities also go to these places where their peers are going? Why/Why not? What types of barriers do they experience? Are these barriers different depending on the type of disability?” (e.g., physical versus intellectual disability). Be sure to ask this question for women and girls separately. Do not put them together in a single question.
 3. Ask the group: “In this community, where do women with disabilities feel safe? Where do they feel unsafe or avoid going? What makes this place safe or unsafe?” Refer to the map or drawings as appropriate. Repeat the questions asking about girls.
 4. Ask the group: “Can you describe the kinds of violence women with disabilities face in the community? What about girls with disabilities? How does it differ according to the type of disability?” (e.g., physical versus intellectual disability).
 5. Ask the group: “What happens to the people who commit these acts of violence against women and/or girls with disabilities? Are they punished? If so, how?”
 6. Ask the group: “How does the family respond to a woman with disabilities who has been raped or sexually assaulted? How do they support her? What about for girls with disabilities?”
 7. Ask the group: “What do women and girls with disabilities do to protect themselves from violence? What support systems do they have? What does the community do to protect them?”

Part C: Services in the camp for survivors with disabilities (15 minutes)

Preparation:

Develop short, contextually appropriate case studies about gender-based violence (GBV) committed against persons with disabilities. Use these to guide the questions below. It is important that these case studies are not linked to a specific story or person from the community. A few sample case studies are provided here, but they should be adapted to your context.

Sample Case Study 1: A young girl who is deaf and can’t speak left her shelter during the night to use the latrine. When she exited the latrine, a man grabbed her, pulled her behind the latrines and raped her.

Sample Case Study 2: A single woman has difficulty moving and is unable to work. One day a man comes to her and offers her help. She takes his food and money. After a week, he says that he will no

Tool 2: Group discussion guide

longer help her unless she has sex with him. At that time, she has sex with him.

Sample Case Study 3: A man with intellectual disabilities is living with his sister and brother-in-law. His sister frequently tells him that he is “useless” and a burden on the family. He tries to help by doing household chores, but other men sometimes tease him when they see him doing these activities.

Facilitation:

Begin by explaining to the group, *“We would like to ask you some questions about the services and assistance available in the camp for people with disabilities who experience violence. We are going to begin by sharing a fictional scenario with you, and we will ask you some questions.”*

Read the first case study aloud and ask the questions below. When finished, ask the same questions using a second case study.

1. Ask the group: “If the person with disabilities in the story reported that she/he experienced this type of violence, how do you think people would respond?”
2. Ask the group: “Do survivors with disabilities share experiences like this with other people? What makes it difficult for them to do so?”
3. Ask the group: “Where could this person go to receive appropriate assistance? What kind of assistance and support could the survivor receive?”
4. Ask the group: “Is it likely that this survivor would seek such assistance? What might prevent her/him from seeking assistance?”

Part D: Inclusion of people with disabilities in GBV programming (30 minutes)

Guiding question 1: *What can be done to prevent violence against people with disabilities?*

Facilitation:

- Ask the group: “What could be done in this community to create a safe environment for persons with disabilities?”

This question can be asked about women with disabilities, girls with disabilities and specifically about those with intellectual and mental disabilities. Refer back to the community map to ask about ways to make specific places safer and more inclusive for these different groups.

- Ask the group: “Who is aware of services that help to respond or reduce gender-based violence in this community?”

Guiding question 2: *What are the barriers survivors face to accessing services or participating in activities?*

Facilitation:

- Describe the activities your organization and other organizations run that help to prevent or respond to gender-based violence.
- You may want to use photos to describe these activities.
- This can be followed by additional questions:

- » “How many of you were aware of these activities before the group discussion?”
- » “How did you know that these services existed? How did you get the information?”
- » “What helps persons with disabilities to access these services (facilitators)? What prevents persons with disabilities from accessing these services (barriers)?”

Guiding question 3: *What skills and capacities can persons with disabilities contribute?*

Facilitation:

Split the group into pairs to discuss:

- One activity that I would like to participate in the future.
- One thing that I am good at.
- One thing I can contribute or share with others.

Each person presents to the facilitator what the other shared. This can be done through speech, drawing or even acting and is a good activity to engage persons with disabilities in program improvement.

Conclude the discussion

- Thank participants for their time and their contributions.
- Remind participants that the purpose of this discussion was to better understand the needs and concerns of persons with disabilities, particularly women and girls.
- Repeat what you will do with this information and what purpose it will eventually serve.
- Remind participants about keeping discussions confidential, particularly if people described any personal experiences.
- Remind participants not to share information or the names of other participants with others in the community.
- Ask participants if they have questions.
- Make the participant aware of the services and activities available through your organization.
- If anyone wishes to speak in private, explain that you or someone else will be available after the meeting.

See next page for group discussion documentation form.

Notes:

5. <http://www.who.int/reproductivehealth/publications/violence/9789241595681/en/>
6. See Community Mapping Guidance Note in the GBV Emergency Toolkit http://www.gbvresponders.org/filedepot_download/26/82

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Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 3: Individual interview tool

Purpose of this tool

This tool provides guidance on how to gather information from a community member with a disability who may not be able to participate in a group discussion. The tool includes questions to guide the interview and an observation checklist to help the interviewer get a sense of the environment in which the person lives.

Location of the interview

It is critical to prioritize safety when conducting an individual interview. While the purpose of individual interviews is to reach those who may not be able to participate in group discussions, that does not necessarily mean the interview should take place in the person's home. When arranging an individual interview, the interviewer should ask the individual whether they prefer the interview be conducted in their home, or if they would feel more comfortable in another location. This may mean delaying or rescheduling the interview until you can identify a safe, quiet space and help the person get to the location.

Length of the interview

Individual interviews should not be longer than one hour total. Given the time required to properly initiate the interview (i.e., introduce yourself, get informed consent) and to conclude the interview appropriately, the time the interviewer has for the discussion itself is closer to 45 minutes. It is important to be mindful of this so that you can pace the interview and prioritize questions accordingly.

Instructions

Identify and approach the person with a disability, and introduce yourself. Greet them in the same way that you would greet others in your community. Talk to the person directly to try to establish an optimal method of communication. This includes asking them which mode of communication will be best for them. Ask if they would like to participate and whether they feel safe doing so, and watch for any signs that they not want to or do not feel safe participating. If this is the case, do not proceed — the interview should be stopped immediately.

If the individual has shown interest and consents to participate, present the purpose and ethical guidelines that will be followed during your visit:

- Provide general information about your organization.
- State that the purpose of the meeting is to understand the safety and security concerns of persons with disabilities and their caregivers, and how we can improve their access to programs and services in the community.
- Explain what you will do with this information, and make sure you do not raise any false expectations.

Tool 3: Individual interview tool

- Explain that participation is voluntary.
- Explain that no one is obligated to respond to any questions if they do not wish.
- Explain that no one is obligated to share personal experiences if they do not wish.
- Explain that if they don't wish to continue with the interview, it can be stopped at any time. It should be explained that this will not affect the services that they are already receiving or their opportunity to seek services in the future.

For people with limited communication abilities, ask the caregiver (if present): **How does [state the name of the person] tell you that she/he is unhappy or uncomfortable with something? What makes her/him happy or sad?** Use this information to facilitate the interview if verbal communication is not possible and respect any indications that the participant is not comfortable or willing to continue.

You can also ask the person if they are comfortable with you asking questions to the caregiver. If this option is pursued, the individual should be able to hear the discussion, and continue to be engaged and contribute in whatever way possible. It will be important to support the caregiver to use language that will not harm or disempower the person with a disability. If this happens, help to rephrase the conversation so that the individual is talked about in a more positive way. For example, you might use the term “has a disability” rather than “suffers from disability.” It is also important to remember that the caregiver will often give different information than the individual would, and thus talking with them not a substitute for talking with the individual. As always, respect any indications that the participant is not comfortable or does not want the interview to continue. If this is the case, the interview should be stopped immediately.

Interview questions

1. Tell me a bit about yourself. **Additional prompts:** What kind of things do you enjoy doing? How long have you been living here? Who lives in your household?
2. What kind of community activities do you participate in? **Additional prompts:** Ask about education, women’s groups, health and livelihoods activities, as appropriate. What things do you like about these activities? What things do you find difficult about these activities?
3. Are there any places or activities in the community where you feel uncomfortable or unsafe? What makes these places uncomfortable or unsafe for you?
4. Are there any places or activities in the community where you feel most comfortable or most safe? What makes these places comfortable or safe for you?
5. Do you have contact with other women and girls your age? If so, who provides you support? Where do you go to meet them? If not, what are the challenges to meeting and socializing with other women and girls?
6. Where do you go or who do you talk to if you have problems and concerns? **Additional prompts:** Where do people go if they have experienced some kind of sexual abuse or exploitation? Have you heard about services for survivors who have experienced sexual violence? When do people decide to go to these services? Do people with disabilities have difficulty accessing these services?
7. Are there any services or programs for women/girls in the community that you would like to access or participate in? What has prevented you from accessing these services or activities in the past? How could we help you to participate in this activity or access this service? **Additional prompts:** Ask about different GBV prevention activities that are running in the community – like women’s groups, SASA! activities, awareness-raising, campaigns and trainings.

Observation checklist

During an individual interview, it can be useful to make some notes about what you observe about the individual and their environment. This can help to determine other things in the participant's home life and relationships that may affect their health, safety and well-being. It can also help to identify additional needs, concerns and ways to support the person with a disability to participate in your program and access your services.

The questions below may be useful for guiding your observations.

Communication
How does the person communicate? Watch other family members to see how they interact with the person. Do they use speech, writing or gestures?
Physical
Describe the person's personal appearance and hygiene. Are they dressed in an appropriate way compared with other men and women in the household or community (e.g., Are they naked or partially clothed when others are fully clothed? If so, ask caregivers for a blanket and/or clothing before continuing with the interview). Do they appear to have good hygiene (e.g., Are they more clean or less clean than other women or men in the household)? How are they moving around the room?
Environmental
What is the current state of the individual's home? Is the home of the same quality and/or standard as nearby homes? What is the current state of their surrounding community? How close are they to important facilities (e.g., health centers, schools and community meeting points)?

Conclude the interview

- Thank the person (and the caregiver if present) for their time and their contributions.
- Remind the interviewee that the purpose of this discussion was to understand the safety and security concerns of persons with disabilities and how we can improve our GBV programs.
- Explain what you will do with this information and what purpose it will eventually serve.
- Ask the interviewee (and caregiver) if they have questions.
- Provide information to the interviewee (and caregiver) about the services and activities available through your organization, and facilitate referrals to psychosocial support or other assistance, as requested.

See over for individual interview documentation form.

To download the complete *Toolkit for GBV Practitioners, the report "I See That It Is Possible": Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings and Stories of Change*, visit http://wrc.ms/disability_GBV

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 4: A training module for GBV practitioners in humanitarian settings



Introduction

Approximately 15 percent of any community are persons with disabilities.¹ These rates may be higher in communities that have fled conflict or disaster, as during crisis people may acquire new impairments and have limited access to medical treatment.

Persons with disabilities are among the most vulnerable and socially excluded groups in any crisis-affected community. They may be isolated in their homes, overlooked during needs assessments and not consulted in the design of programs. Persons with disabilities also have difficulty accessing humanitarian assistance due to a variety of societal, environmental and communication barriers.² This increases their protection risks, including their risk of gender-based violence (GBV).³

Gender-based violence is a recognized global public health and human rights concern, and has a greater impact on women's lives and health than conflict, malaria and cancer combined.⁴ Different forms of GBV, particularly sexual violence and exploitation, may escalate in situations of crisis and conflict, where social norms and systems may be weakened or destroyed.⁵ Whilst GBV affects women, girls, boys and men, the vast majority of survivors of GBV are women and girls.⁶ For women and girls with disabilities, the intersection of gender and disability increases their vulnerability to violence. In addition, social norms often designate women and girls as caregivers of people with disabilities, which can reinforce their isolation and further limit their access to social, economic and material support, increasing their vulnerability to violence and exploitation.

Despite GBV response and prevention being integral to humanitarian action from the earliest phases of an emergency, persons with disabilities often do not have the same access as other community members to these services.⁷

Persons with disabilities have a right to protection in situations of risk or humanitarian crisis, and should be able to access services and participate in GBV programs on an equal basis with others.⁸ GBV practitioners and the communities in which they work should seek to understand the needs of people with disabilities, including the factors that make them more vulnerable to GBV and impede their access to and participation in GBV programs.

Purpose of this training

This training module on Gender-Based Violence and Disability was developed by the Women's Refugee Commission (WRC) and the International Rescue Committee (IRC) as part of a two-year project entitled *Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings*, conducted in humanitarian settings in four countries – Ethiopia, Burundi, Jordan and the Northern Caucasus in the Russian Federation. (More information about this project, including related publications and tools, is available at: http://wrc.ms/disability_GBv)

The training module is designed to support GBV practitioners to:

- understand the intersections of disability, gender and violence in the communities where they work; and
- develop ideas and strategies to improve inclusion of persons with disabilities in GBV programming.

How the training should be implemented

The training is designed to build the capacity of GBV staff and community workers to incorporate disability inclusion into their work. It assumes that participants already have at least a basic understanding of GBV, its causes and consequences. It is also meant to be used in conjunction with the IRC's Core Concepts in GBV training⁹ or other basic GBV concept trainings that your organization conducts.

This module takes 5-6 hours to complete. The objectives, activities and suggested time allocation are summarized in the table below. Some additional tools, including example case studies, are provided to assist in the facilitation of activities. Case studies have been developed from examples shared by persons with disabilities and their caregivers involved in the pilot project. Facilitators are encouraged to adapt these according to local contexts and to integrate activities from this module into other trainings on GBV.

Table 1: Contents of the training module on Gender-Based Violence and Disability

Activity	Purpose	Time required	Page number
Activity 1: Where do we stand?	To reflect on beliefs and assumptions relating to GBV and disability (Can also be repeated at the end of the module)	15 minutes	5
Activity 2: Understanding disability	To develop a common understanding of disability	45 minutes	7
Activity 3: Gender, disability and inequality	To identify potential consequences for persons with disabilities who don't meet societal expectations of men and women, and/or gender stereotypes in society	30 minutes	9
Activity 4: Root causes of GBV against women and girls with disabilities	To identify the root causes of GBV against persons with disabilities To reflect on power in relationships between persons with disabilities, perpetrators, caregivers and service providers	30 minutes	11
Activity 5: Vulnerabilities to GBV of women and girls with disabilities	To identify the factors that make persons with disabilities more vulnerable to GBV <i>Optional activity: Adolescent girls with disabilities</i>	30 minutes 30 minutes	13
Activity 6: Principles of working with persons with disabilities	To define guiding principles for working with persons with disabilities in GBV programs	30 minutes	16
Activity 7: Barriers to access and participation	To identify barriers to access and participation of persons with disabilities in GBV prevention and response activities	30 minutes	18
Activity 8: Strategies for inclusion	To define strategies for removing barriers and promoting participation of persons with disabilities in GBV programs	30 minutes	19
Training tools for activities	Collection of tools to assist in the facilitation of activities		21

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A note about language for training facilitators

In different contexts, different language is used to describe disability and to refer to persons with disabilities. Some words and terms may carry negative, disrespectful or discriminatory connotations and should be avoided in our communications. The Convention on the Rights of Persons with Disabilities is translated into many languages and can be a useful guide when deciding which terms to use in your context. Translations are available at: http://wrc.ms/CRPD_translations

Organizations of persons with disabilities (DPOs) can also provide guidance on the terminology preferred by persons with disabilities in a given country. In some humanitarian settings, the affected population may have established disability associations or committees to represent persons with disabilities. They are also a good resource for guidance on acceptable language, particularly in refugee populations.

Avoid...	Consider using...
Emphasizing a person's impairment or condition For example: Disabled person	Focus on the person first, not their disability For example: Person with disabilities (CRPD language)
Negative language about disability For example: "suffers" from polio "in danger of" becoming blind "confined to" a wheelchair "crippled"	Instead use neutral language For example: "has polio" "may become blind" "uses a wheelchair" "has a disability"
Referring to persons without disabilities as "normal" or "healthy"	Try using "persons without disabilities"

Notes

1. World Health Organization & The World Bank (2011). *World report on disability*. Geneva: WHO. http://www.who.int/disabilities/world_report/2011/en/.
2. Women's Refugee Commission (2008). *Disabilities among Refugees and Conflict-affected Populations*. New York: Women's Refugee Commission. <http://www.womensrefugeecommission.org/resources/document/609-disabilities-among-refugees-and-conflict-affected-populations>.
3. Women's Refugee Commission (2014). *Disability Inclusion: Translating Policy into Practice in Humanitarian Action*. <http://www.womensrefugeecommission.org/resources/document/984-disability-inclusion-translating-policy-into-practice-in-humanitarian-action>.
4. World Health Organization (2013). *Global and regional estimates of violence against women: prevalence and health effects on intimate partner violence and non-partner sexual violence*.
5. Inter-agency Standing Committee (2005). *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*. http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-gbv.
6. International Rescue Committee. *GBV emergency response and preparedness: Participant handbook*, page 7. <http://gbvresponders.org/wp-content/uploads/2014/04/GBV-ERP-Participant-Handbook-REVISED.pdf>
7. Women's Refugee Commission and International Rescue Committee (2015). *"I See That It Is Possible": Building capacity for disability inclusion in GBV programming in humanitarian settings*. http://wrc.ms/disability_GBV.
8. United Nations (2006). Convention on the Rights of Persons with Disabilities. <http://www.un.org/disabilities/convention/conventionfull.html>
9. www.gbvresponders.org

To download the complete *Toolkit for GBV Practitioners*, the report *"I See That It Is Possible": Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings*, and *Stories of Change*, visit http://wrc.ms/disability_GBV

Activity 1: Where do we stand?

Purpose of activity

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

Activity description

Timing: 15 minutes

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

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

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

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

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

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

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

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

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

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

True – For women and girls with disabilities, their gender and disability make them especially vulnerable and at increased risk of violence. They may be isolated in their homes, discriminated against by the community, unable to access services or protect themselves from violence. Women with disabilities are also often expected by their families, husbands and society to undertake the many duties and responsibilities, as well as access services, in the same ways as other women without the support or adaptations they need. They also experience extreme forms

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of discrimination when families, husbands and societies do not understand or seek to recognize their situation or their abilities. They may become alienated from their families and partners, unable to interact or socialize with friends or family, or be abandoned — which can in turn lead to greater stigma, rejection and violence in the community.

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

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

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

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

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

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

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

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

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

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

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

Activity 2: Understanding disabilities

Purpose of activity

- To develop a common understanding of disability.

Learning points

- Disability happens when a health condition interacts with societal barriers that make it difficult to do everyday things and participate in community life in the same way as others.

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

(Convention on the Rights of Persons with Disabilities, 2006)

- There are different kinds of disabilities. Some disabilities are obvious, like not being able to walk and thus using a wheelchair, and some are invisible, like a mental disability or being deaf. Some people have more than one type of disability.
- There are many different ways in which society may view or interact with persons with disabilities that can result in their exclusion or inclusion in our society.
 - » Charitable model: People may look at persons with disabilities as not having any capacity to help themselves and think they must be “cared for” or “protected.”
 - » Medical model: People may think that persons with disabilities need to be cured through medical interventions before they can actively participate in the community.

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

- » Social model: People instead look at the barriers that exist in the community and remove them so that persons with disabilities can participate like others.
- » Rights-based model: Persons with disabilities have the right to equal opportunities and participation in society. We all have a responsibility to promote, protect and ensure this right is actualized, and persons with disabilities should be able to claim these rights.

Activity description

Timing: 15 minutes

Training Tool 1: Types of disabilities

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

Ask everyone to draw a picture representing the different types of disabilities they know exist in the community. Stick these on the wall. Alternatively, you can use your own pictures of persons with different types of disabilities (see *Training Tool 1: Types of disabilities*).

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

Activity description

Timing: 30 minutes

Training Tool 2: Quotes – Models of disability

There are many different ways in which society may view or interact with persons with disabilities that can result in their exclusion or inclusion in our society. Describe the four different models of disability:

- Charitable model
- Medical model
- Social model
- Rights-based model

Give a scenario (or show pictures) such as:

- A young woman using a wheelchair
- A man with intellectual disabilities
- Parents with a hearing-impaired daughter

Ask participants to give examples of the type of things people would say about these individuals when using different models of disability.

[See Training Tool 2: Quotes – Models of Disability for examples – you can also give these quotes to the participants.]

What are the advantages and disadvantages of each approach?

How does each approach make the person with disabilities feel?

How does each approach contribute to equality and non-discrimination?

Activity 3: Gender, disability and inequality

Purpose of activity

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

Learning points

- Persons with disabilities are exposed to violence and discrimination based on both gender and disability, which results in inequality and power imbalances in their relationships with spouses, family and wider community members.
- In some settings, community members perceive that persons with disabilities are unable to, or should not, undertake tasks or do things they want or need to do, or that are expected of other men and women. They may be denied the right to marry, to have children or to earn income because of these perceptions, or face stigma and discrimination when engaging in these activities. This affects their status in the community, opportunities to be self-supporting, and power in relationships, which in turn can increase their risk of GBV.
- Household roles may change when someone has a disability. Men with disabilities may have less opportunity to work, making women in the household responsible for income, services and assistance, adding to their workload and risk of violence. Women caregivers experience additional risk of violence and exploitation, since they may be isolated and face constraints in accessing social and economic assets and support.
- Women with disabilities may find it hard to continue performing the many duties expected of her by her family, spouse and society. She may subsequently be alienated from her family, abused by her husband or stigmatized by the community.
- Some persons with disabilities are dependent on others for daily care and activities, and to access services and assistance. This may be used by others as a way of exercising power over the individual. It also hinders their ability to socialize, access services or move about freely in the community.

Activity description

Timing: 30 minutes

Training Tool 3: Card set – Disability and gender inequality

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

- Which cards show men and women with disabilities undertaking tasks that are part of their regular activities?

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

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

Purpose of activity

- To identify the root causes of GBV against persons with disabilities.
- To reflect on power in relationships between persons with disabilities, perpetrators, caregivers and service providers.

Learning points

The root causes of GBV against persons with disabilities are the same as for other people:

- ⇒ Abuse of power
- ⇒ Inequality
- ⇒ Disrespect

For many women and girls, their experience of violence based on their gender intersects with other inequalities. This includes the oppression inflicted by majority populations against others based on race, religion, age, class, sexual orientation and disability, all of which contribute to further marginalization and result in less power and status in relationships, households and the community for women and girls with disabilities.

Most women and girls with disabilities have experienced a long history of discrimination and disempowerment — by family members, caregivers, partners and even service providers. People with new disabilities may be facing changes in their independence, decision-making ability and status in relationships, households and communities.

As GBV practitioners, we must work with women, girls and all survivors with disabilities to support them to develop their “power within” and have “power to” make their own decisions about services and assistance. We must be careful not to reinforce negative and harmful power dynamics between persons with disabilities and others and/or exercise “power over” these individuals in the design or implementation of programs.

Activity description

Timing: 30 minutes

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

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

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

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

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

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

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

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

- spouses
- caregivers
- service providers

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

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

Activity 5: Vulnerabilities of women and girls with disabilities

Purpose of activity

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

Learning points

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

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

- Stigma and discrimination: Persons with disabilities experiencing negative attitudes in their communities, which leads to multiple levels of discrimination and greater vulnerability to violence, abuse and exploitation, especially for women and girls with disabilities. It may also reduce their participation in community activities that promote protection, social support and empowerment.
- Perceptions about capacity of persons with disabilities: Perpetrators perceive that persons with disabilities will be unable to physically defend themselves or effectively report incidents of violence, which makes them a greater target for violence. This is particularly true for women and girls with physical disabilities, and persons with intellectual disabilities, who experience a number of barriers to reporting violence and/or negotiating sex in an abusive relationship. People may not listen to them or believe them, especially when it is a survivor with mental or intellectual disabilities, which reduces their access to services. It is often assumed that they do not understand what has happened to them or are not able to express their needs, adding to impunity for perpetrators of such violence.
- Loss of community support structures and protection mechanisms: This is particularly severe in contexts of new displacement where families and communities have already been separated. In general, women and girls with disabilities are often shunned or alienated from others if they have a disability. Some families may resort to tying up their relative and/or locking them inside the home to prevent them from moving around the community where they fear they may experience violence. Adolescent girls with disabilities may also be excluded from protective peer networks and programs, which could otherwise serve to strengthen important assets and support their transition into adulthood.
- Extreme poverty and lack of basic supplies: The lack of income or basic supplies increases the risk that women and girls with disabilities may be abused and exploited, including by service providers or community members. It could also increase the risk of abuse and exploitation

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perpetrated by partners, and reduce their ability to leave violent relationships due to their dependence on others.

- Environmental barriers and a lack of transportation: Persons with disabilities must rely on other community members to access services and assistance, including food and non-food item distributions, which increases risk of exploitation and abuse, and makes it difficult to access GBV response services in a confidential way.
- Isolation and a lack of community support: This increases women with disabilities' risk and vulnerability to violence, particularly inside the home. Some persons with disabilities may be hidden by family members. Others find it difficult to move outside of their homes and meet other people. A lack of community support and friendships can mean that they do not acquire the information and skills they need or have people to go to when they experience violence. It also means that violence is often perpetrated in private, with few options to report or seek outside assistance.
- Lack of information, knowledge and skills: Women and girls with disabilities often have little information about GBV and personal safety, which means that they are less able to protect themselves. This is particularly true for women and girls with intellectual disabilities who may be more easily targeted by perpetrators. They are also consistently excluded from all programs and activities, and information is usually not conveyed in a way that they can understand, making it more difficult for them to seek assistance.

Activity description

Timing: 30 minutes

Training tool 4: Case studies

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

- What types of violence are persons with disabilities experiencing in this case study?
- How are other people in the case study affected? In what ways?
- Identify three factors that make persons with disabilities in the case study vulnerable to GBV.
- What other factors exist that have not already been mentioned?

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

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

Optional activity: Adolescent girls with disabilities

Timing: 30 minutes

Training tool 5: Power walk

Asset building is a widely used approach to working with adolescent girls, and has been demonstrated to reduce their vulnerabilities and increase their access to opportunities. Supporting girls to develop foundational assets — such as health, education, communication skills, self-esteem and social networks — can enable them to transform their lives and positively impact their families and communities. For more information about adolescent girls programs, see the WRC report *Strong Girls, Powerful Women*, available at: <http://wrc.ms/StrongGirlsReport>

This activity will demonstrate the importance of assets on the vulnerability to GBV and resilience of adolescent girls with disabilities. Two volunteers are each given a character. The rest of the group will read out different scenarios experienced by each character. The volunteers take steps forward or steps backwards according to how the scenario promotes opportunities for and strengthens assets of that individual. An individual may have both positive and negative things happening in each scenario, and so they may take multiple steps forward or backwards accordingly. There may also be events that affect the other women and girls in the family, and this may have additional impact on the individual.

See these key questions to facilitate discussion on whether each girl should move forward or backward.

- What are the good and bad things that are happening in this scenario for the girl?
- What personal/social/physical/financial assets are they developing?
- What personal/social/physical/financial assets are they missing?
- What kind of power exists in the relationships around them? (e.g., power over/power within/power to/power with)
- How does this affect their vulnerability or resilience to challenges?
- How does this affect their risk of or protection from GBV?

Activity 6: Guiding principles of working with persons with disabilities

Purpose of activity

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

Learning points

The following are guiding principles should be considered when working with persons with disabilities in GBV programs:

The right to participation and inclusion: GBV practitioners should recognize the diversity of the population they serve, including the different risks faced by women, girls men and boys with different types of disabilities in humanitarian settings, and the need to make services and activities accessible to and meaningful to these groups. Inclusion of people with disabilities and caregivers, especially women and girls, to reduce their risk of GBV should be a core part of their work, not something special or separate.

Focus on the whole person, not their disability: They have life experiences, skills and capacities, dreams and goals. They have many identities, including as mentors, leaders, wives, mothers, sisters, friends and neighbors.

Don't make assumptions: GBV practitioners should not assume that they know what a person with disabilities wants or feels, or that they know what is best. Don't assume that because a person has a disability that they are incapable of certain things or wouldn't be interested in participating in certain activities. Take time to consult with them, explore their interests and provide them with opportunities, as with other GBV survivors.

Identify and utilize strengths and capacities: Work with people with disabilities, as well as their family members, to identify their skills and capacities, and use these to inform GBV program design, implementation and evaluation. People with disabilities are the experts on their disability and can provide critical guidance on how to adapt programs and activities to better serve them. Individual action plans should be built around people's capabilities.

Focus on "working with": People with disabilities, particularly women and girls, often have decisions made for them by other people, including by family members, caregivers, partners and even service providers. GBV practitioners should instead take the approach of working *with* people with disabilities through a collaborative process that identifies their concerns, priorities and goals. Avoid reinforcing negative power dynamics by making decisions for them, and instead support them to develop their own sense of agency and power to make their own decisions.

Working with caregivers and families: Disability also affects family members, particularly women and girls who may assume caregiving roles. GBV practitioners should seek to understand the concerns, priorities and goals of caregivers, and to both support and strengthen healthy relationships and balanced power dynamics between caregivers, people with disabilities and other family members.

Activity description

Timing: 30 minutes

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

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

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

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

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

As a large group, discuss the common features of stigmatization of women and girls, stigmatization of persons with disabilities and stigmatization of women and girls with disabilities.

What kinds of principles are most important when working with women and girls with disabilities? How can we integrate these principles into our work? What principles do we want to encourage in staff, partners and the community?

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

Activity 7: Barriers to access and participation

Purpose of activity

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

Learning points

- There are many things that prevent persons with disabilities from being included in our activities, not just their health condition. Potential barriers include:
 - » Attitudinal barriers – Negative stereotyping of persons with disabilities, social stigma and discrimination by staff, families and community members.
 - » Physical or environmental barriers – Such as buildings, schools, clinics, water pumps, roads and transport that are not accessible to persons with disabilities.
 - » Communication barriers – From written and spoken information, including media, flyers and meetings, and complex messages that are not understood by persons with disabilities.
 - » Other barriers – Rules, policies, systems and other norms that may disadvantage persons with disabilities, particularly women and girls.
- Analyzing potential barriers is a first step in planning strategies and actions to include persons with disabilities in our programs.

Activity description

Timing: 30 minutes

Training tool 4: Case studies

Put four signs on the wall: “Physical barriers”; “Attitudinal barriers”; “Communication barriers”; “Other barriers.”

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

Key questions:

- What barriers are preventing access to services or inclusion of persons with disabilities in our activities? How is it different for women, girls, boys and men with disabilities?
- Does this barrier only affect the person with disabilities? Are caregivers or other family members and community members also affected?
- What barriers do you think are most common in this community?

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

Activity 8: Strategies for inclusion

Purpose of activity

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

Learning points

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

Activity description

Timing: 30 minutes

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

- i. Services (e.g., counseling or case management)
- ii. Empowerment (e.g., classes and activities at the women's center)
- iii. Prevention (e.g., community mobilization or SASA! activities)
- iv. Advocacy (e.g., working group meetings or bilateral conversations with refugee leaders)

Each group should identify:

- One specific activity that is undertaken in their context.
- One barrier that prevents persons with disabilities from accessing services or participating in the activity identified (e.g., adolescent girls who are blind are not able to find their way to the women's center for classes). **Note: The participants may wish to look at the list on the wall from the previous activity to get ideas.**
- One thing we could do to help to overcome this barrier (e.g., we could organize for the girls to walk together to the women's center and escort girls who are blind).
- One way in which persons with disabilities could provide input or feedback in order to improve our

Tool 4: A training module for GBV practitioners in humanitarian settings

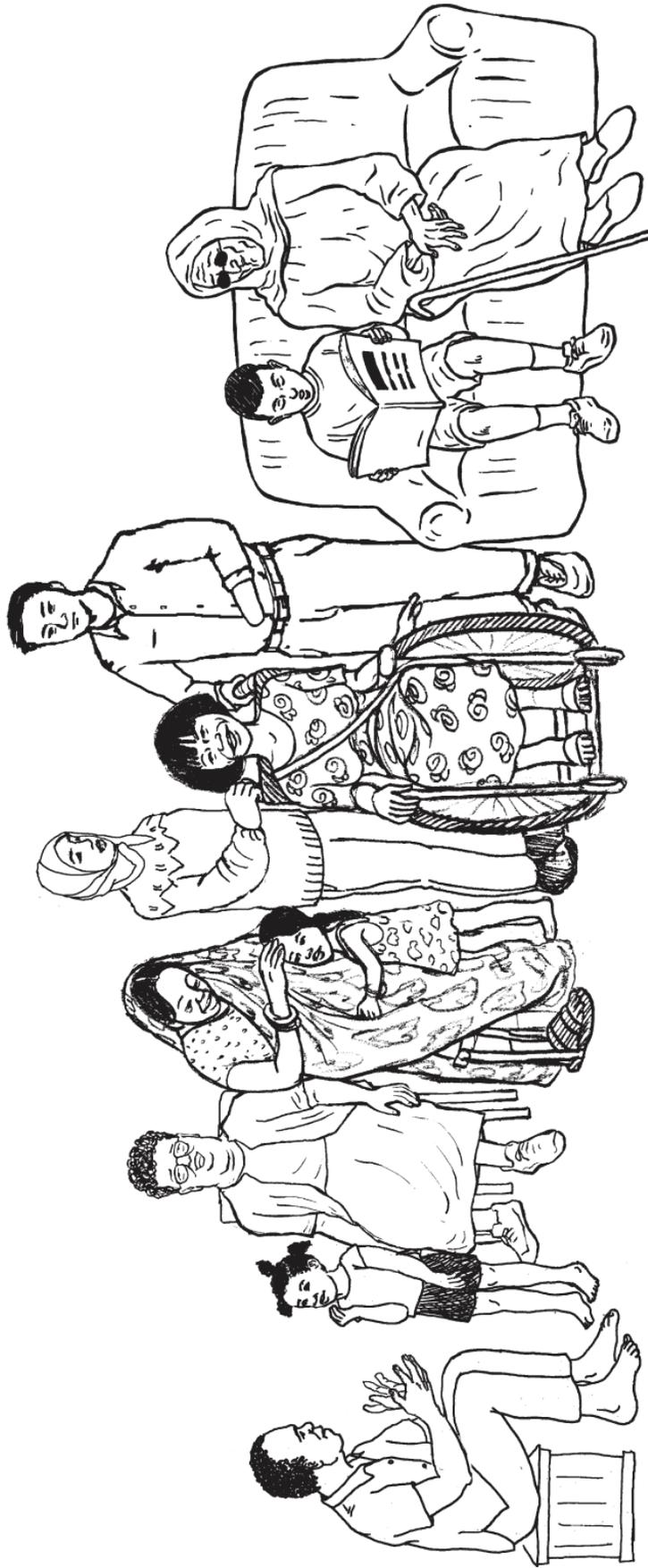
program activities (e.g., the girls who are blind could run a class with the other girls on how to guide blind persons).

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

Discuss as a large group:

- What suggestions are feasible to implement now in your program?
- What suggestions require additional support (e.g., time, funds or expertise) to implement?

Training Tool 1: Types of disabilities



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Training Tool 2: Quotes – Models of Disability

Situation	Charitable Model	Medical Model	Social Model	Rights-based Model
A girl using a wheelchair attending an adolescent girls safe space	"She can't come to our safe space. The other girls might tease her. It would be better if we had a special place for her and other girls like her."	"She can't participate in the activities in the safe space. Once she learns to walk, then she will be able to participate."	"We can think of some different activities in the safe space – activities that don't require moving around."	"This is a safe space for ALL girls! We will ask her about what changes need to be made."
Man with an intellectual disabilities attending sexual and reproductive health training	"It is no use inviting him as he can't learn new things, and he will never get married or have children anyway. His family should take good care of him and make sure that no one abuses him."	"He needs a specialist doctor – these are the only people who can help him."	"Maybe he can come to the training with his brother, so that they can discuss the topics in more detail later."	"Let's ask him what he thinks of our training — it is important for us to know his opinion and ideas on how to improve it."
Mother of a child with disabilities who is iso-lated in her home	"It must be very sad having a child with disabilities. We should priori-tize them for material assistance to help their situation at home."	"This child needs a therapist. Maybe we can refer her to one in the capital city."	"Let's run a GBV session in their home. This way the mother can still get information and also meet her neighbors."	"This child has a right to be in the same activities as the other children. Let's discuss this with her mother, and start exploring what activities might interest her the most."

Adapted from *Making PRSP Inclusive*. <http://www.making-prsp-inclusive.org/en/6-disability/61-what-is-disability/611-the-four-models.html>

Training Tool 3: Card set – Disability and gender roles

43

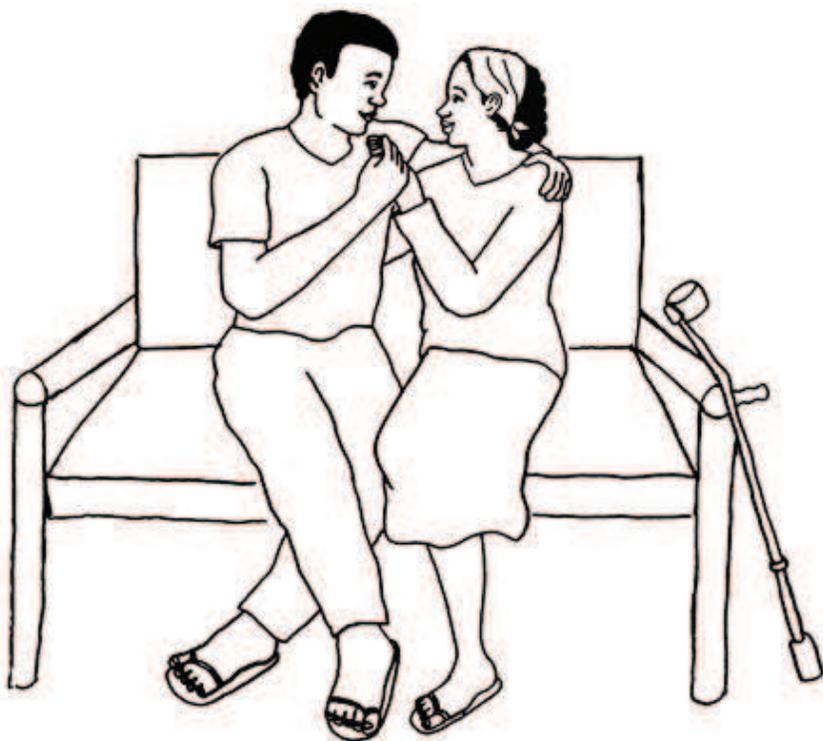


Image by Stacy Patino



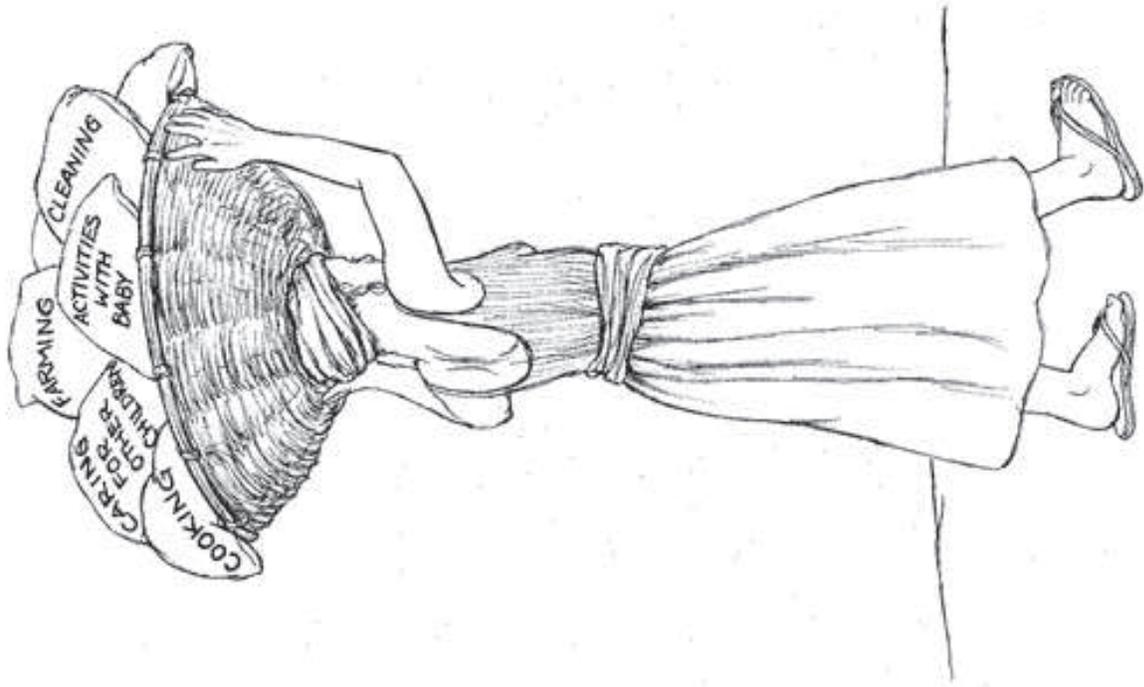
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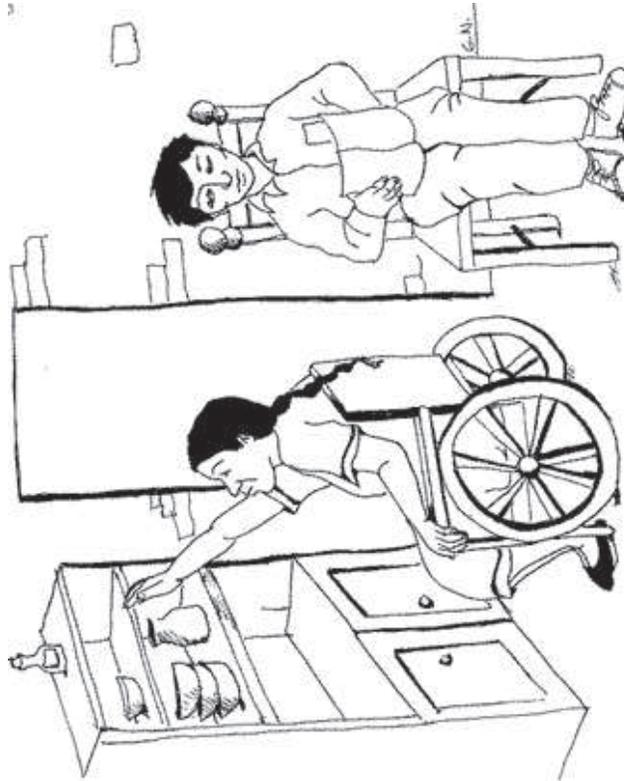
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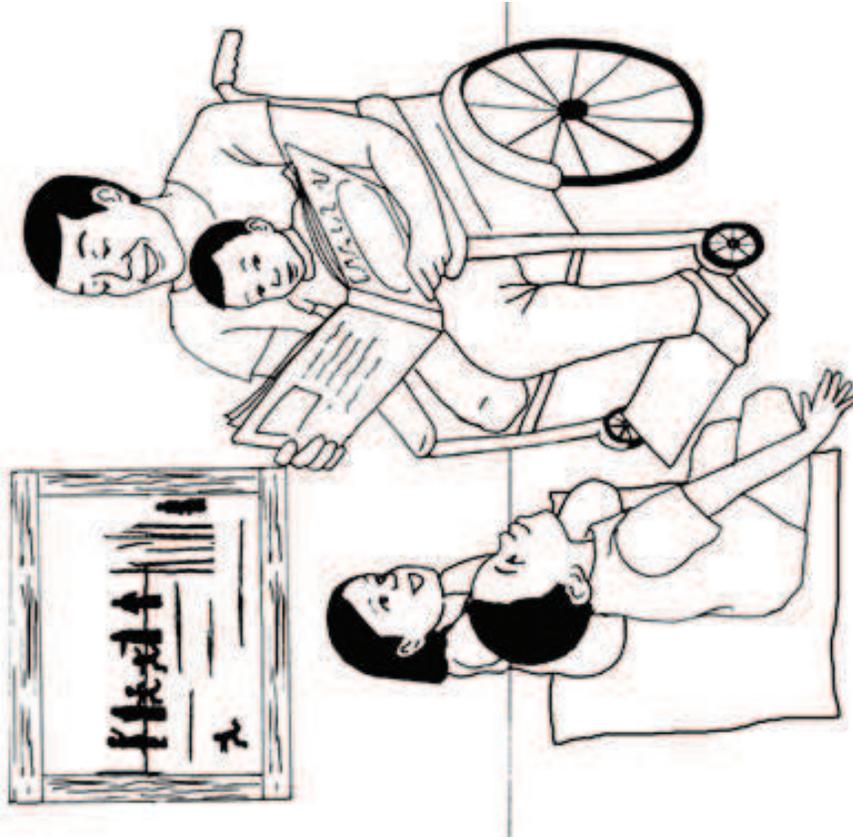


Image by Stacy Patino



Image by Stacy Patino

Training Tool 4: Case studies

Case Study 1 – Selam (Eritrean refugee living in Ethiopia)

Selam is a 17-year-old woman living in a refugee camp in Ethiopia. She lives with her mother, father, five sisters and three brothers. Selam is unable to speak and needs assistance with her daily care. Her mother, Beletu, and her two younger sisters assist her with feeding, washing and toileting. One of her younger sisters has dropped out from school, as her mother is feeling tired and is in need of more support to take care of Selam. Selam smiles when her two younger sisters stay with her and play games in front of her. She cries when she feels hungry or thirsty – this is how her family knows that she would like food or water.

Selam started menstruating when she was 12 years old, but she can't change her sanitary napkin on her own. Her mother and younger sister have taken care of her menstrual hygiene needs for the last five years. They have expressed that this is the most difficult task as Selam has grown bigger.

Beletu doesn't feel comfortable leaving Selam with other people and worries about her safety. When other women visit her at the house, they talk to her about the awareness-raising sessions being conducted by the Community Wellness Initiative (CWI) and other organizations. She would like to attend such sessions, but can't because the sessions are conducted far away from her home, and there is nobody to look after Selam.

Case Study 2 – Esther (Congolese refugee in living in Bujumbura, Burundi)

Esther is from the Democratic Republic of Congo. She has been living in Bujumbura (capital city of Burundi) with her children and her father. She is unmarried. Esther has a mental disability, which means that she sometimes has "crises" or seizures. She says, "This is when men come to rape me. I don't know any of the fathers of my children."

"Some of my children are the age to go to school and I have no means of sending them to school. I have to seek men to even pay for sugar in the tea and they can do whatever they want to me. My children can't even have books for school. My father used to help, but now he is disabled. It is hard for me in my head and in my heart and it sometimes brings on an attack. Sometimes when I am ill, I go to a special hospital. The medication they give me needs to be taken with food, but I can't get sufficient food and so I feel dizzy in my head. But what hurts me most is the situation of my children."

Esther and other women consulted in a group discussion are aware that services are available for GBV survivors at the CUCOR – a center delivering services and assistance to refugees. They know that they can come here to meet with IRC staff, who will describe to them their options and help them access any services which they choose. The women say that "the CUCOR is far from some people" and "there is no transport, so even if you know where the services are, you still can't get there.... Can we reduce the procedures? It takes a long time to come to the CUCOR and then to go to the hospital. If we go straight to the hospital, we are not welcome — we need a paper from [the IRC staff]. It would be better to have a number we can call and to meet at the hospital!"

Case study 3 – Sabeen (Syrian refugee living in Zaatari refugee camp, Jordan)

Sabeen is 13 years old and has an intellectual disability. Her mother says that she is “super active.” She likes to dance and draw, and is always going to visit her neighbors. She always wants to learn something new. Sabeen used to go to school in the camp, but now she can’t find someone to walk with her. Sabeen likes to go out, even when it is dark. One night, she went to her neighbor’s house and when she came back, her mother noticed that she looked different. Her mother asked Sabeen what happened, and she explained that some boys took off her underpants. The boys said that next time they were going to “play husband and wife.” Her mother has now stopped Sabeen from visiting neighbors where there are men and boys, because she feels Sabeen will do whatever these people say. Sabeen went to a group meeting with her mother where they talked about violence in the camp, but she didn’t really pay any attention – she preferred to practice her drawing.

Case Study 4 – Alieva (Northern Caucasus)

Alieva is 15 years old. She was born with her disability – she has difficulty moving, and was slow to develop speech. The doctors said that Alieva would never go to school, and she spends most of her time inside the house. Alieva’s mother helps her with daily care, like washing and going to the toilet. Her father recently left the family, and so Alieva’s mother had to find a job to earn income for the family.

Alieva is home alone most of the day, but different relatives come throughout the day to help her go to the toilet or have lunch. Sometimes her cousin is late, and when Alieva complains, her cousin gets angry at her and refuses to take her outside. Alieva likes being outside in her wheelchair, and will talk to anyone who stops to say “hello.”

Alieva’s sister and another neighbor have started attending a group a local women’s center. The social workers spend time talking to Alieva. When she is ready they organize transportation so the three girls can travel together to the center. Alieva looks forward to these days being around the other girls, and is hoping to learn more about computers.

One day the girls are meeting to identify the activities they would like to do at the center. Alieva doesn’t speak at this meeting, but all the other girls want hairdressing. They all say that Alieva will enjoy this, as they can all do her hair for her – she can be the client, and doesn’t need to stand up to do that.

Case study 5 – Men with new disabilities (Syrian refugees living in Jordan)

Over half a million Syrian refugee are currently living in refugee camps and urban centers in Jordan. Many are arriving with new disabilities as a result of war injuries. Men with new disabilities living in Jordan were consulted about GBV concerns.

“As an injured person, when he goes outside for treatment, his wife will have to go with him, and she will get a lot of sexual harassment. If he says something to these people, they will say ‘You are a half man.’ Also the wives may not have time to take the children from the school, and so they have to go on their own – [our wives] can also be sexually harassed.”

(Participant in group discussion with men with disabilities and male caregivers in Ramtha, Jordan.)

Tool 4: A training module for GBV practitioners in humanitarian settings

“It depends on the character of the man – if he is strong willed, then he can still be head of the house, even if he is not able to work after getting his disability. But the husband usually becomes dependent on the wife. If he needs to pay for something, the wife has to go out to work.... It becomes more work for the wife. There are more risks for the wives of men with disabilities because people will take advantage of her. She may become a maid for another family or have to come home late when it is dark. Her psychological state will get worse. If the man has a new disability, he may get jealous when he sees his wife going out. This also creates risk for her [in the home]. Sometime society’s perception of these wives will change because they don’t know why she is going out and this is not normal here – she may become stigmatized by the community.”

(Participant in group discussion with men with disabilities and male caregivers in Zaatari refugee camp, Jordan.)

Training Tool 5: Power Walk

✂ _____

1. Alieva

Alieva is 15 years old. She was born with her disability – she has difficulty moving, and was slow to develop her speech. The doctors said that Alieva would never go to school, and so she spends most of her time inside the house.

✂ _____

2. Alieva

Alieva's mother helps her with daily care, like washing and going to the toilet. Her father recently left the family, and now Alieva's mother must find a way to get income for the family. Alieva's younger sister must stay at home to help her with things when their mother goes out for meetings.

✂ _____

3. Alieva

Alieva's mother now has a job. Alieva is home alone most of the day, but different relatives come throughout the day to help her go to the toilet or have lunch. Sometimes her cousin is late, and when Alieva complains her cousin gets angry with her and refuses to take her outside. Alieva likes being outside in her wheelchair, and will talk to anyone who stops to say "hello."

✂ _____

4. Alieva

Alieva's sister and another neighbor have started attending a group a local women's center with Alieva. The social workers spend time talking to Alieva – when she is ready, they organize transportation so the three girls can travel together to the center. Alieva looks forward to these days being around the other girls, and is hoping to learn more about computers.

✂ _____

5. Alieva (FINAL)

One day you meet with the girls to identify the activities they would like to do at the center. Alieva doesn't speak at this meeting and all the other girls want hairdressing. They all say that Alieva will enjoy this, as they can all do her hair for her – she can be the client, and doesn't need to stand up to do that.

What power dynamics are happening here? How will you address these dynamics?

✂ _____

Tool 4: A training module for GBV practitioners in humanitarian settings

⌘ _____

1. Amina

Amina is 16 years old. She finished her primary education, but has missed a lot of her secondary school because her family members are always asking her to undertake different chores. Her aunty has been encouraging her to do some classes, so she can get a job one day.

⌘ _____

2. Amina

Amina has a lot of friends from primary school. They meet sometimes in the shops and talk a lot on the phone. Some of her friends are going to the center to learn accounting, and Amina would like to join them. Her friends give her lots of information that she shares with her parents, and they say it is OK for her to go, as long as she is able to continue her other work.

⌘ _____

3. Amina

Amina has learned a lot at the center and now has many more friends. Her brothers sometimes take away her phone to prevent her from talking to these friends. The other girls at the center sometimes have the same thing happen, and they discuss different ways to talk to their families about this.

⌘ _____

4. Amina

Amina has passed her accounting course and wants to find work. The teachers at the center give her some different ideas of places to look for work and how the recruitment processes work. Amina talks to her aunty – she also works and has a lot of experience. Amina's aunty supports her when she discusses this idea with her family.

⌘ _____

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 5: Pre- and post-training test for the GBV and disability training module

Name: _____

Date: _____

1. How do you define persons with disabilities?

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

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

4. The root causes of GBV against persons with disabilities are (circle all that apply):
 - (a) Perceptions that persons with disabilities are weak and unable to defend themselves
 - (b) Low status in the community
 - (c) Inequality in power relationships with other people
 - (d) Poverty and lack of basic needs
 - (e) All of the above

5. The following factors make women and girls with disabilities more vulnerable to GBV (circle all that apply):
 - (a) Not going to school
 - (b) Having contact with other women and girls their own age
 - (c) Staying inside their home all day
 - (d) Reliance on others to access services and assistance
 - (e) All of the above

Tool 5: Pre- and post-training test for the GBV and disability training module

6. List three things that may prevent persons with disabilities from accessing GBV services and programming.
- (i)
 - (ii)
 - (iii)
7. Girls with intellectual disabilities may be at increased risk of GBV because (circle all that apply):
- (a) They don't have the same knowledge and skills about GBV and personal safety as other girls
 - (b) Information on GBV is not conveyed in a way that they can understand
 - (c) They are unable to learn new things
 - (d) Family and caregivers hide them inside the home
 - (e) All of the above
8. Persons with disabilities are unable to access services or participate in our activities because of their health condition.
- True
 - False
9. The community may perceive that persons with disabilities are unable to, or should not, have the same opportunities as other men and women.
- True
 - False

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

Pre- and post-training test answer key

1. How do you define persons with disabilities?

The answer should reflect three key components:

- (i) A long-term impairment in the body (1 point)
- (ii) Interaction with other barriers (1 point)
- (iii) Preventing participation in society on an equal basis with others (1 point)

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

- True
- False

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

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

- True
- False

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

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

- (a) Perceptions that persons with disabilities are weak and unable to defend themselves
- (b) Low status in the community
- (c) Inequality in power in relationships with other people
- (d) Poverty and basic needs not being met
- (e) All of the above

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

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

- (a) Many women and girls with disabilities don't go to school
- (b) Having contact with other women and girls their own age
- (c) Staying inside their home all day
- (d) Reliance on others to access services and assistance
- (e) All of the above

Answer: (a), (c) and (d). Please note: Having contact with other women and girls their own age

Tool 5: Pre- and post-training test for the GBV and disability training module

can help with acquiring information and skills, but also provide support to women and girls with disabilities should they experience violence. (1 point)

6. List three things that may prevent persons with disabilities from accessing GBV services and activities.
- (i)
 - (ii)
 - (iii)

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

7. Girls with intellectual disabilities may be at increased risk of GBV because (circle all that apply):
- (a) They don't have the same knowledge and skills about GBV and personal safety as other girls.
 - (b) Information on GBV is not conveyed in a way which they can understand.
 - (c) They are unable to learn new things.
 - (d) Family and caregivers hide them inside the home.
 - (e) All of the above.

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

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

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

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

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

Tool 5: Pre- and post-training test for the GBV and disability training module

How confident are you in your knowledge and understanding of the following issues?

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

For questions 10 –13, we want to know if their confidence changes as a result of the training. Give 1-5 points depending on which box they select. (5 points each question)

Total Score: _____ **out of 33**

To download the complete *Toolkit for GBV Practitioners, the report “I See That It Is Possible”*: *Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings* and *Stories of Change*, visit http://wrc.ms/disability_GBV

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 6: Guidance on communicating with persons with disabilities

Purpose of this tool

This tool provides guidance on how to communicate effectively with persons with disabilities. It is not specific to communicating with GBV survivors with disabilities, but can be used to help staff understand basic ways to adapt verbal and non-verbal communication when working with survivors with disabilities or involving persons with disabilities in community activities.

Persons with disabilities have a right to participate in our activities on an equal basis with other members of the community. As service providers and practitioners, the way we interact and communicate with persons with disabilities and talk about them can help to break down barriers to participation and send positive messages to colleagues, partners and community members. It also improves the quality of our programs by ensuring that they are inclusive of all ideas, skills and capacities that exist within the community.

Communication tips

Use respectful language

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

Organizations of persons with disabilities (DPOs) can also provide guidance on the terminology preferred by persons with disabilities in a given country. In some humanitarian settings, the affected population may have established disability associations or committees to represent persons with disabilities — these can also be a good resource for guidance on respectful language (see table on page 2).

Tool 6: Guidance on communicating with persons with disabilities

Avoid...	Consider using...
Emphasizing a person's impairment or condition For example: Disabled person	Focus on the person first, not their disability For example: Person with disabilities (CRPD language)
Negative language about disability For example: "suffers" from polio "in danger of" becoming blind "confined to" a wheelchair "crippled"	Instead use neutral language For example: "has polio" "may become blind" "uses a wheelchair" "has a disability"
Referring to persons without disabilities as "normal" or "healthy"	Try using "persons without disabilities"

Use a strengths-based approach

- Do not make assumptions about the skills and capacities of persons with disabilities — this can affect the way we communicate and interact with them. Remember that persons with disabilities are people, first and foremost. Just like all people, they have different opinions, skills and capacities.
- Look at what they can do. This can often give insight into how they can communicate and participate in your activities.
- Greet persons with disabilities in the same way you would other people. For example, offer to shake hands (if culturally appropriate), even if they have an arm impairment.
- Speak directly to the individual with disabilities, not to their interpreter or assistant/caregiver.
- When speaking for a length of time, try to place yourself at eye level with the person if they are not already at the same height (e.g., by sitting in a chair or on a mat).
- Treat adults with disabilities like you treat other adults. Discussions and activities should continue to be age appropriate and then adapted for the communication needs of the individual.
- Ask for advice. If you have a question about what to do, how to do it, what language to use or the assistance you should offer — ask them. The person you are trying to work with is always your best resource.

Working with people with different impairments

In addition to the tips provided above, there are specific communication and engagement strategies to consider, depending on the type of disability the person has.

When working with people with physical impairments:

- Move at their speed. Do not walk ahead of them if they are moving slower than you.
- When offering assistance, always ask first what they require. Follow their instructions, and not what you think is best.

Tool 6: Guidance on communicating with persons with disabilities

- Do not lean on or move someone's wheelchair or assistive device without their permission.
- Discuss transportation options for activities and events. Consider what is going to be safest, most affordable and the least amount of effort for the individual and family.
- Check that venues and spaces for activities are accessible (including toilet facilities, etc.) and have sufficient space for people with mobility aids to move around the room.
- When arranging meetings with a participant who uses a wheelchair, provide space at the table for a wheelchair (i.e., move one chair away) and ensure there is enough space for them to move around the room freely.

When working with people who are deaf or hearing impaired:

- Find out how the person prefers to communicate. People with hearing impairments may use a combination of writing, lip reading and/or sign language. This can be determined by observing their interactions with others or by using simple gestures to suggest communication options.
- Get the person's attention before speaking, by raising your hand or waving politely.
- Face and talk directly to a person who is deaf, not to the interpreter (as they are only facilitating the communication).
- Speak clearly — don't shout or exaggerate words as this will make it more difficult to lip read.
- Try not to sit or stand with your back to the light — this can put your face in the dark and make it difficult to lip read.
- Do not cover your mouth or eat while talking. This will make it difficult to lip read.
- Allow the person who is deaf or hearing impaired to choose the best place to sit at a meeting to be able to see people clearly and communicate more easily.
- In meetings, ensure the interpreter can hear the presenter and the rest of the group. They should also be visible to the individual for whom they are interpreting.

A note about sign language: Like spoken languages, sign languages are different in different countries and regions. Some people also use unofficial sign language, and in these cases a family member or friend may need to interpret. Ask them to teach you some simple signs (e.g., good, bad and thank you) and try to include these in your discussion with a person who is deaf or hearing impaired.

When working with people with vision impairments:

- Always introduce yourself and any other people in the group by name.
- Tell the person if you are moving or leaving their space — don't just walk away.
- If the person has arrived at a new place, tell them who is in the room or group, and offer to describe the environment.
- Avoid vague language, such as "that way" or "over there" when directing or describing a location.
- Always ask the person first if they would like assistance to get from one place to another. Ask for

Tool 6: Guidance on communicating with persons with disabilities

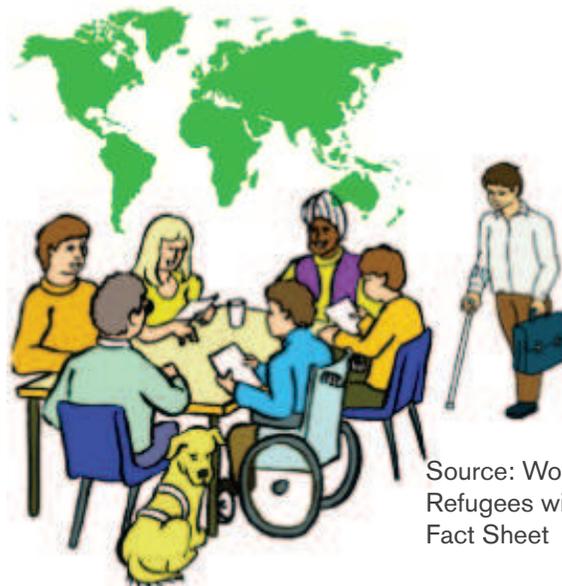
instructions on how they would like to be assisted and where they would like to go. Some people prefer verbal guidance, whereas others may prefer for you to physically guide them.

- If you are asked to physically guide someone with a vision impairment, they may want to hold your arm just above the elbow. This will allow them to walk slightly behind you, following you as you turn or step up or down onto steps.
- In the event that a person uses a support pet or guide dog to assist them, do not distract or pet the animal while it is working.
- In presentations, meetings and events, describe all pictures and diagrams that are shown.
- Ask persons with vision impairments if they would like documents in alternative formats, such as Braille or large print. In some contexts where people have access to computers, persons with vision impairments may prefer electronic documents that are accessible through screen reader software (e.g., Word documents).

When working with people with intellectual impairments

People with intellectual impairments may experience difficulty in understanding, learning and remembering, as well as applying information to new situations. It is important to note, however, that persons with intellectual disabilities can learn new things and participate in our activities, with just some small changes to the way we work.

- Communicate in short sentences that convey one point at a time.
- Use real life examples to explain and illustrate points. For example, if discussing an upcoming medical visit, talk the person through the steps they are likely to go through both before and during the appointment.
- Give the person time to respond to your question or instruction before you repeat it. If you need to repeat a question or point, then repeat it once. If this doesn't work, then try again using different words.



Source: Women's Refugee Commission, Refugees with Disabilities, Easy to Read Fact Sheet

Tool 6: Guidance on communicating with persons with disabilities

- Allow time for persons with intellectual impairments to ask questions.
- Make sure that only one person is speaking at any given time, and that the person with an intellectual impairment is not being rushed to answer.
- Persons with intellectual impairments may want some more time to think about decisions or to discuss their options with someone they trust.
- Identify quiet environments to have conversations in order to reduce distractions.
- Pictures can also be used to communicate messages to people with intellectual impairments — these are sometimes called “Easy to Read” documents.

When working with people with speech impairments:

- Plan more time for communicating with people with speech impairments.
- It is OK to say “I don't understand.” Ask the individual to repeat their point, and then say it back to them to check that you have understood it correctly.
- Don't attempt to finish a person's sentences — let them speak for themselves.
- Try to ask questions that require short answers or yes/no gestures.
- If you have tried several ways to understand a person without success, ask if it is OK to communicate in a different way, such as through writing or drawing.

References:

VSO (2006). *A handbook on mainstreaming disability*. http://www.vsointernational.org/Images/A_Handbook_on_Mainstreaming_Disability_tcm76-21046.pdf

North Dakota Center for Persons with Disabilities (n.d.). *Communicating effectively with people who have a disability*. <http://www.ndcpd.org/projects/medicaid/publications/pdf/Communicating.pdf>

MIUSA (2006). *Respectful disability language: A guide for using appropriate disability language and terminology*. <http://www.miusa.org/ncde/tools/respect>

Shawn Lawton Henry (2007). *Just ask: Integrating accessibility throughout design*. <http://www.uiac-access.com/accessucd/interact.html>

Women's Refugee Commission. *Refugees with Disabilities — Easy Read Version*. <http://womensrefugeecommission.org/programs/disabilities/research-and-resources/download/1070>

To download the complete *Toolkit for GBV Practitioners, the report “I See That It Is Possible”: Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings and Stories of Change*, visit http://wrc.ms/disability_GBV

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 7: Accessible information, education and communication (IEC) materials

Purpose of this tool

This tool provides guidance on how to adapt and use information, education and communication (IEC) materials so that they can be understood by people with disabilities.

People with disabilities have a right to access all information relating to gender-based violence (GBV) programs on an equal basis with others. GBV messages, whether they are related to prevention or access to services for survivors, should be communicated in multiple formats and incorporate different dissemination methods. Depending on the context, examples may include producing information in Braille, sign language and simplified messaging, such as pictograms and pictures, which are then disseminated through workshops, dialogues, home visits and community awareness-raising activities. It can be extremely useful to work with persons with disabilities, particularly those with intellectual, vision and hearing disabilities, to identify how they access information and what formats are the most appropriate for them.

Analyze existing IEC materials

You can use the following simple questions to evaluate whether adaptation and/or targeted approaches may be necessary to reach people with varying disabilities with your information.

1. Who will be able to understand this information in its current form?
2. Who won't be able to understand this information in its current form?
3. How does the information reflect the needs of different people in the community? Will people with disabilities and their caregivers see themselves and their experiences reflected in the images?¹
4. What do people with disabilities think about the IEC materials? Do they have any advice or feedback? While it is helpful to have their advice and guidance before you start, it is also important to take the finished materials back to people with disabilities and their caregivers and ask them to review, critique and comment, then make adjustments accordingly.

Develop a dissemination plan

It is important to think through how the information will be disseminated. Using a matrix like the one on the next page can help you in this process. In your planning, it might also be helpful to do some social mapping with women, girls, boys and men with disabilities and their caregivers to find out where they go, what time of day and so on, so that you are putting your messages in places where they are most likely to be received.

Tool 7: Accessible information, education and communication (IEC) materials

<i>Type of disability/ impairment and effective communication methods</i>	People who are visually impaired or blind	People who are hearing impaired or deaf	People with intellectual disabilities	People with physical disabilities
Radio	✓		✓	✓
Television	For audio content	For visual content	✓	✓
Printed materials: posters, billboards and flyers (dependent upon literacy)		✓	Simplified picture-based messages	✓
Drama	For spoken content	For visual content	✓	✓
Discussion groups	✓	With appropriate sign interpretation	If simplified and accepted by group members	✓

Example of analysis of existing IEC materials

On the next page is an example of how to analyze existing IEC material. Look at the picture, which depicts the referral pathway for GBV survivors from a GBV program in Ethiopia. How do you think this material responds to the key questions listed above?

- (i) Who will be able to understand this information in its current form?
- (ii) Who won't be able to understand this information in its current form?
- (iii) Do the pictures that you are using on the billboard reflect different people in the community?
- (iv) What do persons with disabilities think about the billboard?
- (v) Where will you put the billboard?

Example: Referral Pathway Billboard from My'Ani, Ethiopia



Below is guidance on each question as it relates to the example above.

(i) Who will be able to understand this information in its current form?

The billboard is designed to communicate to all refugees, but particularly those who cannot read written messages (which is why it is in picture form). There are many different people who can't read written messages — some may have disabilities and some may not. Good quality IEC materials designed to communicate messages to those who are illiterate will also reach persons who are deaf, persons with intellectual and mental disabilities and, of course, persons with physical disabilities, with very minimal adaptations.

(ii) Who won't be able to understand this information in its current form?

People who are blind won't be able to access the information on this billboard or any other poster. So it may be necessary to have an additional IEC communication approach to convey information about the referral pathway, like radio or announcements or discussions that target persons who are blind.

(iii) Do the pictures that you are using on the billboard reflect different people in the community?

Often people with disabilities and their families won't think to access services because all the messages (written and/or visual) subtly reinforce that these services are for non-disabled people. So it may be helpful to have just one image on this billboard that shows a person with disabilities. For example, the girl at home looking after a baby could actually be a girl with a physical disability. This very small adaptation makes the overall billboard a better reflection of the different types of women in the refugee community.

(iv) What do persons with disabilities think about the billboard?

As with many IEC materials, it would help to “test” the billboard with the community before you finalize it. You may like to bring a small group of persons with disabilities together to ask them what they think about the billboard. Can they understand it? Are they comfortable with how persons with disabilities are represented? What further changes do they recommend?

(v) Where will you put the billboard?

What is the best place to put this billboard so that persons with disabilities will see it and spend some time processing the information? Again, persons with disabilities can give advice on this. For example, it may be useful to place this poster in the offices of any disability associations or organizations working with persons with disabilities. To reach people isolated in their homes, you could produce small flyers to give out during home visits or awareness-raising activities.

Note:

1. Effective IEC materials should target specific populations as appropriate. For example, information about services in response to GBV should reflect and target women and girls, including those with disabilities, who are the most affected by GBV.

To download the complete *Toolkit for GBV Practitioners, the report “I See That It Is Possible”: Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings and Stories of Change*, visit http://wrc.ms/disability_GBV

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 8: Guidance for GBV caseworkers: Applying the guiding principles when working with survivors of disabilities

*This tool has been adapted by the Women's Refugee Commission (WRC) from resources developed in partnership with the International Rescue Committee as part of the project **Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings**.*

Purpose of this tool

Many of the issues faced by survivors with disabilities are similar to those faced by all GBV survivors, though in the case of persons with disabilities, they may be magnified by the discrimination, misunderstandings and assumptions often associated with disability.

This tool has been developed to support GBV caseworkers to uphold a survivor-centered approach to working with GBV survivors with disabilities. The guidance is consistent with the best practice principles outlined in globally endorsed documents on responding to GBV (e.g., the *Handbook for Coordination of GBV in Humanitarian Settings*¹) and the United Nations Convention on the Rights of Persons with Disabilities.²

Applying the core GBV guiding principles to survivors with disabilities

The core GBV guiding principles described below should always be upheld when working with survivors with disabilities. The two key issues we must consider in our implementation of the guiding principles with survivors with disabilities are:

(i) Communication: How do we need to adapt our communication methods to convey the same ideas when we cannot rely solely on verbal communication? In most cases, survivors with disabilities can communicate directly with GBV practitioners with no adaptations, or relatively small adaptations, such as identifying someone who can interpret their form of sign language or by using simplified language in discussions. In other cases, it may be less clear what the best way to communicate with a survivor is, and additional steps may be required to determine this. When working with persons who find it difficult to communicate:

- Take time, watch and listen. This is a process, not a one-time event. Each time you meet the person you will learn something new about them and understand better how they communicate and what they mean.
- Conduct open conversations with caregivers in which the individual can hear what is being said

Tool 8: Guidance for GBV caseworkers: Applying the guiding principles when working with survivors of disabilities

and participate in any way possible. Remember that people who can't speak or move may still understand what is happening around them and what people are saying about them.

- Pay attention to any way in which the individual wishes to communicate. This could be through gestures and sometimes their emotions. Some persons with intellectual and mental disabilities can exhibit a wide range of behaviors. This is sometimes the way they communicate with others.

(ii) Caregiver involvement: *How and when do we involve caregivers in the care and support of the survivor?* For some individuals with disabilities, family members and caregivers may assist with communication and daily care. While we want wherever possible to have direct communication with and participation of survivors with disabilities, in some cases we may also need the advice and support of their caregivers. Family members and caregivers can be critical partners in helping us define and implement strategies for effective communication and participation with persons with disabilities. The relationship between the survivor and the caregiver is sometimes an enduring, central relationship, and we can focus on supporting and strengthening positive features of this relationship throughout the case management process. Working with and establishing trust with caregivers will also create space for more effective direct engagement with the survivor.

The content below summarizes how the guiding principles are implemented in our work with GBV survivors.

Respecting the wishes, rights and dignity of survivors

The essence of this guiding principle is that the caseworker should always seek to validate and empower the survivor. Validating the survivor means that we believe her story and we let her know this. It means that we do not judge her actions, opinions and decisions, but rather we affirm that she is not to blame for the violence or abuse she experienced. Empowering the survivor means that we let her know she is brave for sharing her story and for coming for help, and we communicate that we are here to listen and support her. We allow her to make the decision that is best for her, and we trust that she knows what is best for her.

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

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

When you understand, acknowledge this with the individual. In the past, they may have been dismissed when trying to communicate their feelings and experiences. Reassure them that you believe them, validating any experiences and emotions that they share with you.

(ii) Caregiver involvement: Societal attitudes, stigma and discrimination relating to disability can affect the way service providers approach case management with survivors with disabilities. In many societies, persons with disabilities are perceived as individuals who must be "cared for" or "protected." This may result in assumptions that the survivor is incapable of making their own decisions, and staff may defer to others, including family members or other service providers, to make decisions on their

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behalf. These attitudinal barriers often result in a failure to fully investigate the survivor's capacity to consent, and reinforces their disempowerment by having others make decisions for them.

In situations where we may have to involve a caregiver in order to better understand the survivor's situation, obtain consent for services and make decisions about the survivor's care, we can still empower the survivor by: directing our conversation to the survivor first; always asking permission from the survivor to consult with the caregiver from the very beginning and throughout the conversation; and always checking back in with the survivor throughout the process. More information is provided below and in [Tool 9](#) regarding the informed consent process for survivors with disabilities.

Ensuring the physical and emotional safety and security of the survivor

All case actions must safeguard the survivor's physical and emotional well-being in the short and long term. This means that we must ensure that the space in which we speak to the survivor feels safe to her. In our assessment of the survivor's needs and in our case action planning with the survivor, we must prioritize discussions and actions that will minimize the survivor's risk for further harm. Care and treatment provided by the caseworker and others must be carried out in a space and in such a manner that the survivor can trust that she will not be physically or emotionally harmed by the caseworker or the caseworker's actions.

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

(ii) Caregiver involvement: While many caregivers play a supportive role in the survivor's disclosure of abuse and healing, there may also be cases when the caregiver is the perpetrator of abuse, or we have concerns that the survivor will be harmed if the caregiver finds out about the abuse and/or the survivor's disclosure. It is important to remember that in many GBV cases, a survivor seeking help can significantly increase their risk of further harm if the perpetrator or perpetrator's family and friends find out. In such cases, safety is paramount, and we need to support the survivor in telling us who and where is not safe for her and with whom and where she feels safe. It may be possible, then, with the survivor's consent, to involve this person/people in the survivor's care and to make sure the survivor has a safety plan in place.

Maintaining confidentiality and only sharing necessary information with permission from the survivor

This principle requires that caseworkers and others involved in the care and treatment of the survivor protect information gathered about survivors and agree to only share information about a client's case with their explicit permission. This means ensuring 1) the confidential collection of information during interviews; 2) that sharing information happens on a need-to-know basis or in line with laws and policies, and that permission is obtained from the survivor before information is shared; 3) in the

Tool 8: Guidance for GBV caseworkers: Applying the guiding principles when working with survivors of disabilities

case of referrals, only the details relevant to the referral are shared with the other service provider, and survivor and caseworker reach a decision together about what information should be shared; and 4) case information is stored securely.

All standard rules of confidentiality apply when working with adult survivors with disabilities. Caseworkers and service providers should only share information about a survivor with the survivor's explicit permission.³ They should never discuss case details with family and friends, nor with colleagues unless knowledge of the abuse is necessary for service provision.⁴ Caseworkers should, however, consult with their supervisors when they believe that a survivor does not have capacity to consent and in making decisions that are in their best interests.

Caseworkers and service providers should only share information without the permission of an adult survivor if they believe that the individual may hurt themselves or others, or if there are mandatory reporting requirements in the local setting.⁵ For example, if the person has a legal guardian, caseworkers and service providers may be required by law to provide information to that guardian, but this will vary across settings.⁶

(i) Communication: Any support persons engaged in the case management process, be they family members, caregivers and/or interpreters, should be briefed on the principles of confidentiality. Participatory activities may also be useful to assist persons with intellectual disabilities to better understand the principles of confidentiality and who they may want to share information with, and to explore different strategies or ways to respond to questions from others.

(ii) Caregiver involvement: Caseworkers should consider strategies to appropriately manage confidentiality if seeking further advice from family members and caregivers on communication methods and/or in decision-making processes. Wherever possible, the decision about who to involve and when should be made in partnership with the survivor, and include an analysis of risks to the survivor's safety. The caseworker must think through what additional steps need to be taken with the caregiver or assistant in order to ensure that they are a supportive person in the survivor's life. For example, do you need to set up a different meeting with the caregiver in order to explain what happened and provide information about how they can be supportive in the survivor's healing process (e.g., by maintaining confidentiality, by not judging or blaming the survivor, by reinforcing their strength and courage to tell someone and seek help, and by not pushing a particular action or service in response to the incident)?

Ensuring non-discrimination

This guiding principle means that we provide the same quality of service to every survivor regardless of their sex, age, ethnicity or disability. By learning the best practices for how to adapt our communication and informed consent processes to survivors with different types of disabilities, we can maintain a survivor-centered approach and deliver quality services to this population.

(i) Communication: Societal attitudes, stigma and discrimination relating to disability can affect the way caseworkers and service providers undertake the case management process. Be careful not to make assumptions about the capacity of a survivor with disabilities. This may result in a failure to fully present the different options to a survivor with disabilities, resulting in discrimination in service provision and reinforcing disempowerment as others make decisions for the survivor. It is important

Tool 8: Guidance for GBV caseworkers: Applying the guiding principles when working with survivors of disabilities

to present all available options to a survivor with disabilities, even if you are not yet sure how they will participate in these activities. Present all the options in a way that you think the survivor will understand. Be prepared to try several different ways of communicating these options (e.g., if there is an English class in your women's center, you may want to support the survivor to visit the class to show her what it involves). Give the survivor time to think about these options and to ask questions.

(ii) Involving caregivers: Women and girls in the household often assume caregiving of persons with disabilities, in addition to the other roles expected of them in society. They are isolated and at risk of violence inside the home. Hence, it is important to also consider the support that caregivers may need when providing case management to a survivor with disabilities. Thinking through the perspectives and needs of both the survivor and the caregiver, and the intersections and relationships between each individual and the caseworker, can help to shape the process of case management in a way that ensures that the needs of both individuals are met, and that their relationship is strengthened.

Promote the best interests of the survivor

This principle is particularly important for survivors who may not have the capacity to consent to services. If an adult lacks capacity to consent to interventions, caseworkers and service providers have a duty to provide care in the best interests of the survivor. Such decisions should be made, however, in consultation with his/her supervisor. Decisions or actions considered to be in the best interest of a survivor are those that:

- protect the survivor from potential or further emotional, psychological and/or physical harm;
- reflect the survivor's wants and needs;
- examine and balance benefits and potential harmful consequences; and
- promote healing and recovery.⁷

(i) Communication: Even people who lack capacity to consent have a right to information and can play a role in decision-making.⁸ Share information, listen to their ideas and opinions, and explain how and why decisions have been made. Always seek informed assent from the survivor, which is the survivor's expressed willingness to participate in the services or activities proposed. You can also use pictures, hand gestures or symbols to determine if someone is willing to participate in an activity or to access a service.

(ii) Caregiver involvement: The best interests of the individual are the priority for decision-making, and it is important to note that sometimes the decisions of caregivers may not be linked to the best interests of the individual.⁹ For example, caregivers may want to pursue justice options. If the survivor does not understand the legal processes involved, then it is unlikely to promote healing and recovery, and may even expose them to further emotional harm, as they will have to recount their experiences to others. This referral may not be in the best interest of the survivor, but rather in the best interests of the caregiver, who may be seeking their own form of healing and recovery. Exploring the reasons why caregivers think certain actions are in the best interest of the survivor can help to come to decisions that reflect the wider needs and interests of the individual.

Tool 8: Guidance for GBV caseworkers: Applying the guiding principles when working with survivors of disabilities

Notes:

1. <http://gbvaor.net/wp-content/uploads/sites/3/2012/10/Handbook-for-Coordinating-Gender-based-Violence-in-Humanitarian-Settings-GBV-AoR-2010-ENGLISH.pdf>
2. <http://www.un.org/disabilities/default.asp?navid=15&pid=150>
3. *Supporting sexual assault survivors with disabilities: A chapter update to the "Support for Survivors" training manual*, p. 12. <http://www.calcasa.org/wp-content/uploads/2010/12/Survivors-with-Disabilities.pdf>
4. Ibid. IRC WPE Program Case Management Guidelines — July 2013 (DRAFT), p. 12.
5. IRC WPE Program Case Management Guidelines — July 2013 (DRAFT), p. 76.
6. *Supporting sexual assault survivors with disabilities: A chapter update to the "Support for Survivors" training manual*, p. 12. <http://www.calcasa.org/wp-content/uploads/2010/12/Survivors-with-Disabilities.pdf>
7. Adapted from the following publications:
<http://gbvaor.net/wp-content/uploads/sites/3/2012/10/Caring-for-Child-Survivors-of-Sexual-Abuse-Guidelines-for-Health-and-psychosocial-service-providers-in-Humanitarian-settings-IRC-UNICEF-2012-ENGLISH2.pdf>
<http://www.dhsspsni.gov.uk/consent-guidepart4.pdf>
http://www.briscomhealth.org.uk/files/Best_Interests_Guidance.pdf
8. *Consent and people with intellectual disabilities: The basics*. <http://www.intellectualdisability.info/how-to-./consent-and-people-with-intellectual-disabilities-the-basics>
9. *Seeking consent: Working with people with learning disabilities*. <http://www.dhsspsni.gov.uk/consent-guidepart4.pdf>

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Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 9: Guidance for GBV service providers: Informed consent process with adult survivors with disabilities

Purpose of this tool

The Convention on the Rights of Persons with Disabilities (CRPD) highlights that persons with disabilities have the same rights to make their own decisions as everyone else, and that appropriate measures must be taken to support them to exercise their legal capacity. ***An individual cannot lose their legal capacity to make decisions simply because they have a disability.***¹ Where a person does not have capacity to make their own decisions, and someone else will be speaking for them, we need to take measures to ensure that decisions are made in a way that reflects the rights, will and preferences of the individual, are tailored and appropriate to the person's circumstances and are reviewed on a regular basis to ensure that all opportunities to exercise capacity are optimized.² As highlighted in [Tool 8](#) (*Guidance for GBV caseworkers: Applying the guiding principles when working with survivors of disabilities*), a critical element to the survivor-centered approach is that the survivor makes decisions about their care and treatment, and such decisions are respected and followed by service providers.

This document is intended to help service providers navigate informed consent processes with **adult** survivors with disabilities.

Understanding informed consent

Informed consent is defined as “the voluntary agreement of an individual who has legal capacity to give consent.” To provide “informed consent,” the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. Determining who is “legally” able to give consent for certain types of services will depend on the context that you work in — however, usually children under age 15 are not legally able to provide consent on their own.

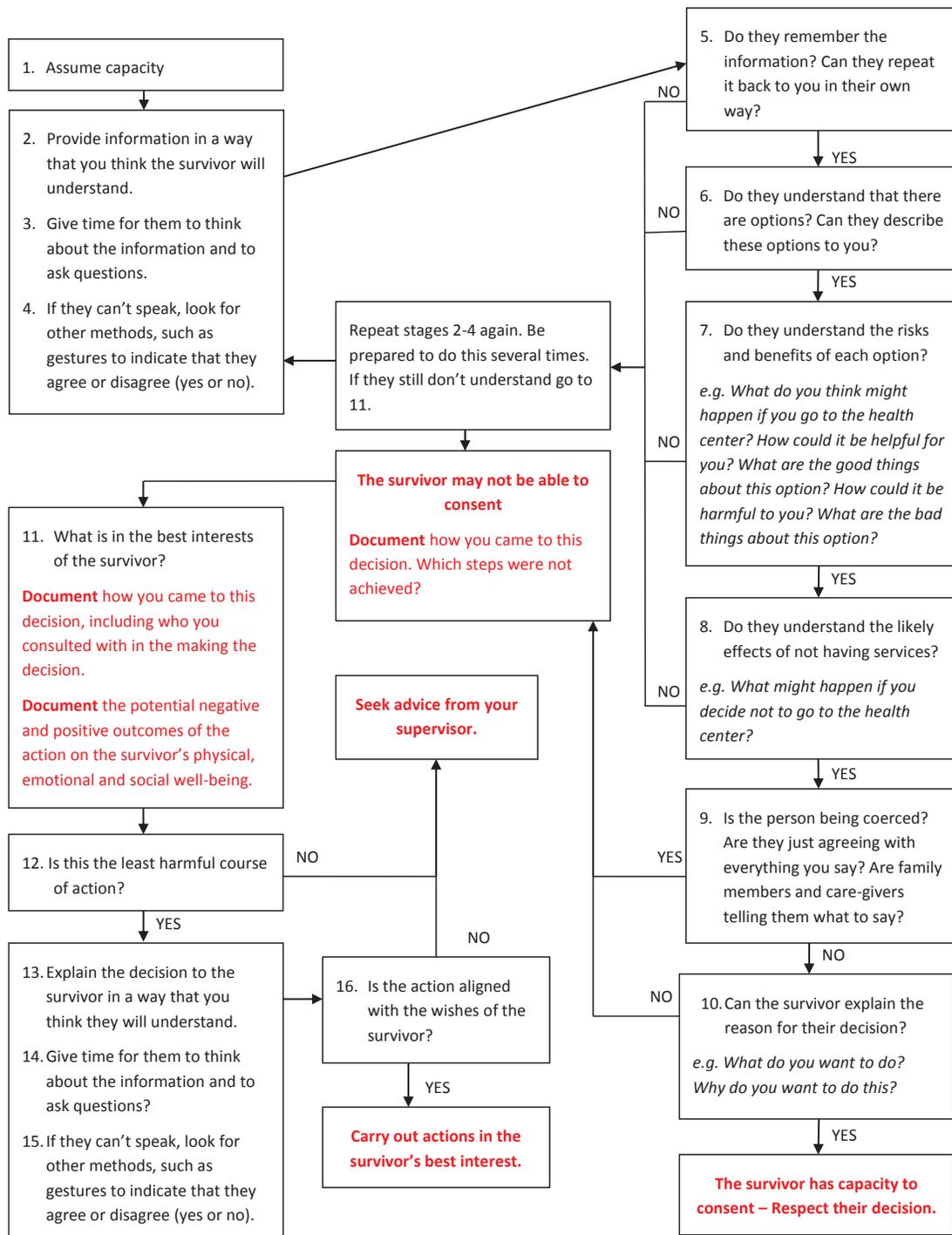
The informed consent process has three key components:

- i. providing all possible information and options to a survivor in a way they can understand;
- ii. determining if they can understand this information and/or their decisions (also referred to as “capacity to consent”); and
- iii. ensuring that the decisions of the survivor are voluntary and not coerced by others (e.g., family members, caregivers or even service providers).

Determining capacity to consent for survivors with disabilities³

The flow chart below can help you navigate the informed consent process with a survivor with a disability by helping you determine their capacity to consent and when it may be in the best interest of the survivor to get consent from a family member or caregiver, or take action on behalf of the survivor. Tips are also provided that elaborate upon the guidance in the flow chart.

Capacity to consent and best interest flow-chart



Adapted from: Consent and persons with intellectual disabilities: The basics. <http://www.intellectualdisability.info/how-to./consent-and-people-with-intellectual-disabilities-the-basics>

1. When conducting the informed consent process, it is important for service providers to remember the following:

- **Assume capacity to consent.** All adults have capacity to make their own decisions unless demonstrated otherwise. This applies to people with all types of impairments, including those with intellectual impairments. While family members and caregivers play a significant role in the lives of many persons with disabilities and are a valuable resource in facilitating understanding and communication, they do not necessarily have the legal authority to make decisions for an adult with disabilities.⁴
- **Capacity to consent refers to the ability to make a particular decision at a particular time.** Capacity can change over time, but also according to the nature and complexity of the decision. For example, Maria has an intellectual disability. She may have the capacity to understand and consent to HIV post-exposure prophylaxis, because she understands the concept of taking medicine as a treatment and has taken medicines before to prevent other illnesses. She may, however, find it more difficult to understand what legal assistance means and therefore would not be able to consent to a referral to legal assistance. Consent is an ongoing process and not a one-time event. It is important that we never assume that a survivor's consent to one service means that she consents to everything.
- **Capacity to consent depends on understanding, and understanding can vary according to how we communicate information.** For example, Maria may initially decline or accept referral to an economic empowerment activity. But have we conveyed the information in a way that she can understand it and use it in making her decision? If we discuss her goals, describe the activities to her, explore what she likes and doesn't like about these activities and support her to visit the class without having to make any commitment to participating, then Maria will understand better the activity, and the possible positive and negative outcomes for her, enabling her make a more informed decision, and enhancing her capacity to consent. Hence, in some circumstances, it can be more helpful to seek consent for smaller steps in a longer process, so that survivors are in control of every part of a process and can stop it at any time.

2. If you determine that a survivor does not have the capacity to consent, it is important for you to consult a supervisor to determine the best way to proceed, using the best-interest principle.

- **The initial informed consent process: consent to receive your organization's services.** When working with a survivor who you are not sure has the capacity to consent, it may be necessary in the initial informed consent process to involve another trusted individual who can help facilitate the communication and understanding regarding the services you are offering. To the extent possible, the decision about whom to involve should be made in partnership with the survivor. If there is no one accompanying the survivor, consult your supervisor as to how to proceed, using the best-interest principle. For example, you may decide that it is in the best interest of the survivor to approach the caregiver and get their consent for services on behalf of the survivor. A staff member should never make such a decision on their own. Such a decision must always be reached by analyzing the survivor's situation with respect to safety. Remember that getting the caregiver's consent for your organization's services does not mean that you have the survivor's or the caregiver's consent for any other interventions.
- **Consent for referrals and other services.** If caregivers or others are involved, it is important that you continue to use the best-interest principle to ensure that the survivor's wishes and needs

Tool 9: Guidance for GBV service providers: Informed consent process with adult survivors with disabilities

remain the focus, and the survivor feels safe. **Be sure to observe the survivor's interactions with the caregiver.** If you feel the power dynamic and relationship between the caregiver and the survivor is affecting the right of the survivor to participate in decision-making and/or if decisions are not aligned with their wishes and desires, consult your supervisor in order to determine how to proceed. Remember that the **interests of family members and caregivers may not be linked to the best interests of the individual.**⁵ For example, in the case of Maria, a GBV survivor with a disability, her mother and father may want to pursue justice options for the case. If Maria does not have the capacity to consent to this referral, then caseworkers must ask, "Is this in Maria's best interest?" As she does not understand the legal process, it is unlikely to promote healing and recovery, and may even expose her to further emotional harm, as she will have to recount her experiences to others. This referral may not be in her best interests, but rather something the mother and father want to do for their own reasons. Exploring the reasons they want to seek legal assistance and whether it would be in Maria's best interest to do so can help Maria's parents better understand that such an action does not reflect Maria's needs and interests. If the parents' refuse to reconsider, you should bring such a case to the attention of your supervisor so that options for intervening on behalf of the survivor can be discussed.

3. When involving others in the informed consent and decision-making process, remember:

- **Even people who lack capacity to consent have a right to information and can play a role in decision-making.**⁶ Share information, listen to their ideas and opinions, and explain how and why decisions have been made. This interaction will also assist in the monitoring of changes in capacity to consent over time and with different types of decisions.
- **Always seek informed assent from the survivor.** If you deem that a survivor is not able to provide "legal consent," you must seek to obtain informed assent, which is the survivor's expressed willingness to participate in the services or activities proposed. Use pictures, hand gestures or symbols to ask if someone is willing to participate in an activity or to access a service. Also watch for signs of agitation, anger or distress that may indicate that the individual is not happy with something that is being discussed or an activity that is being undertaken.

Notes:

1. *Handbook for parliamentarians on the Convention on the Rights of Persons with Disabilities.* <http://www.un.org/disabilities/default.asp?id=212>
2. Article 12 of the CRPD relates to equal recognition before the law. <http://www.un.org/disabilities/documents/convention/convopt-prot-e.pdf>
3. Adapted from: *Consent and people with intellectual disabilities: The basics.* <http://www.intellectualdisability.info/how-to../consent-and-people-with-intellectual-disabilities-the-basics>. See also, *Informed consent in adults with developmental disabilities.* <http://www.surreyplace.on.ca/Documents/Informed%20Consent%20in%20Adults%20with%20DD.pdf>
4. This is sometimes referred to as "substituted decision-making" — when the guardian or caregiver has court-authorized power to make decisions on behalf of the individual without necessarily having to demonstrate that those decisions are in the individual's best interest or according to his/her wishes. Even where an individual has legal authority, the Convention on the Rights of Persons with Disabilities calls for safeguards to be put in place to protect against abuse of these mechanisms. <http://www.un.org/disabilities/default.asp?id=242>
5. *Seeking consent: Working with people with learning disabilities.* <http://www.dhsspsni.gov.uk/consent-guidepart4.pdf>
6. *Consent and people with intellectual disabilities: The basics.* <http://www.intellectualdisability.info/how-to../consent-and-people-with-intellectual-disabilities-the-basics>

To download the complete *Toolkit for GBV Practitioners, the report "I See That It Is Possible": Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings and Stories of Change*, visit http://wrc.ms/disability_GBv

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 10: Working with caregivers of survivors with disabilities

Purpose of this tool

Working with caregivers of survivors with disabilities is critical to ensuring the safety and opportunities of both the survivor and the caregiver. This tool provides information and guidance to support service providers in developing positive, useful and balanced relationships with caregivers of survivors with disabilities.

Key issues for us to consider in our work with caregivers include:

Caregivers are people first and foremost (most often women and girls) with their own perspective, needs and feelings. Caregiving is a complex role, and caregivers may have conflicting feelings — they may feel guilty, resentful, angry, afraid, concerned and as though they have failed. They may prioritize the person they are caring for above everything else, including themselves, and they may focus all their attention and love in one direction, which can be difficult for others in the household. They may also have unmet needs of their own, particularly if they carry the full responsibility for care with no one to support them. For female caregivers, caring for a person with disabilities comes in addition to the many other responsibilities and duties expected of them at home.

The relationship between the survivor and the caregiver is the enduring, central relationship, and focusing on supporting and strengthening this is important to the survivor's healing. It is important to pay attention to the dynamic between the survivor and their caregiver. What are the strengths of this relationship? What do both people have confidence in and what is this relationship built on? What are the mutual expectations and assumptions? How do these interact? What tensions can you see? What do you think is contributing to these tensions?

Caregivers are also exposed to the threat and reality of GBV, and we have to pay attention to their safety concerns and their opportunities to have more control over their lives. Caregivers are most often women and adolescent girls, meaning they already experience disadvantage within the household and community, and are likely over-burdened with domestic responsibilities, including the care of children and the elderly, and household chores. Caregiving can be a very isolating experience, and more so for women who are already less likely to have access to opportunities outside the home. This is also an opportunity to talk about female caregivers' own exposure to and risk of violence, including violence from the people they care for or domestic violence, and work with them to plan for safety and access to services.

Caregiving is a demanding role that can impact caregivers' own well-being, their other responsibilities and household and family dynamics. We may have expectations and assumptions about how people should behave in different roles, and it is important to make sure that these are not clouding our assessments when it comes to working with caregivers. We should be mindful about not reinforcing norms and values that hold women responsible for the care of others and judge them harshly on how they provide it. For example, if a woman responsible for the care of an adolescent girl with disabilities locks the girl in a room while she goes to the market, it may be that she feels this is her only option to keep the girl safe while she is not there. Within

Tool 10: Working with caregivers of survivors with disabilities

their responsibilities as caregivers, women may have very limited options and few people who help them. It is essential to talk with caregivers about their context, environment and constraints before helping them to explore alternatives, and to understand the rationale for their actions and decisions, rather than working from our own assumptions and judgements.

Providing good support for caregivers is one of the most effective ways to improve the safety and well-being of those they care for. It may be useful to work separately with caregivers (in addition to working with survivors and caregivers together). This can serve a psychosocial intervention in and of itself by creating a safe space for caregivers to talk about the issues that affect them, their own emotions — positive and negative — without feeling that they are being demanding or selfish, or that they are not properly heard. It is also important to recognize that feelings about being a caregiver are complex, and it is normal to feel frustration, resentment and anger, along with love and concern. Helping women to develop ways to understand and manage these feelings can be very helpful in strengthening the core relationship between the caregiver and the person being cared for, and developing strategies for ensuring that a caregiver's needs are met.

In providing such support to the caregiver, it is important for the caseworker to think about: *What is the caregiver looking for from you? What kind of alliance do you want to build with them, and what kinds of boundaries will you need to pay attention to? How realistic/possible are their expectations? What elements of this relationship might be difficult, and what can you build on?*

Practical tips to support caregivers

- Discuss the social networks and support available to caregivers. Strategizing ways to find respite, to identify opportunities to meet other women and to strengthen supportive relationships can be very valuable, including as a way to break through the isolation caregivers often experience. Peer support groups can provide an opportunity for caregivers to meet others and to share experiences, challenges and successes with each other.
- Talk with caregivers about the impact of caring on their well-being and their capacity to think about their own needs and the feelings that they have. Make sure you recognize that these are normal feelings to have and that caring is complicated and demanding. Help them to identify their own feelings without guilt, particularly when their feelings are difficult and when they are different from the messages women get about how they are supposed to feel.
- Discuss strategies for paying attention to their own feelings and needs, such as:
 - » forming relationships with other women and/or caregivers in similar positions;
 - » finding ways to maintain activities that are important to their own self-care and well-being (e.g., taking time to eat well, bathe, sleep and attend community activities they enjoy);
 - » identifying people that they trust to ask for help or additional support.
- Breathing and visualization exercises can sometimes be useful when feeling overwhelmed and/or anxious.
- Support caregivers to have access to the different services and programs that they can attend, such as skills training or economic empowerment and women's groups, which will support their empowerment.

To download the complete *Toolkit for GBV Practitioners, the report "I See That It Is Possible": Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings and Stories of Change*, visit http://wrc.ms/disability_GBV

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 11: Reflection tool for GBV practitioners

Purpose of this tool

This tool is designed to support program staff to reflect on the process of disability inclusion that their GBV program has undertaken. It provides questions to guide a group discussion among staff to help them identify changes in their own knowledge, attitudes and practice that have allowed greater accessibility and participation for people with disabilities and caregivers. It also allows staff to identify persistent gaps and further actions to be taken to remedy such gaps. Ideally, someone outside of the program who can maintain an objective viewpoint should facilitate the discussion. If this is not possible, it is important to identify someone in the program who has not been directly involved in the disability inclusion process.

Facilitator: _____

Note-taker (if applicable): _____

Date: _____ Location: _____

Translation: Yes No

If yes, the translation was from _____ (language)

to _____ (language)

Group description: _____
(e.g., community mobilizers; GBV case workers)

Instructions

Note: This group discussion format requires about 2 hours, so may be best spread over two blocks, with a break. Part C can also be finalized by groups outside of the discussion.

- Introduce all facilitators and translators.
- Present the purpose of the activity:
 - » to identify changes in knowledge, attitudes and practices related to disability inclusion among GBV practitioners;
 - » to share successes and ongoing gaps in capacity on disability inclusion;

Tool 11: Reflection tool for GBV practitioners

- » to plan a vision for the future and next steps.
- Frame the activity as a reflective learning discussion with the intention of sharing what they have learned and identifying areas that need more attention. Ensure that people feel comfortable sharing and engaging with things that they have found difficult (there may need to be ground rules).
- Agree on confidentiality, and ensure that people are careful to share examples and stories that will not identify the individuals concerned, whether staff or beneficiaries.

Discussion questions and participatory activities

Part A: Our capacity as GBV practitioners — How has it changed?

1. Ask each person to think of 2–3 things that describe their capacity related to disability inclusion “before” the project (purple paper) and “now” (blue paper). Provide time for people to think and write these down.

(10 minutes)

2. If the group is small and participants know each other well, you can invite people to read out their own statements and stick them on the wall under the signs “Before” and “Now.” For larger groups or those who are less comfortable with each other, you can collect statements and read them out anonymously, again sticking them on the wall under the signs “Before” and “Now.”

(30 minutes)

3. Large group discussion:

- » What differences do you see between the “before” and “now” groups?
- » What is the most important change that you see in the capacity of GBV practitioners relating to disability inclusion (i.e., changes in knowledge, attitudes or practices)?
- » How or why do you think this change happened? Write these factors on green paper and stick them on the wall.

(30 minutes)

Note: This activity is more likely to elicit discussion on facilitators than barriers. If participants raise barriers, gaps or challenges in this discussion, these can be documented on red paper and referred to in the next discussion.

Part B: Our capacity as GBV practitioners — What do we want for the future?

1. Large group discussion:

- » What are some of the ongoing gaps/challenges/barriers for GBV practitioners relating to disability inclusion?
- » How and why do you think these did not change or still exist? Write these factors on red paper and stick them on the wall.

(10 minutes)

2. Now ask participants to think of 2-3 things that they wish to feel more confident about regarding disability inclusion (yellow paper). Provide time for people to think and write these down.

(10 minutes)

3. If the group is small and participants know each other well, you can invite people to read out their own statements and stick them on the wall under the sign “The Future.” For larger groups or those who are less comfortable with each other, you can collect statements and read them out anonymously, again sticking them on the wall under the sign “The Future.”

(30 minutes)

Part C: Our key messages

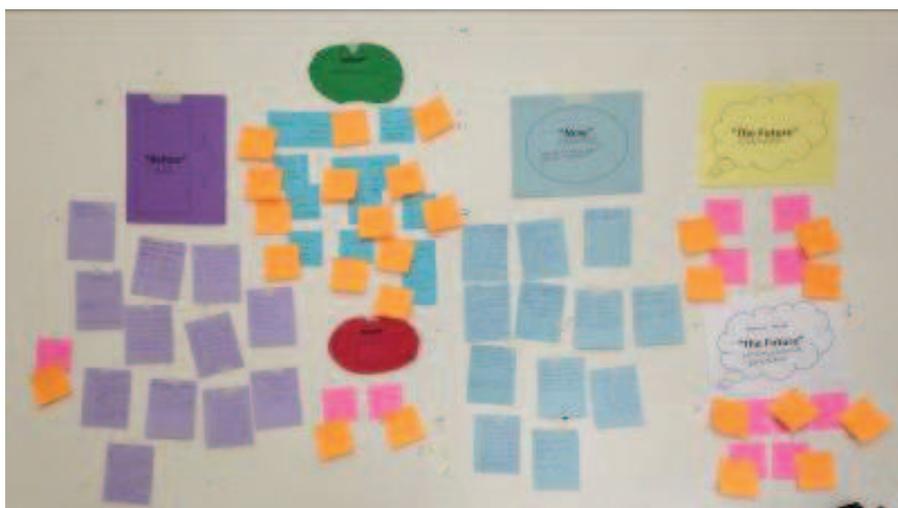
1. Large group discussion:

- » How would you like to present your successes and recommendations for the future to other stakeholders? Some suggestions include conducting a stakeholder workshop where GBV practitioners and persons with disabilities share their successes and recommendations for the future.

(15 minutes)

Conclude the discussion

- Thank staff for their participation and contributions.
- Congratulate them on their successes and progress.
- Clarify the next steps for staff capacity development.



Participatory activity with GBV practitioners — Capacity on disability inclusion “Before,” “Now” and “The Future”

To download the complete *Toolkit for GBV Practitioners, the report “I See That It Is Possible”: Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings* and *Stories of Change*, visit http://wrc.ms/disability_GBV

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Tool 12: Documenting “Stories of Change”

Purpose of this tool

This tool can be used to document how persons with disabilities and caregivers have been included in GBV activities, and what has been the most important change for them. The tool includes questions to facilitate a group discussion with people with disabilities and caregivers. It can help program staff understand the actions that make their programs more accessible to and inclusive of people with disabilities and caregivers, and gather ideas about next steps. A stakeholder workshop can also be convened to provide space for persons with disabilities and caregivers to share their stories, and use these for program evaluation and planning.

Please note: This tool **should not be used with GBV survivors**, but rather with community members who have participated in other types of social or economic programming or prevention work.

Facilitator: _____

Note-taker (if applicable): _____

Date: _____ Location: _____

Translation: Yes No

If yes, the translation was from _____ (language)

to _____ (language)

Group description: _____

(e.g., adolescent girl with disabilities; female caregiver)

Instructions

- Introduce all facilitators and translators.
- Present the purpose of the activity:

“We want to find out how you have been included in GBV activities and what has allowed you to participate. We will ask you to share examples, stories and things you think other people should do in their programs. You can choose to share your story in any way you like. You could tell it to others or write it down; you could use a drawing; or you could take some photographs to help tell your story. You may like to do this on your own or with a friend or family member. It

Tool 12: Documenting “Stories of Change”

is your choice. We will then have a meeting where people can come to share these stories and learn from each other.”

- Get consent from participants:
 - » People should be asked about consent before the activity begins. Explain that participation in these exercises is completely voluntary. People are free to withdraw from the activity at any time, without giving reasons. Participating or not participating is not connected to any use of or entitlement to current or future services or activities.
 - » Explain how the stories might be shared and used before anyone starts to share their story. Explain that they can also share their story anonymously, if they prefer.
- Agree on confidentiality:
 - » Be clear with participants that there is no need to share personal experiences of violence, and that they are welcome to talk about their general participation in services, activities and so on.

For people with limited communication abilities, ask caregivers: ***How does [state the name of the person] tell you that she/he is unhappy or uncomfortable with something? What makes her/him happy or sad?*** Use this information to facilitate the interview if verbal communication is not possible, and respect any indications that the participant is not comfortable or willing to continue.

Questions to guide story documentation¹

Tell me a bit about yourself. How long have you been living here? Who lives in this household with you?

What kind of community GBV activities do you and your family members participate in?

Ask probing questions relating to specific activities that are running in the community.

Tell me a story that describes the most important change or outcome for you since participating in these activities.

Alternative phrasing: Tell me a story about the outcome of these activities for you. How have they helped you? What has been most important to you?

Tool 12: Documenting “Stories of Change”

How (if at all) did organizations working on GBV contribute to these changes?

Ask probing questions. What did our programs and staff do to help these changes happen? Can you tell me more about this?

What would you like to do next?

What kinds of activities or programs are you interested in now? What kinds of things would you like to participate in? What prevents you from participating? How could we help you to participate in this activity?

Recommendations

What ideas or suggestions do you have for ways we can improve the GBV program in this community for persons with disabilities? What are the three key messages you want to give to people running GBV programs?

Conclude the discussion

- Thank individuals for their participation and contributions.
- Clarify the next steps for sharing stories with other stakeholders.

1. Adapted from: MSC Technique and Guide to Its Use, R. J. Davies & J. Dart (2004). <http://www.mande.co.uk/docs/MSCGuide.pdf>

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Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings

Identifying skills and capacities of survivors with disabilities

Purpose of this tool

This tool has been developed by the Women's Refugee Commission to support GBV practitioners to **identify the skills and capacities of persons with disabilities** that may be useful in both case management with survivors and supporting participation in empowerment activities. It is designed to be used when meeting with survivors with more profound functional limitations in both communication and movement. It complements existing protocols for assessments, action planning and monitoring of survivors and/or those who are at risk of GBV. It is not intended to replace these steps or processes. More guidance for case managers working with survivors with disabilities is available in the *Toolkit for GBV Practitioners*, developed by the Women's Refugee Commission and International Rescue Committee, at: http://wrc.ms/disability_GBV

Some general principles

- Focus on the person first, not their disability or health condition.
- Assume capacity. Look at what they can do, not just at what they can't do. This gives us many more options for communication and participation.
- Treat adults with disabilities as you would other adults, paying particular attention to gender issues. For example, it is best practice for women staff to work with women around issues of GBV.
- Take time, watch and listen. This is a process, not a one-time event. Each time you meet the person, you will learn something new about them and understand better how they communicate and what they mean.
- Conduct open conversations with caregivers in which the individual can hear what is being said and participate in any way possible. Remember that people who can't speak or move may still understand what is happening around them and what people are saying about them.
- Pay attention to any way in which the individual wishes to communicate. This could be through gestures and sometimes their emotions. It is OK, however, to say "I don't understand."
- When you understand, acknowledge this with the individual. In the past, they may have been dismissed by others when trying to communicate their feeling and experiences. Reassure them that you believe them, validating any experiences and emotions that they share with you.
- Some persons with intellectual and mental disabilities can exhibit a wide range of behaviors. This is sometimes the way they communicate with others.

Guidance for case managers: Identifying skills and capacities of survivors with disabilities

- Watch for signs of agitation, anger or distress that may indicate the individual is not happy to proceed at this time, and respect this, even if you are talking with the caregiver. Come back another day to see if they are more comfortable and want to continue.
- Choose quiet times and familiar places for early discussions as this will help both you and the person with disabilities to concentrate on communication.
- Give the person time to respond to your question or instruction before you repeat it. Family members may try to encourage them to answer you, but different instructions from different people can be confusing. Try to have just one person talking at a time.
- Some people may be able to speak and communicate with you, but they would like the support of a trusted person to make decisions. Ask them if they would like this type of support, and encourage them to pick the person they trust the most.

Remember you have many skills that you can use with persons with disabilities. Every day you are listening to, communicating with and supporting women, girls, boys and men who are all different in their own ways. All of us use speech, writing, pictures and posters, and activities, as well as emotions and gestures, to both convey and understand information. Different approaches may work better with each individual. Ask persons with disabilities and their caregivers for advice about their preferred communication method, and then try different things.

Key questions to ask the individual and/or their caregiver

These questions are currently written to be used with an individual, but can also be used with the caregiver if there is no way to communicate directly with the individual. These questions are not designed to gather information about the survivor's experience of violence, but rather to establish how you and they might communicate most effectively, as well as to identify skills and capacities that can be used when engaging them in activities.

Approach the person with disabilities and introduce yourself. Greet them as is appropriate for their age and gender (e.g., shaking hands). Talk to the person directly and try to establish a method of communication. Even when it is not possible to communicate directly with the individual, continue to engage with them while talking to caregivers, so that they can hear the discussion and contribute in any way possible. Try to maintain eye contact so they know you are connected with them. Be sensitive to any negative language being used by family members and present a positive example, rephrasing in positive language as appropriate. Watch for signs that the individual may not want to participate (e.g., becoming distressed, agitated or crying) and respect this, even if you are mostly asking questions of the caregiver.

For people with limited communication, ask caregivers: ***How does [state the name of the person] tell you that she/he is unhappy or uncomfortable with something? What makes her/him happy or sad?*** Use this information to facilitate the interview if verbal communication is not possible and respect any indications that the participant is not comfortable or willing to continue.

1. Tell me a little about yourself. How old are you? What do you do during the day? Who lives here with you?

This introductory question will help you to understand the situation of the survivor with disabilities

and their family. It can give indications of support networks and interests that we can gather more information about.

2. What kind of community activities do you participate in? What are some of things that make it hard to participate in these activities? What are some of the things that help you to participate in these activities?

Ask about education, women's groups and livelihoods activities as appropriate. How did they learn about it? How do they get there? This will give us ideas of how to support them to access our services and activities.

3. What makes you happy? What things do you enjoy doing the most?

People with intellectual disabilities sometimes respond better to real-life examples.

4. Tell me one thing that you are good at. One thing that you can do on your own, or that you are really proud of.

If you have identified that there are things the person likes, then you may be able to direct this question towards that.

5. What makes you sad or angry? What things do you not like doing?

You may also consider asking: How do other people treat you? Does that ever make you sad or angry?

6. Do you have contact with other women/men/children your age? If so, who and where? If not, what makes it difficult for you to meet with others?

If they don't answer or say that they don't have any contact with others, then probe with questions like: Do you know other women/men/children living near here? Have you ever talked with them? It is also good to ask about siblings and cousins.

7. Do you have contact with other persons with disabilities? If so, who and where? If not, what makes it difficult for you to meet other persons with disabilities?

As above, you can ask: Do you know other people who use a wheelchair like you? Or do you know other families who have family members with disabilities? Have you ever talked with them?

8. Who do you talk to when you have a problem or concern? Where do you go if you or your family has problems and concerns?

This may indicate other people that they trust and may want to have involved in different activities. Ask about other family members, and what their relationships are like.

9. Is there a particular organization that you have regular contact with? How do you usually have contact with them? What do you do when you want to talk to them?

10. Are there any activities or programs that you have heard about and would like to participate in? What kinds of things make it difficult to participate in these activities? How could we help you to participate in this activity?

Checklist

The following checklist can help to identify potential communication methods, as well as strategies that promote participation of the individual with disabilities. Sometimes it can be helpful to have some paper, pens and pictures with you, as they can be used to test out different communication methods.

Communication
<p>Is the person with disabilities able to tell you their name?</p> <p>How do family members and caregivers communicate with them? Be sure to also ask siblings and children in the household — they can be very creative and may have their own way of communicating with the individual.</p> <p>Can they answer simple yes/no questions? Maybe using head or hand gestures?</p> <p>How do they express if they are happy or sad? Watch for facial expressions that may indicate that they are happy or sad during your meeting.</p> <p>Can they write or draw? Have some paper and a pen to draw pictures yourself, and let them have a try as well.</p> <p>How do the caregivers and family members engage them? Do they talk to them directly? Do they use signs and gestures?</p>
Physical
<p>Are they dressed in an appropriate way compared with other men and women in the household or community? (e.g., Are they naked or partially clothed when others are fully clothed? If not, ask caregivers for a blanket and/or clothing before continuing with the interview).</p> <p>Is the person with disabilities excluded from household activities (e.g., are they inside a room on their own, or near the other family members)? Are they physically restrained in some way?</p> <p>How are they moving around the room? By themselves? With assistance from caregivers? If being assisted by caregivers, is the individual or the caregiver at risk of an injury?</p> <p>Watch for hitting and other forms of physical violence between family members (especially between children). Are there any obvious signs of injury or illness (e.g., bruises, bandages, or scabies)?</p>
Behavior
<p>Has there been any recent change in their behavior (e.g., mood swings; agitation; fear of other people; sleep or eating disturbances; withdrawal; changes in their usual communication; self-injury; or inappropriate sexual behaviors)?</p> <p>How are they interacting with you and with other family members? For example, maybe they are watching you closely, or trying to play with a brother or sister? Look for things that interest them and ask about these.</p>

Environmental
What is the current state of the individual's home? Is the home of the same quality and/or standard as nearby homes?
Toilet and bathing space: Does this space provide for privacy for the person with disabilities?
How close are they to important facilities (e.g., health centers, schools and community meeting points)?
Do they have any equipment that might help them to reach these places (e.g., a wheelchair)? What is the current state of the equipment?
Is there any transportation available near to their home? What types of transportation are available?
Are there any places nearby where other women and girls/men and boys seem to be meeting to discuss different things? Could the individual with disabilities get to this space?

See summary chart on next page.

To download the complete *Toolkit for GBV Practitioners*, the report *"I See That It Is Possible": Building Capacity for Disability Inclusion in Gender-based Violence Programming in Humanitarian Settings*, and *Stories of Change*, visit http://wrc.ms/disability_GBV

Summary

This page can help you to summarize the findings from your meeting. Complete it after the meeting and continually update as you learn more about the individual.

<p>Things she/he can do...</p> <p>Communication</p> <p>Day-to-day activities</p>	<p>How can I use this in case management planning?</p>
<p>Things she/he enjoys ...</p>	<p>How can I use this in case management planning?</p>
<p>Things she/he doesn't enjoy ..</p>	<p>How can I use this in case management planning?</p>
<p>Other opportunities</p>	<p>How can I use this in case management planning?</p>



**WOMEN'S
REFUGEE
COMMISSION**

