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## The Intersection of Disability and Gender in the Global South: Narratives, Gaps and Opportunities

CBM UK advocacy paper  
April 2018

**CBM is an international Christian disability and development organisation working in over 60 countries to transform the lives of people with disabilities, their families and communities. CBM addresses poverty as a cause and a consequence of disability, and works in partnership to create an inclusive society for all, through healthcare, education, rehabilitation, livelihood development and service delivery, including in humanitarian situations.**

### **This paper aims to:**

- Analyse the current narratives on intersectionality and explore examples and evidence of discrimination and exclusion on the basis of disability and gender, in the global South
- Explore the reasons why women and girls with disabilities are amongst those at most risk of being 'left behind'; being mindful to avoid a victimhood narrative whilst highlighting the realities of discrimination and abuse
- Outline positive pathways to equality and inclusion for women and girls with disabilities
- Offer some insight and recommendations to the UK Government on further actions to tackle the power inequalities that result in exclusion of women and girls with disabilities.

## Introduction

The intersection of disability and gender has received increasing attention over recent years, from international institutions, national governments, NGOs, academics and activists; often using the narrative of 'double discrimination' whereby people with disabilities face exclusion and discrimination on the grounds of both their gender and their disability. Much of the literature and policy-making on gender focuses on women and girls, in an effort to address the persistent discrimination, exclusion and inequality females experience across their lives, in a number of spheres; and this paper follows suit in addressing discrimination based on the social constructs of gender.

A third intersecting 'vulnerability' of poverty further compounds the chances of women with disabilities being amongst the most 'left behind' in social, economic and political participation; however, whilst poverty exists throughout the world, it is a focus on low and middle income countries/ global South, where CBM works, that provides the context for this paper.

Whilst this paper touches on age, it does not explore other intersectionalities such as ethnicity, religion, sexuality and location. It is by no means an exhaustive analysis but rather an initial exploration of the intersection of disability and gender, building upon existing work undertaken across the CBM federation, with some initial recommendations to the UK Government.

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## I. Understanding the intersection of disability and gender

Whilst there is growing interest in disability and gender, there is still a limited volume of research and evidence on the intersectionality of the two areas. This lack of research may go some way to explaining the often generalised analysis resulting in, as described by Janet Price and Nidhi Goyal, the 'myths' presented around women with disabilities, 'who are almost universally believed to be: living in poverty, often close to destitution; without work and without education, thus lacking skills to support themselves; subject to widespread magical beliefs of fate and misfortune, even of being witches; asexual and unable to establish a relationship or have children; and conversely, hypersexual and/or the victims of rape and domestic violence'.<sup>1</sup>

However, Price and Goyal do concede that 'Generalizations such as these do not emerge without there being an element of truth to them' but go on to argue 'there is much in the contextual detail framed by local epistemologies that offers deeper perspectives on the lives of women living with disability in the global South, perspectives commonly ignored or dismissed.'<sup>2</sup>

Often, the intersection of disability and gender is analysed in terms of:

1. The **prevalence** of disability amongst women and girls and the particular forms of disability predominantly or solely occurring in women and girls; and
2. The **impact** of the 'double' or multiple discriminations experienced by women and girls with disabilities – or, to put it another way, the impact of ablest and patriarchal social constructs on women and girls with disabilities.

### 1. Prevalence of disability amongst women and girls

An estimated 19 per cent of women across the world have a disability, compared to 12 per cent of men<sup>3</sup> and in the global South, women constitute three quarters of people with disabilities.<sup>4</sup> This higher prevalence is often attributed to 'women's longer life expectancy, the later onset of dementia and the impact of poor maternal health care, particularly in developing countries'<sup>5</sup>, although different levels of self-reporting between women and men on disability may also have an impact.<sup>6</sup>

However, a gendered analysis suggests that the higher prevalence of disability is not a facet of being female per se, but a result of social and cultural norms relating to gender, such as 'systemic exclusion from health care and education, poorer nutrition and gender-based violence'.<sup>7</sup> For example, whilst blinding conditions such as cataracts normally occur later in life, thus affecting numerically more women than men, women are less likely to receive sight saving cataract surgery, such as in Cote d'Ivoire, where

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<sup>1</sup> Janet Price and Nidhi Goyal, 'The Fluid Connections and Uncertain Spaces of Women with Disabilities: Making Links Across and Beyond the Global South' in S. Grech, K. Soldatic (eds.), *Disability in the Global South: The Critical Handbook, International Perspectives on Social Policy, Administration, and Practice*. 2016

<sup>2</sup> Ibid

<sup>3</sup> *World Report on Disability*. World Health Organisation and The World Bank, 2011  
[http://www.who.int/disabilities/world\\_report/2011/report.pdf](http://www.who.int/disabilities/world_report/2011/report.pdf)

<sup>4</sup> *Making the SDGs count for women and girls with disabilities*. UN Women, 2017  
<http://www.unwomen.org/en/digital-library/publications/2017/6/issue-brief-making-the-sdgs-count-for-women-and-girls-with-disabilities>

<sup>5</sup> *Situation of women and girls with disabilities and the Status of the Convention on the Rights of Persons with Disabilities and the Optional Protocol thereto*. Report of the Secretary-General, 28<sup>th</sup> July 2017 [www.un.org/disabilities/documents/gadocs/A\\_72\\_227.doc](http://www.un.org/disabilities/documents/gadocs/A_72_227.doc)

<sup>6</sup> *World Report on Disability*

<sup>7</sup> Gender And Development Network Gender and Disability Group, *The Intersection of Gender and Disability: A Resource for International Development Practitioners*. May 2017

CBM has found that fewer women access surgery because their economic status within the household weakens their value and bargaining power.

In the case of obstetric fistula, a disabling injury unique to women and girls, a number of gendered social factors contribute to its prevalence in low income countries, including lack of emergency obstetric care, early pregnancy and associated child marriage, the practice of female genital mutilation, poverty, limited decision-making power of women, illiteracy and low status of women, malnutrition and poor health services.<sup>8</sup>

Trachoma is a blinding disease that affects more women than men, with women 1.8 times more likely to contract the trachoma infection than men.<sup>9</sup> It is commonly thought this is because women and girls provide a greater proportion of care than men, throughout their lifetime, for young children and thus face a greater risk of contracting the infection, which is spread through direct personal contact; and 'that for each additional child with active trachoma in a household there is a subsequent additional risk of trichiasis in the mother'.<sup>10</sup>

Identifying the prevalence of disability resulting from preventable and treatable conditions amongst women and girls compared with men and boys, serves to alert us to instances of gender inequality - the focus on preventable impairment here is not to suggest a primacy of prevention over inclusion.

## **2. Impact of multiple discriminations**

Second, whilst there are gaps in information and data, as well as divergent definitions of disability and, increasingly, of gender, there is evidence across a number of indicators that **women and girls with disabilities are more likely to face discrimination and exclusion** than people without disabilities, and compared with men and boys with disabilities. The following section highlights a few areas that are of particular relevance to the work of CBM UK, but it is by no means comprehensive.

### **a) Health and wellbeing**

The greatest causes of disease, and disability, amongst women are **Non-Communicable Diseases** (NCDs) (eg cardiovascular diseases, cancers, respiratory diseases, diabetes) and 80% of NCDs occur in low and middle income countries. Yet, the British Medical Journal (BMJ) argues, 'NCDs continue to be sidelined as a major concern to the health of women globally... This has occurred in part, because of the widely held assumption that the occurrence and outcomes of NCDs, as well as the efficacy of preventative measures, are the same for men and women, and that the findings of studies into disease processes involving only men apply equally to women.'<sup>11</sup>

Women and girls with disabilities are at a **greater risk than those without disability of exclusion from screening for and diagnosis of health problems,**

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<sup>8</sup> B.K. Gulati, S. Unisa, A. Pandey, D. Sahu, and S. Ganguly, Correlates of Occurrence of Obstetric Fistula among Women in Selected States of India: An Analysis of DLHS<sup>1</sup>-3 Data. *Facts, Views & Vision Issues In OBGYN*, 2011, 3 (2): 121-128

<sup>9</sup> *Women and Trachoma: Achieving Gender Equity in the Implementation of SAFE*. The Carter Centre, 2009

[https://www.cartercenter.org/resources/pdfs/health/trachoma/women\\_trachoma.pdf](https://www.cartercenter.org/resources/pdfs/health/trachoma/women_trachoma.pdf)

<sup>10</sup> Ibid

<sup>11</sup> Peters SAE, Woodward M, Jha V, et al. *Women's health: a new global agenda*. BMJ Global Health, 2016 <http://gh.bmj.com/content/1/3/e000080>

for example breast and cervical cancer.<sup>12</sup> Observations from CBM's Amhara Trachoma Control Programme in Ethiopia found that the women engaged in the programme were more inhibited in seeking treatment for the infection due to: limited control over the finances of the household; in some places, restrictions on movement; and restrictions on time due to caring responsibilities. These observations are reinforced by findings from CBM SARO (South Asia), where despite a greater number of women than men attending screening camps, fewer women are accessing clinics for glaucoma related surgery because of financial constraints and lack of decision making power in accessing healthcare.<sup>13</sup>

**b) Sexual and reproductive health and rights, and right to family life**

Women and girls with disabilities in many parts of the world face a number of **barriers to accessing sexual and reproductive healthcare and enjoyment of family life**. These include not only physical barriers such as lack of access to premises and transport, but also cost, communication difficulties and negative attitudes of health workers. An inaccessible society can create extra barriers and challenges for disabled women in carrying out their caring responsibilities for children and other family members.

A comprehensive literature review<sup>14</sup> found that:

- Women with disabilities report that their needs and expectations are not met by gynaecological services
- For women and girls with certain disabilities, such as autism and intellectual disabilities, menstruation is a potentially traumatic experience, resulting in behavioural and emotional difficulties; and hysterectomy for women is regarded as an effective way for treating menstrual problems
- For young people with hearing disabilities, the difficulty of communicating effectively with a health worker means that they often visited a facility accompanied by a person (usually family member) to help with communication
- Additionally, clinicians and nurses who provide general interventions, report feeling concerned and unskilled at delivering interventions or assessing the sexual and reproductive health needs of women who have acquired a disability and women with intellectual disabilities.

Very generally, it is argued that in parts of the global South `society views women with disabilities as not capable of having children and therefore, incapable of fulfilling their role of being a mother and participating in family life... women with disabilities are not seen as marriage material and, in many circumstances, are left hidden away resulting in an increased vulnerability to a life of poverty.<sup>15</sup> However, Price and Goyal argue that `time and again, disabled women in the South refute this dominant view of

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<sup>12</sup> *World Report on Disability*

<sup>13</sup> Madhavan S. A, *Equity in eye care: women, children, integration with other health schemes*. Presentation, CBM SARO, 2014

[http://www.cbmindia.org.in/article/downloads/116768/Equity\\_in\\_eye\\_health\\_vision\\_2020\\_-\\_Madhavan\\_S.\\_A.\\_CBM\\_India.pdf](http://www.cbmindia.org.in/article/downloads/116768/Equity_in_eye_health_vision_2020_-_Madhavan_S._A._CBM_India.pdf)

<sup>14</sup> Stine Hellum Braathen, Poul Rohleder, Gloria Azalde, *Sexual and reproductive health and rights of girls with disabilities: A review of the literature*. SINTEF Technology and Society Department of Health and University of East London, 2017

[https://www.sintef.no/globalassets/sintef-teknologi-og-samfunn/en-sintef-teknologi-og-samfunn/2017-00083\\_report-sintef-uel-literature-review-srhr-girls-disability-with-appendices.pdf](https://www.sintef.no/globalassets/sintef-teknologi-og-samfunn/en-sintef-teknologi-og-samfunn/2017-00083_report-sintef-uel-literature-review-srhr-girls-disability-with-appendices.pdf)

<sup>15</sup> *CBM submission on women and girls with disabilities to the Committee on the Rights of Persons with Disabilities as requested by CRPD/C/8/3*. CBM, 16<sup>th</sup> February 2013

[http://www.ohchr.org/Documents/HRBodies/CRPD/DGD/2013\\_Submissions/22.ChristianBlindMission.pdf](http://www.ohchr.org/Documents/HRBodies/CRPD/DGD/2013_Submissions/22.ChristianBlindMission.pdf)

themselves as single and childless of necessity, not choice' and highlight different ways in which disabled women may engage in relationships and marriage; or are even 'freed' from traditional expectations around marriage and family life.<sup>16</sup>

### **c) Access to assistive devices**

There are **inequalities between men and women with disabilities in accessing assistive devices**. Studies from across Southern Africa reported in the *World Report on Disability* 'revealed large gaps in the provision of medical rehabilitation and assistive devices. Gender inequalities in access to assistive devices were evident in Malawi (men 25.3% and women 14.1%) and Zambia (men 15.7% and women 11.9%)'. In addition, the report notes that 'The lack of women in rehabilitation professions, and the cultural attitudes towards gender, affect rehabilitation services in some contexts. The low number of women technicians in India, for example, may partly explain why women with disabilities were less likely than men to receive assistive devices.'<sup>17</sup>

Women may also face additional challenges in the **design and functionality** of assistive devices, 'which are seldom designed to facilitate the different sizes and preferences of women and the type of work or daily life activities. Instead assistive devices are often designed to answer to the requirements and lifestyle of men.'<sup>18</sup>

### **d) Access to water and sanitation**

The impact of **access to water and sanitation as a gendered issue** is increasingly well understood: 'responsibilities for household water collection and management are intrinsically linked to women and girls' domestic role in the household, e.g. cooking, cleaning, laundry, childcare, and care of the sick and elderly.... Furthermore, the unavailability of effective latrines for girls in schools, with facilities for appropriate menstrual hygiene management, has been shown to impede girls' school educational achievement... water collection can be a significant source of chronic stress due to pressure to return home quickly.... inadequate provision and location of facilities can make women and girls more vulnerable to harassment and assault'.<sup>19</sup>

WaterAid and CBM Australia found that, in fact, 'women with less severe disabilities in some ways experienced the most difficulty in terms of access to WASH as they were still required to perform gender related WASH duties, yet these were significantly more difficult to perform due to their disability. Women who experienced more severe disability (and/or were older), and men and boys with disabilities did not have the same expectations on them to perform tasks such as collecting water.'<sup>20</sup>

### **e) Access to education**

The *World Report on Disability* found that in low-income countries, 45.6% of males and 32.9% of females with disability have completed **primary school education**, compared with 55.6% of males and 42.0% of females without disability<sup>21</sup>, putting girls

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<sup>16</sup> *The Fluid Connections and Uncertain Spaces of Women with Disabilities: Making Links Across and Beyond the Global South*

<sup>17</sup> *World Report on Disability*

<sup>18</sup> *Women and Girls with Disabilities, UHC, and the 2030 Agenda*. CBM International, 2016

<sup>19</sup> Julie Fisher, Sue Cavill & Brian Reed (2017) *Mainstreaming gender in the WASH sector: dilution or distillation?*, *Gender & Development*, 25:2, 185-204

<https://doi.org/10.1080/13552074.2017.1331541>

<sup>20</sup> WaterAid, CBM Australia and Di Kilsby Consulting, *Gender Equality and Disability Inclusion within water, sanitation and hygiene: Exploring integrated approaches to addressing inequality*. June 2017 <http://www.cswashfund.org/shared-resources/references/gender-equality-and-disability-inclusion-within-water-sanitation-and>

<sup>21</sup> *World Report on Disability*

with disabilities at the most risk of being left behind from early on. Additionally, 'enrolment rates also differ according to impairment type, with children with physical impairment generally faring better than those with intellectual or sensory impairments'<sup>22</sup> – thus placing intellectually disabled, deaf, blind or deafblind girls at the furthest disadvantage from early in life.

Within the school environment, children with disabilities can face a number of obstacles to inclusion, such as lack of physical accessibility and alternate methods of communication and materials, for example braille. Additionally, 'when schools do not provide safe, private and accessible sanitation facilities for girls and women, or when educators and parents do not believe that girls and women with disabilities should or could be educated, then girls and women with disabilities face additional barriers to accessing education'.<sup>23</sup> However, CBM notes a lack of analysis within much existing research of the impact of the intersection of disability and gender on children's education.<sup>24</sup>

#### **f) Livelihoods, work and pay**

The issue of work and pay is highly gendered, and the gender pay gap persists across much of the world. **Employment rates** across the intersection of disability and gender reflect a similar pattern to education, with a proportion of working age population in employment, in low-income countries, of 58.6% for men and 20.1% for women with disabilities, compared with 71.2% for men 31.5% for women without disabilities. Unsurprisingly, women with disabilities tend to earn less than men with disabilities;<sup>25</sup> all of which has an impact on disabled women's risk of poverty.

Sustaining a livelihood, Hanass-Hancock and Mitra argue, is dependent on building and maintaining financial, human, social, physical and natural capital, which they argue are disproportionately significant to the income opportunities of people with disabilities. They also note the importance of education and training for building human capital and point to the impact of unsuitable vocational training on women's lack of access to employment, in particular.<sup>26</sup>

In some parts of the world such as Asia and the Pacific, however, the unemployment rate amongst people with disabilities is lower in low-income than high-income countries, possibly because of greater availability of low-skilled and informal jobs, lower availability of benefits in poorer countries and greater likelihood of self-employment. However, this kind of work is typically more vulnerable, with little social protection or stability.<sup>27</sup> And whilst globally, 'informal work is a greater source of employment for men (63 per cent) than for women (58 per cent)... women are more

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<sup>22</sup> Ibid

<sup>23</sup> *Inclusive Education is for Everyone: CBM and the Global Campaign for Education 2014*. CBM, 2014

[http://www.cbm.org/article/downloads/54741/Inclusive Education is for Everyone CBM and the Global Campaign for Education 2014.pdf](http://www.cbm.org/article/downloads/54741/Inclusive_Education_is_for_Everyone_CBMA_and_the_Global_Campaign_for_Education_2014.pdf)

<sup>24</sup> Wapling, L, *Inclusive Education and Children with Disabilities: Quality Education for All in Low and Middle income Countries*. CBM, 2016

<sup>25</sup> *World Report on Disability*

<sup>26</sup> Jill Hanass-Hancock and Sophie Mitra, 'Livelihoods and Disability: The Complexities of Work in the Global South' in S. Grech, K. Soldatic (eds.), *Disability in the Global South: The Critical Handbook, International Perspectives on Social Policy, Administration, and Practice*. 2016

<sup>27</sup> *Disability at a Glance 2015 Strengthening Employment Prospects for Persons with Disabilities in Asia and the Pacific*. Social Development Division Economic and Social Commission for Asia and the Pacific. 2016

[http://www.unescap.org/sites/default/files/SDD%20Disability%20Glance%202015\\_Final.pdf](http://www.unescap.org/sites/default/files/SDD%20Disability%20Glance%202015_Final.pdf)

often to be found in the more vulnerable categories of work, for instance as domestic workers or self-employed home-based workers'.<sup>28</sup>

### **g) Gender based violence**

Women and girls with disabilities not only see their human rights denied, but also **face violation of rights more commonly than others**. It is estimated that 'Women with disabilities are twice as likely to experience domestic violence and other forms of gender-based and sexual violence as non-disabled women, and are likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence'.<sup>29</sup>

CBM previously reported to the CRPD: 'however, what is clear is that women with disabilities are more exposed to practices which qualify as torture or inhuman or degrading treatment; are more susceptible to violence and abuse; are at an increased risk of poverty; and if they are from ethnic or indigenous communities, are more likely to have to contend with forces that exclude them on the basis of gender as well as disability, culture and heritage'.<sup>30</sup>

The *World Report on Disability* found that 'there are many cases of involuntary sterilization being used to restrict the fertility of some people with a disability, particularly those with an intellectual disability, *almost always women...* Sterilization may also be used as a technique for menstrual management'<sup>31</sup> [our emphasis]. In Mexico, for example, Disability Rights International found that in 2017, 'women with psychosocial disabilities at state-run clinics in Mexico City were sometimes pressured into being sterilized or, when pregnant, into having abortions'.<sup>32</sup>

It also appears that women with disabilities are at the same risk of victim-blaming for abuse as non-disabled women; and of being expected to 'escape' the situations of violence, rather than the abuser being expected to desist or leave.<sup>33</sup>

In Nigeria, CBM works with the NGO Disability Rights Advocacy Center (DRAC) to tackle violence against women and girls with disabilities, through awareness-raising on rights, advocacy work on the implementation of policies and laws, and work with health, justice and support services to ensure that women and girls with disabilities are able to receive help.

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<sup>28</sup> *Empowering women working in the informal economy*. Issue Brief prepared for the 2nd Meeting of the Global Commission on the Future of Work 15–17 February 2018. ILO, 2018 [http://www.ilo.org/wcmsp5/groups/public/---dgreports/---cabinet/documents/publication/wcms\\_618166.pdf](http://www.ilo.org/wcmsp5/groups/public/---dgreports/---cabinet/documents/publication/wcms_618166.pdf)

<sup>29</sup> Ortoleva, Stephanie and Lewis, Hope, *Forgotten Sisters - A Report on Violence Against Women with Disabilities: An Overview of its Nature, Scope, Causes and Consequences* (August 21, 2012). Northeastern University School of Law Research Paper No. 104-2012. Available at SSRN: <https://ssrn.com/abstract=2133332>

<sup>30</sup> *CBM submission on women and girls with disabilities to the Committee on the Rights of Persons with Disabilities as requested by CRPD/C/8/3*

<sup>31</sup> *World Report on Disability*

<sup>32</sup> *Human Rights Watch World Report 2018 (Events of 2017)*

[https://www.hrw.org/sites/default/files/world\\_report\\_download/201801world\\_report\\_web.pdf](https://www.hrw.org/sites/default/files/world_report_download/201801world_report_web.pdf)

<sup>33</sup> E.g. Opoku, Maxwell & Huyser, Nicole & Mprah, Wisdom & Badu, Eric & Atim Alupo, Beatrice. (2016). *Sexual Violence against Women with Disabilities in Ghana: Accounts of Women with Disabilities from Ashanti Region*. Disability, CBR and Inclusive Development. 27. 91-111. 10.5463/dcid.v27i2.500.

## ***h) Situations of conflict and humanitarian crisis***

The challenges that women and girls with disabilities face in their everyday contexts are amplified, or experienced in different ways, in situations of conflict and disaster; for example, limited mobility can result in an inability to flee dangerous situations or access basic services such as sanitation and healthcare.<sup>34</sup> Menstrual hygiene is often challenging for women and girls with disabilities, especially those with fistula, incontinence, or who are pregnant or post-natal.<sup>35</sup>

Women and girls with disabilities face increased vulnerability to violence and exploitation in displacement settings, especially sexual violence – indeed, they may be targeted specifically by displaced or host communities ‘because they are seen to be less able to protect themselves’; and in many places this results in pregnancy.<sup>36</sup>

Conflict and disasters also can erode traditional and informal support networks that women and girls with disabilities may have relied on.<sup>37</sup> Women and girls with disabilities in humanitarian situations may also face barriers to formal support in refugee camps where they are unable to provide official documentation of disability, especially where humanitarian staff are untrained in identifying disability, and in particular those with psychosocial and invisible disabilities. Scarcity of access to new or repaired assistive devices also compound exclusion.<sup>38</sup>

The Age and Disability Capacity Programme (ADCAP), which is designed to ensure older people and people with disabilities are included during emergency responses, has also identified that attitudinal barriers, such as assumptions about decision-making capacity, leads to the exclusion of people with disabilities and women and girls from humanitarian assistance and protection. For CBM, participation in this programme has highlighted the complexities of social identities and the importance of addressing intersectionality in humanitarian situations.<sup>39</sup>

However, there is evidence that power relations between women and men can equalise somewhat in certain humanitarian situations because of ‘dislocation, the new living contexts and refugee assistance impact on gender relations and the social status of women’.<sup>40</sup>

## **II. Analysis**

The convergence of discriminations against disabled people and women and girls is based on the very body itself – as Rosemarie Garland-Thomson posits: ‘Many parallels exist between the social meanings attributed to female bodies and those

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<sup>34</sup> Jeanne Ward and UN Women, *Violence against Women in Conflict, Post-conflict and Emergency Settings*. December 2013

<http://www.endvawnow.org/uploads/modules/pdf/1405612658.pdf>

<sup>35</sup> Rohwerder, B, *Women and girls in forced and protracted displacement* (GSDRC Helpdesk Research Report 1364). Birmingham, UK: GSDRC, University of Birmingham. 2016 <http://www.gsdrc.org/wp-content/uploads/2016/06/HDQ1364.pdf>

<sup>36</sup> Ibid

<sup>37</sup> *Violence against Women in Conflict, Post-conflict and Emergency Settings*

<sup>38</sup> *Greece: Refugees with Disabilities Overlooked, Underserved*. Human Rights Watch, 18<sup>th</sup> January 2017. <https://www.hrw.org/news/2017/01/18/greece-refugees-disabilities-overlooked-underserved>

<sup>39</sup> Supriya Akerkar and Rhea Bhardwaj, Good practice guide: embedding inclusion of older people and people with disabilities in humanitarian policy and practice. Lessons learnt from the ADCAP programme. Oxford Brookes University, 2018 <https://www.cbmun.org.uk/wp-content/uploads/2018/04/Good-Practice-Guide-FINAL-ONLINE.pdf>

<sup>40</sup> Rohwerder, B, *Women and girls in forced and protracted displacement*

assigned to disabled bodies. Both are cast as deviant and inferior; both are excluded from full participation in public as well as economic life; both are defined in opposition to a norm that is assumed to possess natural physical superiority'.<sup>41</sup>

A number of perspectives can be offered as to why people with disabilities and women and girls face discriminatory attitudes, from fear of the 'other' and historical and cultural beliefs about the value of women or disabled people, to unconscious bias. The bridge from belief and attitude to exclusion is power; and across the world, power has been maintained in favour of those without disabilities and of men and boys. These imbalances in power have allowed inequalities to flourish.

'Blame' for stigmatisation is also often placed on religious and customary beliefs, for example, that disability is a punishment and that women have lesser authority than men. Yet, there must also be an analysis of market economy values, common to liberal democracies, that prioritise human productivity at the lowest cost possible and resist creating infrastructure and opportunities that are accessible to and inclusive of people with disabilities on the grounds that they are 'too costly'.

CBM notes that 'the wider call for gender equality argues that without a comprehensive understanding of the social structures and power relations that frame not only laws and policies, but also the economy, social dynamics, family and community life, and cultural beliefs that society's values, women's full equality will not be achieved. This holds equally true for women, men, girls and boys with disabilities.'<sup>42</sup> For example, analysis of the attribution of a higher proportion of women with disabilities to their longer life expectancy raises questions, particularly in the case of preventable NCDs, around the economic, social and cultural reasons as to why women are not accessing preventative interventions, such as blood pressure medication, in earlier life.

Whilst corporeal objectification may form a shared experience of discrimination for disabled people and women and girls, it is also important to pay attention to divergences between narratives on disability and gender. Whilst neither people with disabilities or women and girls are homogenous groups, there are distinct tensions between some sections of disability activism and some sections of feminism – in particular on the issue of abortion on the grounds of disability.

A number of critics argue that the public health, social policy and political focus on women's sexual and reproductive health is at the expense of other areas, for example NCDs.<sup>43</sup> Whilst it is essential that women and girls have access to sexual and reproductive health care and services, this focus risks a) reducing women and girls to their capacity for reproduction and sexual activity; and b) ignoring or even creating further inequalities in other areas of health. Additionally, the description of caring responsibilities as a 'burden', often used within the women's movement, may be an anathema to some women with disabilities who are denied the right and choice to have and care for children. Obviating ongoing dialogue will not resolve these tensions, but it is not clear what will.

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<sup>41</sup> Rosemarie Garland-Thomson, *Re-shaping, Re-thinking, Re-defining: Feminist Disability Studies*. Center for Women Policy Studies, 2001

<https://www.womenenabled.org/pdfs/Garland-Thomson,Rosemarie,RedefiningFeministDisabilitiesStudiesCWPR2001.pdf>

<sup>42</sup> *The 3Ps for inclusion of women with disabilities: The Personal, The Political, The Policy*. CBM, [http://www.cbm.org/article/downloads/54741/The\\_Personal\\_The\\_Political\\_The\\_Policy.pdf](http://www.cbm.org/article/downloads/54741/The_Personal_The_Political_The_Policy.pdf)

<sup>43</sup> Peters SAE, Woodward M, Jha V, et al, as above

There is often a desire to identify whether it is disability or gender that ‘tips’ the scales of discrimination and exclusion. Some would argue that people are more reluctant to challenge gender norms and that disability inclusion is more of an ‘easy win’; whereas others would argue that commitment to disability inclusion becomes only surface level when faced with the reality of investing resources.<sup>44</sup> This is not a simple matter, but it is clear that across a number of indicators that women and girls with disabilities are the most excluded and ‘left behind’.

### III. Pathways to equality and inclusion

CBM’s vision is of an inclusive world in which all people with disabilities enjoy their human rights and achieve their full potential. For many women and girls with disabilities, there is further to go than for disabled men and boys before the world reshapes itself to enable this.

Based on our experience, analysis and assumptions, progress towards equality and inclusion for women and girls with disabilities needs to include the following fundamental action:

- **An end to unequal power relations and discrimination**

Greater equality for, and inclusion of, women and girls with disabilities would be truly transformational for individuals and wider society. However, embedding such norms requires ambition, political will and a willingness to accept a rebalance of power in structures and systems – at the expense of privilege and the status quo. This may include protective and positive action.

- **Recognition of the agency of women and girls with disabilities**

Whilst challenging power imbalances, there needs to be recognition of the power and agency that disabled women and girls do have. Disempowering assumptions of victimhood should be avoided, and the approach of ‘nothing about us without us’ implemented, with leadership from women and girls with disabilities.

- **Specific needs of women and girls with disabilities are met**

CBM advocates the twin track approach of mainstreaming disability inclusion as well as ensuring that people with disabilities are empowered and their specific needs met. Within this, intersectional needs must also be addressed and provided for.

- **A holistic, multi-sectoral and joined-up approach**

Disability and gender should not be siloed into particular policy areas, such as health or welfare. The intersection of disability and gender reaches across the political, economic and social spheres, across all contexts and across age and other intersectionalities. Additionally, action to further the equality and inclusion of women and girls with disabilities requires action from a broad range of actors, including government, civil society, the private sector, financial institutions and others.

### IV. Recommendations to UK Government

The UK Government has a vital role to play in shaping the political landscape and furthering norms around non-discrimination, equality and inclusion of women and girls with disabilities, through its aid and development portfolio, civil society and private

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<sup>44</sup> *Gender Equality and Disability Inclusion within water, sanitation and hygiene*

sector funding and contracting decisions, humanitarian work, international negotiations, diplomatic efforts, and military interventions. CBM UK has a number of specific recommendations that we believe would strengthen the Government's current approach:

### 1. Framing and understanding of the intersection of disability and gender:

We welcome DFID's commitment to challenging unequal power relations that perpetuate gender inequality, and would further encourage the Government, as a duty bearer, to:

- i. Apply a **power analysis** in all of its work that touches on the intersections of disability and gender; and broaden its analysis of stigma and discrimination to include the impact of political and economic philosophies, national and global, as well as religious and traditional beliefs
- ii. Recognise the capacity and agency of women and girls with disabilities; and understand 'problems' as **systems and structures** that do not work for women and girls with disabilities, rather than the identities of disability and gender themselves
- iii. Analyse any **assumptions of 'vulnerability'** within disabled women and girls, and address the source of threat as the impediment.

### 2. Policy frameworks: The UK already has in place a number of good frameworks and commitments for tackling the exclusion of people with disabilities and of women and girls. There are a number of additional steps the Government could take to strengthen these:

- i. Ensure coherence between the Government's commitment to spending 50% of **DFID's budget on fragile states and regions**,<sup>45</sup> and policy commitments to women and girls and people with disabilities, by including women and girls with disabilities in policies, frameworks and plans relating to conflict and post-conflict situations; including through the work of governmental special representatives<sup>46</sup>
- ii. Build upon the updated **UK National Action Plan on Women, Peace and Security**<sup>47</sup> to implement the active inclusion and participation of women and girls with disabilities in *each* of the seven strategic outcomes of decision-making, peacekeeping, gender-based violence, humanitarian response, security and justice, preventing and countering violent extremism, and UK capabilities
- iii. Address outstanding issues and recommendations from the UK's 2017 periodic review by the **Committee on the Rights of Persons with Disabilities** (CRPD) in relation to Article 32 (international cooperation) through a gender-sensitive lens<sup>48</sup>
- iv. **Overall, we would welcome the incorporation of this paper's recommendations into DFID's Strategic Vision for Gender Equality and updated Disability Framework.**

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<sup>45</sup> Department for International Development single departmental plan, December 2017 <https://www.gov.uk/government/publications/department-for-international-development-single-departmental-plan/department-for-international-development-single-departmental-plan>

<sup>46</sup> Prime Minister's Special Representative on Preventing Sexual Violence in conflict; Ministry of Defence's Gender Champion; Foreign and Commonwealth Office's Special Envoy for Gender Equality; Department for International Trade's Trade and Gender Committee; etc

<sup>47</sup> *UK national action plan on women, peace and security 2018 to 2022*. HM Government, January 2018 <https://www.gov.uk/government/publications/uk-national-action-plan-on-women-peace-and-security-2018-to-2022>

<sup>48</sup> *Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland*. Committee on the Rights of Persons with Disabilities, 3<sup>rd</sup> October 2017 <https://tinyurl.com/yd65ueul>

### 3. Aid and development assistance:

- i. **Consult** with local women and girls with disabilities on the inception and design of and bilateral development programmes and aid, addressing, but not limited to, the thematic areas discussed above and the other Sustainable Development Goal areas
- ii. Include **indicators** on women and girls with disabilities in bilateral development programmes and aid.

### 4. International advocacy and influence:

As the Government seeks to tackle poverty increasingly through non-aid means, the role of inter-governmental advocacy will gain importance as the opportunity for influence through aid potentially decreases. We call on the Government to:

- i. Use **international policy fora, decision-making and agreement forming processes**, and other opportunities such as the Global Disability Summit, to advocate for the elimination of all forms of discrimination against women and girls with disabilities
- ii. Identify and advocate policies that promote an **enabling environment** for the Government's What Works Global Programme, in particular preventing the 'context-specific and disability-specific risks' of **violence against women and girls** with disabilities.<sup>49</sup>

### 5. Capacity building across government departments:

As the amount of Overseas Development Assistance (ODA) spending by government departments other than International Development (DFID) is set to increase, and the definition of ODA broadened, we recommend that the Government:

- i. Sets the same expected **standards** as of DFID on gender and disability from other departments and cross-department bodies spending ODA, along with their suppliers, contractors and funding recipients
- ii. Provides **sensitisation and training opportunities** on gender, disability and the intersection of the two in low-income contexts, to leaders and staff in other government departments (OGDs) that spend ODA.

### 6. Data and evidence:

- i. Gather **data disaggregated** by disability and gender, and disability type where possible, and analyse intersectionalities in order to inform government policy and practice
- ii. Continue to press, at **inter-governmental fora**, for data collection on disability in relation to Sustainable Development Goal indicators; and for **implementation** of policies to address patterns of inequality on the grounds of disability and gender identified through data
- iii. Include **older persons** in data gathering, in order to ensure that older women with disabilities are represented.

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<sup>49</sup> *What Works Evidence Review: Preventing violence against women and girls with disabilities in lower and middle-income countries*. What Works to Prevent Violence, September 2017  
<http://www.whatworks.co.za/resources/evidence-reviews/item/349-what-works-evidence-review-the-relationship-between-poverty-and-intimate-partner-violence>