

# Women and girls with disabilities in conflict and crises

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## Question

*What risks/vulnerabilities do women and girls with disabilities affected by conflict and crises face? What is the available evidence on interventions to support women and girls with disabilities affected by conflict/crises?*

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## 1. Overview

People with disabilities have been found to 'form one of the most socially excluded groups in any displaced or conflict-affected community' (Pearce et al, 2016: 119). They may have difficulty accessing humanitarian assistance programmes, due to a variety of societal, attitudinal, environmental and communication barriers, and are at greater risk of violence than their non-disabled peers (Pearce, 2014: 4). Women and girls with disabilities are 'particularly vulnerable to discrimination, exploitation and violence, including gender-based violence (GBV), but they may have difficulty accessing support and services that could reduce their risk and vulnerability' (Pearce, 2014: 4). This rapid review looks at the available evidence on the risks and vulnerabilities faces by women and girls with disabilities in conflict and crises and interventions to support them.

Most of the literature uncovered by this rapid review was grey literature published by organisations working with refugees, rather than peer reviewed articles. The bulk of the evidence was based on work carried out by Women's Refugee Commission (WRC) and their partners.

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Dowling (2016: 5) suggests the experiences of disabled refugees in relation to gender and age is a gap in the evidence about which more should be done. Pearce et al (2016: 119) also find that ‘there is a distinct gap in research on the intersection between and among age, gender, and disability in humanitarian contexts’. Field research on violence against women and girls with disabilities or their lived experiences, unique risks, and their specific needs and capacities, in humanitarian settings is still very limited (Pearce et al, 2016: 120). Sherwood and Pearce (2016: 5) note that ‘rigorous peer-reviewed research on the inclusion of women and girls with disabilities in humanitarian action remains limited’<sup>1</sup>, although there is a ‘growing body of literature including organizational assessments and reports, and UN agency and government policies and strategies, that recognizes that women and girls with disabilities face additional risks in humanitarian crisis, and calls for their participation in humanitarian programme design, implementation, and monitoring’.

Findings about the risks and vulnerabilities faced by women and girls in conflict and crises include:

- **Double discrimination** as a result of their gender and disability increases women and girls with disabilities’ vulnerability, and conflict and crises exacerbate this.
- The breakdown of economic structures, health care, family and community support, educational opportunities, housing, transportation and other infrastructures as a result of **conflict increases the vulnerability** of women and girls with disabilities. They may find it harder to flee or be left behind, making them more vulnerable to attack.
- The loss of assistive devices, caregivers, and protection networks as a result of **displacement make women and girls with disabilities more dependent** on others and at greater risk of exploitation. Women and girls with disabilities in refugee camps and host communities may experience stigmatisation and discrimination, barriers to participation, unsafe shelters, and lack of access to services.
- Conflict and crisis affected women and girls with disabilities face **increased levels of sexual and gender based violence** in and out of the home, especially those with intellectual and mental disabilities. This is a result of factors such as stigma and discrimination, being seen as ‘easy’ targets, extreme poverty, social exclusion and isolation, loss of protective mechanisms, and limited mobility. Women and girls with disabilities are also largely excluded from gender based violence prevention programmes, including the variety of women’s empowerment initiatives aiming to break the cycle of vulnerability to violence.
- Women and girls with disabilities **do not have adequate access to water, shelter, food or health – including menstrual hygiene and reproductive health, in humanitarian contexts**. Many also do not have access to the specific services they may need such as rehabilitation. Barriers to access aid include cultural, attitudinal, communication, environmental, and physical barriers, and lack of training for humanitarian staff.
- Conflict and crises can result in the **loss of the livelihoods** of women with disabilities, which increases their poverty and makes them vulnerable to exploitation.

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<sup>1</sup> WRC undertook a background literature review to document the current evidence base on effective strategies and ongoing gaps in inclusion of women and girls with disabilities in humanitarian programming, and the role of organisations of women with disabilities in humanitarian action. Fifty-five relevant items met the inclusion criteria. Of these, only seven were from peer-reviewed journals or publications. The majority of literature on this topic is from non-peer-reviewed papers, and organisational reports, policies, or strategies.

- Conflict and displacement exacerbate and heighten the discrimination that **adolescent girls with disabilities** already face in times of peace and destroys their protection systems, making them more vulnerable to exploitation. They are often excluded from girls' programming.

**Factors contributing to lack of inclusion of women and girls with disabilities in humanitarian response** include: gaps in policy development and implementation; negative attitudes of family members and communities; limited staff knowledge, attitudes, and practices; and lack of champions and local partners.

**Interventions to support women and girls in conflict and crises** have found that it is important to:

- Have **organisational commitment** to translate policies that integrate both disability and gender mainstreaming into practice.
- Support staff to **identify skills and capacities** when working with women and girls with disabilities rather than just focusing on their risks and vulnerabilities.
- Carry out activities which **strengthen protective peer networks**.
- Set **targets for inclusion** in existing programmes, including economic strengthening programmes.
- Advocate for **representation of women and girls with disabilities** in community committees and **support advocacy** by groups representing women and girls with disabilities.
- **Recruit women with disabilities** as volunteers and staff.
- Partner with, and support, **women's disabled people's organisations**.

## 2. Risks/vulnerabilities faced by women and girls with disabilities in conflict and crises

Women, girls, boys and men with disabilities are one of the most socially excluded groups in crisis-affected communities and in situations of forced displacement, and may be at increased risk of discrimination, exploitation, and violence, as well as facing numerous attitudinal, environmental and communication barriers to accessing services and assistance (UNHCR, 2016: 20; Sherwood and Pearce, 2016: 5; Pearce, 2015: 1-2, 17). Gender, age, and other diversity factors may result in additional multiple and intersecting discrimination (UNHCR, 2016: 20; Pearce, 2015: 4). People with disabilities, including women and girls with disabilities, are disproportionately vulnerable in emergencies 'primarily as a consequence of social disadvantage, poverty and structural exclusion' rather than because of any inherent vulnerability (Hemingway and Priestley, 2006: 64).

### 'Double discrimination' and vulnerability

Women and girls with disabilities in conflict and crises experience 'double discrimination' as a result of their exclusion on the basis of their identity as women and persons with disabilities (Cornelsen, 2012: 109-110; Ortoleva, 2011: 9). The United Nations suggests that the 'level of vulnerability in an emergency or disaster is dependent on socio-economic conditions, civic and social empowerment, and access to mitigation and relief resources' (Dunn and Sygall, 2014: 50). This means that women with disabilities often have a higher level of vulnerability leading into crises as several studies have found that women with disabilities, as a group, tend to 'fare far worse than non-disabled women or disabled men in terms of education, health, employment and social status'

(Dunn and Sygall, 2014: 50; Cornelsen, 2012: 106). Women and girls with disabilities also are at greater risk of gender based and sexual violence in peace time<sup>2</sup>, which is significantly amplified during conflict due to the inherent insecurity in such situations (Bhroithe-Barnett, 2016: 5; Pearce et al, 2016: 120; Stein and Lord, 2011: 404). Ortoleva (2011: 9) also suggests that armed conflict exacerbates the numerous issues affecting women and girls with disabilities disproportionately when compared to men with disabilities and women without disabilities, including health, education, employment, violence, family rights, marriage, housing, and participation in public life (see also Cornelsen, 2012: 110).

Emancipatory research carried out by Inclusive Friends in four conflict-affected local government areas in Plateau State of Nigeria looked at the women with disabilities and their specific experiences of conflict and violence (Jerry et al, 2015). Jerry et al (2015: 1) found that the violence experienced by women with disabilities in times of violent conflict were linked to 'marginalisation and oppression women and girls with disabilities face in daily life, as well as their challenges and the pervasive social and cultural stereotypes concerning them'. Limited access to healthcare and education, as well as barriers to financial autonomy was also cited as issues (Jerry et al, 2015: 1).

### **Risks during conflict**

Conflict increases the vulnerability of women and girls with disabilities and their families through the breakdown of: economic structures and activities in which women and girls with disabilities were engaged, health care institutions and facilities, family and community support, educational opportunities, housing, transportation and other infrastructures (Ortoleva, 2011: 13). Cornelsen (2012: 110) finds that women with disabilities are repeatedly discounted or forgotten in conflict, with government breakdown and insecurity, disruption in resources, re-evaluation of priorities, and the loss of support systems, making it easy to ignore them.

Bergths (2015: 446) find that the mobility of women with disabilities in conflict and crises can be 'curtailed due to fears of abduction, rape or smuggling by human traffickers as well as violence in camps'. Girls with intellectual disabilities in Lebanon were found to have been raped by militias in their area, but their families were too afraid of reprisals and dishonour to react (Bergths, 2015: 446). Trani et al (2011: 1190) find that young girls with disabilities are especially vulnerable to violence and abuse on their journey's to school in conflict affected states. In general they found that girls with disabilities in conflict affected states, especially with the move to secondary school, were less likely than other children to access education (Trani et al, 2011: 1198). Lack of accessible schools also results in housebound disabled children who are particularly vulnerable to sexual and gender based violence (Levitan and Millo, 2014: 24). 89.9 per cent of respondents in conflict areas of Nigeria thought the impact of conflict on women with disabilities was severe or very severe (Jerry et al, 2015: 15).

UNHCR finds that it is likely that women with disabilities, are often among those left behind in countries of origin or transit countries when populations flee conflict (Birchall, 2016, p. 18; Stein

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<sup>2</sup> 'A Lancet systematic review and meta-analysis of studies from high income countries found that children with disabilities were three to four times more likely to experience all forms of violence than their nondisabled peers, and three times more likely to experience sexual violence' (Pearce et al, 2016: 120). Women with disabilities are at least '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' (Ortoleva & Lewis, 2012: 16).

and Lord, 2011: 406). Jerry et al (2015: 15) suggest that this may be because they are seen as an inconvenience during periods of crisis when everyone is trying to flee. HRW found that women with disabilities in Northern Uganda who were unable to flee rebel forces 'were subjected to disability-based abuse and persecution on account of stigma and discrimination' (Stein and Lord, 2015: 406; Barriga and Kwon, 2010: 24, 32-33). For example, a deaf woman told Human Rights Watch that rebels beat her badly because she could not respond to their questions (Barriga and Kwon, 2010: 33). In Nigeria, people with disabilities and the elderly were burned to death by attackers when they were locked in a room by community members who fled the village (Jerry et al, 2015: 15).

Women and girls with disabilities reported finding it difficult to escape violence in conflict affected parts of northern Nigeria and were often abandoned (Jerry et al, 2015: 1, 15). Environmental barriers often leave them reliant on others and they may be unaware of what is happening or how to get to safety (Jerry et al, 2015: 1, 15-16). They often receive no warning of impending danger (Jerry et al, 2015: 1). Jerry et al (2015: 16) give examples of women with visual impairments who often did not know what was happening, where they were or how to get to safety, which in some cases resulted in them running towards attackers rather than to safety as nobody helped them.

Conflict disables a large number of people, including women and girls, through bombs, landmines, and the use of sexual violence as a weapon of war (Cornelsen, 2012: 110-111). Women and girls who have acquired disabilities during the conflict or crisis may be more visible than those who were already disabled prior to the crisis, who may be marginalised in the humanitarian response (Ortoleva, 2011: 13). Women with disabilities often also develop additional or more severe disabilities as a result of conflict and crises (Ortoleva, 2011: 9). However, women who become disabled may be disowned by their families and ostracised by their communities, which increases the risk of physical and sexual abuse (WRC and IRC, 2015: 4; Cornelsen, 2012: 111).

### **Risks during displacement**

Dowling's (2016: 2, 4) review of evidence on disability and unsafe migration finds that disabled women and children have an elevated risk of exploitation and violence during irregular migration. Research carried out by UNHCR (2016: 21) also suggests that the most commonly cited challenges that persons with disabilities face in displacement settings relate to stigmatisation and discrimination, participation, access to health care, and identification and registration. Women and girls with disabilities may also have been forced to leave behind wheelchairs, medications, assistive aids and supportive animals, and prosthetics (Ortoleva, 2011: 13; Jerry et al, 2015: 1, 16-17; Cornelsen, 2012: 110). The loss of these aids makes them more reliant on others and has consequences for their health (Jerry et al, 2015: 1, 17). Caregivers may also be lost in the midst of the crisis and in addition to psychological trauma, the separation or death of their caregivers can lead to women struggling to cope and at greater risk of exploitation, including gender based violence (Jerry et al, 2015: 1, 17).

Ortoleva (2011: 9, 17) finds that refugee camps are 'particularly problematic for women with disabilities because of violence, lack of support systems, and facilities and services that are rarely accessible and are not designed to meet their specific needs'. The women surveyed by MIUSA also highlighted safety as an issue in refugee camps; with certain areas, such as latrines, or times posing additional risk to women with disabilities of sexual violence and abuse due to mobility challenges or difficulty in communicating their distress (Dunn and Sygall, 2014: 50; Stein and Lord, 2011: 408). Experiencing sexual harassment in unsafe shelters can make women with disabilities more dependent on other's help (Handicap International, 2015: 9). Levitan and Millo (2014: 23)

note that dependency on others for housing, food and even legal status also heightens the risk of sexual and gender based violence for refugee women with disabilities.

IRC and WRC found that refugee 'women with physical disabilities who are isolated in their homes in urban settings were being raped on a repeated and regular basis, often involving multiple perpetrators'; and that women and girls with intellectual disabilities were particularly vulnerable to all forms of sexual violence, as well as emotional and physical abuse' in humanitarian settings in Ethiopia, Burundi, Jordan, and Northern Caucasus in the Russian Federation (Rosenberg, 2016: 4, 5). Transportation challenges increase the isolation of women with disabilities, preventing them from accessing services, programmes, and activities (Rosenberg, 2016: 9).

### **Sexual and gender based violence**

Research by WRC across multiple refugee contexts finds that the 'discrimination that women and girls with disabilities face gives rise to a host of [gender based violence] risks, including significant risks of emotional violence and sexual violence, both inside and outside their homes' (Rosenberg, 2016: 5). Displaced people with disabilities, consulted by WRC across eight countries<sup>3</sup>, reported violence in all contexts, with women and girls with disabilities more likely to report concerns about sexual violence and examples suggesting that those with intellectual or mental disabilities may be most at risk (Pearce, 2014: 1, 11; Pearce, 2015: 1; Rosenberg, 2016: 3). Research with conflict affected communities in Burundi, Ethiopia, Jordan and the Northern Caucasus in the Russian Federation found that some women and girls with disabilities 'reporting being subjected to sexual violence, including rape, on a repeated and regular basis and by multiple perpetrators' (Pearce, 2015: 1, 11). One third of the displaced women with disabilities in camps in northern Uganda, interviewed by Human Rights Watch (HRW) reported that they had experienced some form of sexual and gender based violence (Barriga and Kwon, 2010: 7). Research with refugees with disabilities in Nepal, Kenya and Uganda, also highlighted risks of sexual violence, especially for girls with intellectual disabilities (WRC et al, 2015: 4; Tanabe et al, 2015: 412, 419). Research from a four-week field assessment conducted by the WRC in northern and eastern Lebanon in March 2013 looking at disability inclusion in the Syrian refugee response also found that women with intellectual disabilities were at risk of gender based violence (Pearce, 2013: 7). Handicap International carried out research with 400 people with disabilities directly impacted by humanitarian crises, 46 per cent of whom were women (Handicap International, 2015: 6). 33 per cent of these female refugees reported having experienced abuse, including physical, sexual, or psychological (compared to 27 per cent of all respondents) (Handicap International, 2015: 9). Those with communication difficulties, difficulties with memory or concentration, and with hearing or sight impairments are particularly subject to abuse during the crisis (Handicap International, 2015: 9). Exposure to violence during conflict may also result in increased HIV infection and psychological trauma among women and girls with disabilities (Ortoleva, 2011: 9). Many disabled refugee women interviewed in Chad, Kenya, South Africa and Uganda had become pregnant as a result of their experiences of sexual and gender based violence and almost all survivors experienced serious physical and emotional aftereffects (Levitan and Millo, 2014: 22).

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<sup>3</sup> Over 770 displaced persons, including persons with disabilities, were consulted across refugee and displacement contexts in India (New Delhi), Uganda, Thailand, Bangladesh, Nepal, Ethiopia, Philippines (Mindanao) and Lebanon.

Stigma and discrimination; community perceptions that persons with disabilities are unable to physically defend themselves from a perpetrator or effectively report incidents of violence; lack of knowledge about gender based violence and personal safety among women and girls with intellectual and mental disabilities meaning they may be more easily targeted by perpetrators; extreme poverty and lack of basic needs leading to exploitation, survival sex and prostitution; loss of community structures and protective mechanisms, especially when newly displaced; social exclusion and isolation; limited mobility; communication barriers; and service providers questioning their credibility, which makes them reluctant to report cases of gender based violence or access services, are all factors which make women and girls with disabilities more vulnerable to sexual and gender based violence in conflict and crises (Pearce, 2014: 11-12; Pearce, 2015: 1, 12, 15-17; Barriga and Kwon, 2010: 7; Levitan and Millo, 2014: 22). Girls with disabilities were also found to be excluded from peer activities in humanitarian contexts which could help them develop vital social networks and enhance their protection from various forms of violence (Rosenberg, 2016: 4; Pearce, 2014: 11). Some of the refugee women with disabilities in Nepal, Kenya and Uganda did, however, mention that they had protective resources, especially caregivers, counsellors and activities, which offered emotional and mental respite (WRC et al, 2015: 4).

Displaced women with disabilities were also exposed to different forms of violence inside the home as a result of isolation, lack of contact with community networks, and few independent living options (Rosenberg, 2016: 3-4; Pearce, 2014: 11). WRC found that displaced women with disabilities may be experiencing intimate partner violence at higher rates than non-disabled women, with women with disabilities reporting that their male partners do not “value” them the same as non-disabled women (Pearce, 2015: 11). The extreme stress that families experience during conflict and displacement can also create environments in which violence is more likely to occur within the home, placing women and girls with disabilities who are dependent on other family members at greater risk if caregivers resentments are taken out on them (Pearce et al, 2016: 126; Rosenberg, 2016: 9; Pearce, 2015: 15).

### **Access to gender based violence services**

Women and girls with disabilities remain largely excluded from gender based violence prevention programmes, including the variety of women’s empowerment initiatives aiming to break the cycle of vulnerability to violence (Pearce, 2015: 3). The women with disabilities surveyed by Handicap International also reported a greater lack of access to protection services (80 per cent of women compared to 62 per cent of men) (Handicap International, 2015: 11).

WRC and IRC found that attitudinal barriers, such as discrimination and stigmatisation by family members, service providers and the wider community, were the most commonly cited barriers to accessing gender based violence services for conflict-affected women with disabilities (Pearce, 2015: 17). This is an issue for persons with intellectual or mental disabilities especially (Pearce, 2015: 17). Physical barriers, such as lack or high cost of transportation, were more frequently mentioned in relation to accessing prevention activities such as community awareness raising, income generation and women’s centre activities, although attitudinal barriers also exist (Pearce, 2015: 17-18). Communication barriers also prevented access to community based prevention activities (Pearce, 2015: 19). Lack of confidentiality, which is harder to maintain when a survivor has a disability, and resulting stigmatisation were also raised as important issues in camp and urban contexts (Pearce, 2015: 19). It was pointed out that survivors with disabilities may find it harder to return to service providers if they are not seen immediately as they may have fewer financial resources to pay for transportation and need to rely on others for assistance to travel

(Pearce, 2015: 20). The stigma of being raped means women and girls with disabilities are reluctant to report it, while others are unable to report it as they have little interaction with people outside their immediate family or environment (Rosenberg, 2016: 5).

### **Access to humanitarian services**

Three quarters of the 400 respondents to Handicap International's survey of people with disabilities in humanitarian contexts, including women and girls with disabilities, reported that they did not have adequate access to basic assistance such as water, shelter, food or health (Handicap International, 2015: 4). In addition, one out of two respondents with disabilities, did not have the specific services persons with disabilities may need available to them, such as rehabilitation, assistive devices, access to social workers or interpreters, further impeding their access to mainstream assistance (Handicap International, 2015: 4). Women and girls with disabilities in Nigeria felt that interventions to support conflict affected populations were not inclusive of them, and cited examples of how ensuring the accessibility and safety of Internally Displaced Person (IDP) camps for women and girls with disabilities, and addressing the loss of livelihoods they experience, are major gaps (Jerry et al, 2015: 2, 20).

The main barriers to accessing aid in crisis contexts appeared to be as the lack of accessible information on those services and the difficulty in accessing the services themselves: lack of physical or financial access, lack of staff trained in disability, or distance from the services (Handicap International, 2015: 4). Only 30 per cent to 45 per cent of the services provided by humanitarian actors were reported as accessible to persons with disabilities, despite 85 per cent of humanitarian actors responding to the survey recognising that persons with disabilities are more vulnerable in times of crisis and 92 per cent estimating that they are not properly taken into account in humanitarian response (Handicap International, 2015: 4). A different research project by WRC had more positive findings, with 75 per cent of respondents to an online survey reporting that their organisation's activities in humanitarian settings were inclusive of women and girls with disabilities (Sherwood and Pearce, 2016: 13). However, less than half reported having women with disabilities as staff and/or volunteers, and only 41 per cent networked or communicated with women's disabled peoples' organisations (DPOs) (Sherwood and Pearce, 2016: 13).

An informal survey of Mobility International USA (MIUSA)'s international network of 176 disabled women leaders raised a number of issues faced by women with disabilities in emergency response situations which may arise out of conflict and disaster (Dunn and Sygall, 2014: 50). There is a lack of training for emergency response workers which results in a lack of safe and respectful approaches towards women with disabilities who need to access services (Dunn and Sygall, 2014: 50).

In addition, 'due to historic marginalisation women with disabilities face, they may not feel it is their right to access emergency aid or may lack the confidence to speak up for themselves and their needs' (Dunn and Sygall, 2014: 50). This may result in them not receiving food or supplies, because they quietly wait at the back of the queue (Dunn and Sygall, 2014: 50). Cultural barriers may prevent women with disabilities from speaking out in mixed groups of men and women in some countries, especially when their needs may be more private and sensitive; for example the need for hygienic items such as catheters (Dunn and Sygall, 2014: 50). Stigma and discrimination can also result in displaced women and girls with disabilities facing abuse from strangers, neighbours and family members, who may deny them access to food, clothing and shelter (Barriga and Kwon, 2010: 24-25).



## **Menstrual hygiene and reproductive health**

Women and girls in conflict and crisis may struggle to have their menstrual hygiene, or other hygiene needs, met, and the specific needs of girls or women with disabilities frequently overlooked (Rohwerder, 2014: 5). A participatory study looking at the sexual and reproductive health of refugees with disabilities in Kenya, Nepal and Uganda found that the needs of women and girls with disabilities are notably absent from global sexual and reproductive health and gender guidance for humanitarian response (WRC et al, 2015: 1; Tanabe et al, 2015). Refugees with disabilities in all three settings demonstrated varying degrees of awareness, with lack of awareness and misconceptions about sexual and reproductive health apparent among those who were isolated in their homes, as well as refugees with intellectual impairments (WRC et al, 2015: 3; Tanabe et al, 2015: 418). Provider attitudes were often reported as the most significant barrier deterring refugees with disabilities from accessing sexual and reproductive health services<sup>4</sup> (WRC et al, 2015: 3; Tanabe et al, 2015: 411). Pregnant refugee women with disabilities were often discriminated against by providers of healthcare and caregivers for becoming pregnant, and in Nepal many were bringing up their children alone (WRC et al, 2015: 4; Tanabe et al, 2015: 420). Women with disabilities reporting rape have not felt like they were treated with dignity and respect by service providers (Rosenberg, 2016: 10).

## **Poverty and lack of livelihood opportunities**

Women with disabilities may lose their livelihoods due to conflict, as they may lose their customers and their shops and goods may be destroyed or looted (Jerry et al, 2015: 20). Jerry et al (2015: 20) found that in Nigeria, those involved in the response 'do not adequately address the loss of livelihoods experienced by women with disabilities nor help them to recover financially'.

Refugee women with disabilities living in urban contexts have reported that 'poverty and a lack of income-generating opportunities increases the likelihood that they may engage in sex work and/or exploitative relationships' (Rosenberg, 2016: 6).

## **Risks faced by adolescent girls with disabilities**

Based on three research projects carried out by WRC, Pearce et al (2016: 118) find that adolescent girls with disabilities face 'multiple intersecting and often mutually reinforcing forms of discrimination and oppression, which are exacerbated in situations of crisis', as family and community structures break down and traditional and social norms disintegrate. Conflict and displacement exacerbate and heighten the discrimination that adolescent girls with disabilities already face in times of peace (Pearce et al, 2016: 125). This is a result of conflict and crisis creating an environment in which adolescent girls with disabilities are more vulnerable to exploitation since perpetrators take advantage of their lack of knowledge about sex, violence, and relationships, their extreme isolation, and their communication limitations (Pearce et al, 2016: 125). Resource limitations in refugee settings, alongside their limited income generating opportunities, are reported to further increase the risk of exploitation and abuse of girls, particularly for those with intellectual disabilities (Pearce et al, 2016: 125).

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<sup>4</sup> After the research on the sexual and reproductive health needs of refugees with disabilities, those involved are implementing site-specific recommendations to improve disability inclusion in existing services (WRC et al, 2015: 5).

Displacement can result in unsuitable housing for disabled girls and their families, crowded into spaces with others, which can increase their vulnerability to all forms of violence, perpetrated by both strangers and people they know (Pearce et al, 2016: 125). Overcrowding offers little privacy for those girls with disabilities who require daily assistance with personal care, especially once they begin menstruation (Pearce et al, 2016: 126; Rosenberg, 2016: 8).

Conflict and crises also weaken or destroy the formal and informal systems that protect against violence against women and girls with disabilities through the separation of families and neighbours and the weakening of community support structures, which reduces their access to information and services and increases their risk of violence (Pearce et al, 2016: 126; Rosenberg, 2016: 9; Barriga and Kwon, 2010: 27). It is reported that this is particularly relevant when they are newly displaced as they have not yet established trusting relationships with others or rebuilt their support systems in the host communities (Pearce et al, 2016: 126). As a result girls with disabilities reported feeling unsafe at home, in public and in school, as they have fewer people they can trust, which makes them less likely to seek assistance for, or share with others experiences of violence and abuse (Pearce et al, 2016: 126). Even if they do report abuse, negative attitudes towards disability, mean that reports by girls with intellectual or mental disabilities, for example, are discredited and people “think they are crazy and don’t believe them” (Pearce et al, 2016: 126).

Families may also resort to negative coping mechanisms which they believe will protect girls with disabilities from violence, abuse and exploitation, such as locking them in the home or physically restraining them to prevent them going outside (Pearce et al, 2016: 126-127). ‘Girls with intellectual and mental disabilities who exhibit behaviours that are not socially accepted—such as showing physical affection towards others or removing parts of their clothing—are particularly vulnerable to being locked up or physically restrained’ (Pearce et al, 2016: 127; Rosenberg, 2016: 8). However, confining them makes girls with disabilities more isolated, constricting their access to opportunities and services in the community and exacerbating their long-term vulnerability to violence (Pearce et al, 2016: 127; Rosenberg, 2016: 8).

Girls with newly acquired disabilities who are no longer able to fulfil the roles expected of them in their households, may be perceived by themselves and others as a burden (Pearce et al, 2016: 127). The attitudes and assumptions of others about their newly acquired disabilities can have long lasting impacts on their psychosocial wellbeing (Pearce et al, 2016: 127-128).

Girls with disabilities face also barriers to girls programming, such as environmental or communication barriers and the perceptions—and misperceptions—of staff, communities, and families alike, about their identity and capacity to participate with others (Pearce et al, 2016: 128).

## **Factors contributing to lack of inclusion of women and girls with disabilities in humanitarian response**

### **Gaps in policy development and implementation**

There are often no specific references to women and girls with disabilities in global, national, and organisational policies and commitments on protection and empowerment of affected populations, even where they mention persons with disabilities (Sherwood and Pearce, 2016: 1, 13). In addition, there is also ‘no globally endorsed operational guidance to support humanitarian actors to implement policies and commitments to disability inclusion in a systematic way, by ensuring appropriate human and financial resourcing; strengthening staff knowledge, attitudes, and

practices; and monitoring access and inclusion of women and girls with disabilities' (Sherwood and Pearce, 2016: 1). Sherwood and Pearce (2016: 2) find that this has resulted in women and girls with disabilities falling through the cracks in both disability and gender policy and programming in humanitarian contexts, with no enforced accountability mechanism to ensure their inclusion across different sectors.

### **Negative attitudes of family members and communities**

Humanitarian actors surveyed by WRC ranked the “attitudes of family members and communities” as the second most significant challenge to including women and girls with disabilities in humanitarian activities, on the basis of both disability and gender (Sherwood and Pearce, 2016: 14). Some families may hide a woman or girl with a disability making them “invisible” (Sherwood and Pearce, 2016: 14). Humanitarian actors reported that ‘activities to change negative attitudes towards women and girls with disabilities are often met with resistance and can foster a sense of distrust between them and the community’ (Sherwood and Pearce, 2016: 14). Disability actors report that ‘there is a “fear amongst women with disabilities in conflict regions to open up to outsiders” because their families or community members perceive this may expose them to further threats or violence’ (Sherwood and Pearce, 2016: 14). Cultural and language barriers may prevent displaced women and girls with disabilities from engaging with local DPOs (Sherwood and Pearce, 2016: 14). There were also reports that ‘crisis-affected communities perceive that there is “no hope” for women and girls with disabilities, and as such community leaders simply do not view them as a “priority” or represent their needs in community decisions’ (Sherwood and Pearce, 2016: 14). Ensuring the active and meaningful participation of women and girls with disabilities in decision making concerning their lives and wellbeing, as well as that of their families and communities, is an ongoing challenge due to their exclusion as a result of stigmatisation and discrimination (UNHCR, 2016: 21).

### **Limited staff knowledge, attitudes, and practices**

Humanitarian actors surveyed by WRC felt that they were ill equipped to ensure that women and girls with disabilities are included in humanitarian action, despite some training on disability (Sherwood and Pearce, 2016: 14). Disability actors report that humanitarian actors perceive women with disabilities as the objects of charity and protection, rather than as active participants in humanitarian action or change agents in their community (Sherwood and Pearce, 2016: 15). For example, humanitarian actors do not necessarily consider the social factors that shape and contribute to the vulnerability of adolescent girls with disabilities, such as being out of school, living in substandard shelter, being married or having a child, or having little contact with other girls of the same age, due to a focus on their health and rehabilitation needs (Pearce, 2016: 128). Some isolated pilot projects on the inclusion of women and girls with disabilities have exposed humanitarian actors to the skills and capacities of this group, but these are not yet to scale or systematic across the humanitarian sector (Sherwood and Pearce, 2016: 15).

### **Lack of champions and local partners**

Sherwood and Pearce (2016: 15) find that without strong accountability at field levels, women and girls with disabilities are largely reliant on champions to advocate for their inclusion and partners who are prepared to focus on them. However, there is a lack of strong advocates for women and girls with disabilities and a lack of strong partners who can deliver programmes for them (Sherwood

and Pearce, 2016: 15). Even when people with disabilities are included in humanitarian programming, they may be male dominated or not gender sensitive (Sherwood and Pearce, 2016: 25-26). As a result, for example, women with disabilities in refugee camps in Nepal set up self-help groups which provided a vehicle for more detailed consultation and representation of the needs of women and girls with disabilities (Pearce, 2014: 15). Women DPOs could play an important role, yet they may be located far from the conflict affected populations (Sherwood and Pearce, 2016: 15). Women with disabilities who are in leadership positions or working as humanitarian actors face many obstacles from their employers, peers and the communities in which they work due to perceptions and misperceptions about their capacity to contribute (Sherwood and Pearce, 2016: 26).

Lack of awareness on humanitarian issues, architecture, and processes means women's DPOs have reported that they find it difficult to articulate and effectively communicate on humanitarian issues or know where to refer affected women and girls with disabilities to the necessary services, including in relation to gender based violence (Sherwood and Pearce, 2016: 27).

### **3. Interventions to support women and girls with disabilities in conflict and crises**

Sherwood and Pearce (2016: 1) find that 'while humanitarian organizations are increasingly recognising women and girls with disabilities in policies and guidelines, there are still significant gaps in operationalizing this at the field level'. UNHCR (2016: 20) also finds that the diverse skills, capacities and needs of people with disabilities are often not adequately recognised in humanitarian response (see also Sherwood and Pearce, 2016: 1). However there are a number of examples of interventions to support women and girls with disabilities in conflict and crises. They include:

- Strengthening the capacity of networks of women with disabilities on humanitarian issues
- Disability inclusion in gender based violence interventions in conflict affected contexts
- Programming for the inclusion of girls with disabilities
- Providing opportunities for women with disabilities to work in humanitarian response
- Engagement with host community DPOs
- Policy and guidelines

#### **Strengthening the capacity of networks of women with disabilities on humanitarian issues**

The Women Refugee Commission's (WRC) project *Strengthening the capacity of networks of women with disabilities on humanitarian issues*<sup>5</sup> supports organisations of women with disabilities to advocate on humanitarian issues at national, regional, and global levels (Sherwood and Pearce, 2016: 1). The project conducted a global mapping of the role of these organisations in humanitarian response and documented effective strategies for the inclusion of women and girls with disabilities in humanitarian and post-conflict programmes (Sherwood and Pearce, 2016: 1).

Respondents highlighted strategies and examples from different contexts which have been effective in fostering the inclusion of women and girls with disabilities in humanitarian action

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<sup>5</sup> Funded by the Australian government and UN Women.

(Sherwood and Pearce, 2016: 15-20). They include organisational commitments to translate policies that integrate both disability and gender mainstreaming into practice; advocacy by groups representing the needs of women and girls with disabilities, which have been critical in raising awareness amongst humanitarian actors; partnership with women's DPOs and use of their expertise; having women with disabilities in leadership roles in humanitarian organisations, programmes, and activities; and to some small extent donor pressure on humanitarian actors to include women and girls with disabilities by asking for partners to conduct gender analysis and describe how they will reach persons with disabilities in their proposals for humanitarian programmes (Sherwood and Pearce, 2016: 15-19). Sherwood and Pearce (2016: 2) find that these strategies have 'wide-ranging impact on inclusion across a humanitarian response by bringing appropriate expertise, demonstrating skills and capacities, and raising awareness among humanitarian actors and affected populations alike'.

Respondents to the survey who worked for women's DPOs outlined that common activities they undertook to promote the inclusion of women and girls in humanitarian action included training for humanitarian actors; targeted advocacy for the inclusion of women and girls with disabilities in humanitarian action; and networking and alliance building with humanitarian actors (Sherwood and Pearce, 2016: 20). The project found that women's DPOs' strengths or contributions to the humanitarian sector included conducting assessments and monitoring the inclusion of women and girls with disabilities; mobilising women with disabilities in the affected population, with more inclusive programming and stronger peer support demonstrated in humanitarian contexts where groups of women with disabilities are well organised and mobilised; and bringing expertise to, and gaining experience from, partnerships with humanitarian organisations (Sherwood and Pearce, 2016: 20-25).

However the expertise of women's DPOs remains largely untapped in humanitarian crises and they often lack funding and organisational capacity, as well as facing exclusion from both the disability and women's rights movements (Sherwood and Pearce, 2016: 2, 25). 'Lack of funding was voiced as the most significant challenge for women's DPOs to engage in humanitarian action', especially as most of their members have been systematically excluded from educational and livelihoods opportunities throughout their lives which mean they may not have the same financial, administrative, and organisational skills of other women's organisations (Sherwood and Pearce, 2016: 25). A number of capacity development needs were identified, including training on humanitarian principles, frameworks and systems; training on how to engage women and girls with disabilities who are from vulnerable groups, such as survivors of violence; training on gender mainstreaming approaches and how to influence disability actors to be more gender sensitive; and project development and support on soliciting funds for programming that works to address the needs of women and girls with disabilities who are affected by crisis and/or conflict (Sherwood and Pearce, 2016: 27-29).

The WRC project's recommendations include:

- **Strengthen accountability for inclusion of women and girls with disabilities by developing gender-sensitive inter-agency guidelines on disability inclusion in humanitarian action.** Women and girls with disabilities should be mainstreamed in all sectors, especially gender-based violence, sexual and reproductive health, and livelihoods. Indicators for the inclusion of women and girls with disabilities should be established against which humanitarian organisations have to report. Women and girls with disabilities should be supported to form representative groups and should be equally

represented in community committees and humanitarian coordination structures (Sherwood and Pearce, 2016: 2, 30-31).

- **Increase support to organisations of women with disabilities in crisis-affected countries** by setting targets for funding to women's DPOs, including covering both operational costs and activities with affected populations, and prioritising them for organisational capacity building programmes and support (Sherwood and Pearce, 2016: 3, 31).
- **Advance gender equality in humanitarian and development organisations** by setting targets and monitoring the number of women and girls with disabilities participating in formal and non-formal education, adolescent girl activities, economic strengthening, and community leadership, as well as progress towards gender equality in organisations core commitments from the World Humanitarian Summit (Sherwood and Pearce, 2016: 3).
- **Promote the leadership of women and girls with disabilities** in humanitarian action by partnering with women's DPOs to provide capacity building and mentoring on the humanitarian system, and by employing women with disabilities (Sherwood and Pearce, 2016: 3, 31-32).

### **Disability inclusion in gender based violence interventions in conflict affected contexts**

Women's Refugee Commission and International Rescue Committee (IRC) worked together in conflict affected areas of Burundi, Ethiopia, Uganda and Northern Caucasus on disability inclusion in gender based violence interventions (Pearce, 2015). They developed concrete actions to engage women and girls with disabilities and improve the accessibility of their women's protection and empowerment programmes (Sherwood and Pearce, 2016: 6; Pearce, 2015: 21-22). Pearce (2015: 2, 23-24) found that practitioners involved in the project reported positive changes in their attitudes toward working with persons with disabilities, particularly as a result of working directly with survivors with disabilities. This allowed them to 'see beyond the person's impairment, appreciate their skills and capacities, and recognize that they can benefit from and make positive contributions to GBV activities' (Pearce, 2015: 2). They learnt how to adapt their services to meet the needs of survivors with disabilities, including through home visits, home-based activities and specialised case management services with more effective and appropriate communications approaches, which is especially beneficial for people with intellectual disabilities and/or multiple disabilities (Pearce, 2015: 2, 24, 29). However persistent gaps in their capacity were identified, including continuation of negative attitudes towards women with disabilities; more guidance needed on consent processes when working with survivors with intellectual disabilities; and more guidance on how to identify the skills and capacities of people with more complex disabilities to better connect them with opportunities to participate in community and social activities in order to break down social isolation and foster empowerment (Pearce, 2015: 25).

Women and girls with disabilities were provided with social and economic empowerment activities to establish peer networks and greater financial independence (Pearce, 2015: 2). Women and girls with disabilities reported that the development of more robust peer networks through various social empowerment activities, including discussion groups, asset-based programming for adolescent girls and Village Savings and Loan Associations (VSLAs), were the most important outcome (Pearce, 2015: 2, 25). The activities fostered relationship building and trust; led to information exchange and skills building; improved self-esteem and opportunities for women and girls with disabilities to be recognised not for their impairment, but for their roles as leaders, friends and neighbours making positive contributions to their communities (Pearce, 2015: 2, 25-26). These

outcomes can all serve to act as protective factors against gender based violence (Pearce, 2015: 2). Women with disabilities targeted involvement in the VSLAs also led to 'increased independence and decision-making and greater respect and status within the family and community as a result of their newfound access to income-earning opportunities, which can also serve to reduce vulnerability to GBV' (Pearce, 2015: 2). An important learning from the WRC and IRC project is that women and girls with disabilities 'have, and want to be understood as having, multiple identities beyond their impairment' (Pearce, 2015: 28).

Stories of change were gathered from those involved in activities such as hosting coffee mornings with neighbours, leading to sew, and joining village saving and loan associations (WRC and IRC, 2015). One adolescent girl with disabilities in Burundi spoke about how her inclusion by IRC in sewing projects meant she "saw that there is a lot that we can achieve. I can learn, I can work, and I can do professional training" (WRC and IRC, 2015: 3). Women with disabilities in Burundi spoke of how their involvement in the village saving and loans association meant that people started to respect them more and it enabled them to provide for the needs of their family and themselves (WRC and IRC, 2015: 4, 8, 13). Adolescent girls with disabilities were included in hairdressing courses in Jordan which made them "feel that they are like other non-disabled girls, they can go out of their homes, learn new things and find a job in any salon" (WRC and IRC, 2015: 7). A women with disabilities working as a social worker in a camp in Ethiopia spoke of how she works to "make women and girls safer, especially those who have disabilities, those who are not always included in activities, those who are often forgotten about" based on her own experiences (WRC and IRC, 2015: 10). An adolescent girls with disabilities in Burundi who IRC had supported to get a prosthetic leg and go to school said that "with my new leg and my chance of education, I feel safer, smarter and less likely to be taken advantage of" (WRC and IRC, 2015: 12). Support to caregivers can also improve the care for women and girls with disabilities (WRC and IRC, 2015: 11, 14).

While some gender based violence prevention activities may require adaptations to be inclusive of women with disabilities, often an invitation to join an existing programme was sufficient to lift the barrier to participation and successfully promote inclusion (Pearce, 2015: 2). It is important to remember to include those women with disabilities who are at home and cannot easily come to the programmes (WRC and IRC, 2015: 9). This can be done by bringing peer support activities as close to their homes as possible (Pearce, 2015: 26).

Efforts by WRC and IRC to promote the representation and leadership of women with disabilities and caregivers in community institutions and activities led to better attention to the concerns of these groups in organisations and programmes, and to greater appreciation by other community members of the skills and capacities of persons with disabilities (Pearce, 2015: 2, 31).

Some recommendations from WRC and IRC in relation to disability inclusion in gender based violence programmes in humanitarian settings include (Pearce, 2015: 33-34):

- Include women, girls, boys and men with disabilities and their caregivers in the design, implementation and evaluation of gender-based violence programmes.
- Provide training and reflective learning on the intersections between gender and disability for gender-based violence programme managers and service providers, and establish a common understanding of and commitment to the rights-based and survivor-centred approaches when working with this group.
- Recruit women and girls with disabilities as staff and volunteers in gender-based violence programmes.

- Prioritise the inclusion of persons with disabilities and caregivers in activities that strengthen social capital and peer networks.
- Prioritise the inclusion of women with disabilities and female caregivers in economic empowerment programming.
- Ensure that programmes and organisations designed to serve persons with disabilities are gender sensitive.
- Strengthen advocacy on the rights of people affected by crisis and conflict, particularly women and girls, by raising awareness about refugees and displaced persons in organisations for persons with disabilities.

### Programming for the inclusion of girls with disabilities

A number of different pilot interventions in humanitarian settings have sought to include girls with disabilities to reduce their risk of gender based violence (Pearce et al, 2016: 131).

Recommendations from these experiences include:

- **Prioritise the right of girls with disabilities to participation and inclusion:** Recognising the diversity of the populations they serve and including girls with disabilities in adolescent girls' programming is critical to reducing their risk of gender-based violence and should be a core part of such programming, not something thought to be special or separate (Pearce et al, 2016: 129).
- **See the girl first:** The age and gender components of girls with disabilities' identities are often overlooked in humanitarian contexts. Girls with disabilities have 'indicated that they identify first as daughters, sisters and friends, and want to be included in the same activities as their peers' (Pearce et al, 2016: 130).
- **Do not make assumptions:** Humanitarian actors often make assumptions about what girls with disabilities can and cannot do, or what activities would be most suitable for them and do not give them from the same opportunities as their non-disabled peers (Pearce et al, 2016: 130). Consultation with girls with disabilities by humanitarian actors has been reported to result in important changes for them (Pearce et al, 2016: 130).
- **Identify and value all contributions:** As participation will look different for every individual it is important to avoid setting rigid standards for what counts as participation and recognise that everyone has something to contribute (Pearce et al, 2016: 130). This recognition by humanitarian actors can help shape the way others view girls with disabilities (Pearce et al, 2016: 130).
- **Work with families and caregivers:** By engaging wider family units, humanitarian actors can both support and strengthen healthy relationships and balanced power dynamics between and among caregivers, girls with disabilities, and other family members (Pearce et al, 2016: 131).

In addition, humanitarian actors can take practical steps to promote inclusive and accessible humanitarian programming for adolescent girls with disabilities by identifying diversity among adolescent girls in crisis-affected communities; including outreach components to engage with isolated girls with disabilities; putting girls at the centre of programme decision making; making safe spaces "safe" for all girls; and identifying mentors with disabilities (WRC, 2015: 3-4).



## Providing opportunities for women with disabilities to work in humanitarian response

MIUSA found that women with disabilities have offered, and feel like they can offer, a lot to the humanitarian community if they are employed or consulted by them (Dunn and Sygall, 2014: 51, 54-55). Dunn and Sygall (2014: 54-55) give examples of how women with disabilities can contribute to helping make humanitarian assistance programmes more inclusive. Alumni of the MIUSA leadership programme, which trains women with disabilities from across the world, have worked for organisations such as Norwegian Refugee Council to increase disability inclusion in programmes working with internally displaced persons in Colombia, for example (Dunn and Sygall, 2014: 55). Wehbi (2010: 459) highlights the work of activist women with disabilities during the war in Lebanon who were involved in direct emergency relief work, which included identifying the particular needs of people with disabilities in displacement centres and evacuating people with disabilities from areas that were shelled. Their work ‘often took place in a context where no other organization was looking into the needs of people with disabilities or even acknowledging their existence’ (Wehbi, 2010: 459).

## Engagement with host community DPOs

There are some small scale positive examples of host community disabled people’s organisations reaching out to refugees with disabilities and strengthening their protective peer networks, which has been especially effective for women and girls with disabilities (Rosenberg, 2016: 13). For example, in Uganda the ‘National Union of Women with Disabilities of Uganda (NUWODU) reached out to refugee women and girls with disabilities to identify their concerns and recommendations, and used this information to advocate for inclusion with other DPOs, humanitarian agencies, and donors at national, regional, and global levels’ (Rosenberg, 2016: 13). “Afternoon teas” for refugee women and girls with disabilities are conducted every month in different member’s houses so the disabled refugee women can meet new people and get to know safe spaces in Kampala (Rosenberg, 2016: 13).

## Policy and guidelines

A number of policies and guidelines are now providing specific recommendations on the inclusion of women and girls with disabilities in different sectors of humanitarian action. For example, The *Minimum Standards for Age and Disability Inclusion in Humanitarian Action* detail how humanitarian actors should ensure that women and girls with disabilities have “private spaces to wash themselves, to wash and dry stained clothing and cloths used for menstrual hygiene management, and to dispose of sanitary materials,” as well as “sufficient space for the assistance of a carer if required” (Sherwood and Pearce, 2016: 7).

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## Key websites

Women's Refugee Commission – Refugees with disabilities:  
<https://www.womensrefugeecommission.org/disabilities>

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