GENDER & DEVELOPMENT NETWORK

Briefings

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The intersection of gender and disability

A primer for international development practitioners on women and girls with disabilities

This primer seeks to support international development practitioners improve their understanding on gender *and* disability by highlighting the issues faced by women and girls with disabilities. It explores six key areas in this regard: education; sexual and reproductive health and rights; water, sanitation and hygiene; violence against women and girls; economic empowerment; participation, decision-making and leadership; and situations of risk and humanitarian crisis.

1. Introduction

This primer aims to push international development practitioners beyond thinking about gender *or* disability and towards an intersectional understanding of gender *and* disability. It draws attention to issues faced by women and girls with disabilities – from girlhood to older age – as they confront compounded discrimination and disadvantage in many spheres of life. The challenges they face are often distinct and produce inequalities that differ across cultures and across types of impairments – inequalities that have often been neglected by both the women's rights and disability rights movements. This paper thus seeks to foster dialogue and partnerships across the development sector with the goal of equality for all.

Whilst this briefing explores the intersection of gender and disability, it cannot map every issue. Rather, it provides an overview of six key areas pertinent to women and girls with disabilities across the life course: education; sexual and reproductive health and rights (SRHR); water, sanitation and hygiene (WASH); violence against women and girls (VAWG); economic empowerment; participation, decision-making and leadership; and situations of risk and humanitarian crisis. Each section identifies key issues and relevant literature with the aim of encouraging engagement with the implications of gender and disability in each area.

Why gender *and* disability?

Gendered inequality and disability are two key axes of exclusion – alongside socioeconomic class, racialisation, citizenship status and so forth – that tend to produce distinctive intersectional effects for those individuals and groups who experience both in their everyday lives.[i] Together, they also highlight critical needs of one of the most marginalised groups in development and humanitarian settings: women and girls with disabilities. The World Health Organisation estimates that 19.2 per cent of women have a disability, compared to 12 per cent of men, largely due to systematic exclusion from education and health care (including sexual and reproductive health care), poorer nutrition and gender-based violence.[1] Deteriorating health leading to impairment is strongly associated with age, and as women tend to live longer than men, they are more likely to be affected by disability in old age, with previous exclusion from healthcare exacerbating deterioration of health.

Nonetheless, women's rights movements and disability rights movements have historically excluded women and girls with disabilities – the cohort where the two movements intersect – leaving them facing significant barriers to the implementation of their rights. While it has often been assumed that targeting poor communities through development interventions ensures that persons with disabilities are appropriately included – and likewise, that programmes directed at women will necessarily reach women with disabilities – it is increasingly recognised that this is not always the case.[2] Persons with disabilities are often not represented as valuable members of society because of social stigma and a lack of understanding about how to remove barriers; and are therefore often invisible at social and political levels.

As the UN Committee on Economic, Social and Cultural Rights explains, discrimination against persons with disabilities ranges from:

[I]nvidious discrimination, such as the denial of educational opportunities, to more "subtle" forms of discrimination such as segregation and isolation achieved through the imposition of physical and social barriers…Through neglect, ignorance, prejudice and false assumptions, as well as through exclusion, distinction or separation, persons with disabilities have very often been prevented from exercising their economic, social or cultural rights on an equal basis with persons without disabilities. The effects of disability-based discrimination have been particularly severe in the fields of education, employment, housing, transport, cultural life, and access to public places and services.[3]

Some societies consider persons with disabilities to be weak, unproductive, of lesser value or even not fully human. Disability also carries stigma that paints it as a curse or a punishment from god. Consequently, persons with disabilities may not be considered as deserving of equal rights.[4] For instance, in some African countries, traditional beliefs hold that people with albinism are ghosts or witches whose body parts can bring good luck or healing.[5] Disability-based discrimination also entails an element of vertical

[i] For further resources on intersectionality, visit GADN's resource page: https://gadnetwork.org/issues/intersectionality

discrimination whereby certain sub-groups such as persons with intellectual or psychosocial disabilities, persons with deaf-blindness and persons with multiple disabilities face more significant barriers due to higher levels of discrimination and marginalisation.

Throughout their life course, women with disabilities face discrimination based on their gender as well as on their disability, giving rise to complex forms of discrimination that cannot be fully understood or tackled if viewed purely through a lens of gender *or* disability.[6] Women and girls with disabilities are at increased risk of social exclusion and human rights violations and deprivations, and they are less likely to be included or recognised in development policy and programming. The barriers they face can also be "subtle" and take the form of segregation or isolation.[7] Disability also carries stigma that paints women with disabilities as especially weak, unproductive, of lesser value or even not fully human, and their impairments as curses or mystical endowments that potentially justify abuse against them.[8] These complex forms of discrimination may be further compounded by discrimination on the basis of age, ethnicity, racial background, social status, religion, sexuality, political situation or convictions, and geographical location.

Box 1: Definitions

Accessibility: One of the eight guiding principles that underpin the CRPD. It affirms the right of persons with disabilities to enjoy "access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas".[9] Accessibility is a precondition of inclusion: in its absence, persons with disabilities cannot be included.

Disability: The CRPD describes disability as "an evolving concept" and provides a deliberately flexible definition: "Disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others".[10] Persons with disabilities include those with physical, intellectual, psychosocial, sensory and communication impairments.

Disability inclusion: Achieved when persons with disabilities meaningfully participate in all their diversity, when their rights are promoted and when disability-related concerns are addressed in compliance with the CRPD.[11]

Discrimination on the basis of disability: Any distinction, exclusion or restriction on the basis of disability that has the purpose or effect of impeding or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including failure to respond flexibly to reasonable demands (denial of reasonable accommodation).[12]

Definitions (continued)

Intersectionality: An analytic framework that demonstrates how forms of oppression (such as racism, sexism, ableism and ageism) overlap, producing distinctive modes of discrimination and exclusion. An intersectional approach assumes that harms and violations associated with disability, race and ethnicity, gender or other identities cannot be understood sufficiently by studying them separately. To see clearly how discrimination affects access to resources or create risks for persons with disabilities, it is necessary to see how disability, age, gender and other factors interrelate and evaluate their overall effect.[13]

Mobility aids, devices and assistive technology: External products (devices, equipment, instruments, software), specially produced or generally available, that maintain or improve an individual's functioning, independence, participation or overall wellbeing.[14] They can also help prevent secondary impairments and health conditions. Examples of assistive devices and technologies include wheelchairs, prostheses, hearing aids, visual aids and specialised computer software or hardware that improve mobility, hearing, vision or communication.

Organisations of persons with disabilities: These organisations should be rooted in and committed to the CRPD and should fully respect the principles and rights that it affirms. They must be led, directed and governed by persons with disabilities. A clear majority of their memberships should be persons who have disabilities.[15]

Reasonable accommodation: Requires individuals and institutions to modify their procedures or services, where this is necessary and appropriate, either to avoid imposing a disproportionate or undue burden on persons with disabilities or to enable them to exercise their human rights and fundamental freedoms on an equal basis with others.[16]

2. Models of disability

Women and girls with disabilities are discriminated against differently in different cultural contexts, and the discrimination they encounter may be determined by their impairment type – physical, sensory, intellectual or psychosocial. Their level of disability differs depending on the material and social environment and the physical, family, attitudinal and institutional barriers therein. Although the UN and a number of countries have recognised the marginalisation of persons with disabilities for decades, practical international development approaches to working with, supporting and delivering services to persons with disabilities have often been based on a medical or charity model of disability.

The **medical model** views disability as a medical problem that resides within the individual – a defect in or a failure of a bodily system that results in disadvantages and limits societal participation. This model emphasises the individual impairment rather than the whole person and her position in society. Because it fails to address the environmental factors and behaviours that cause exclusion, this model promotes

interventions on (rather than with) persons with disabilities, which can exacerbate the stigma around disability at the family, community and national levels.

Similar to the medical model, the **charity model** locates the issue in the individual, who is to be pitied and looked after. Consequently, the medical and charity models can take away life-choice decision-making by persons with disabilities, which increases dependency and has negative effects on opportunities for independent living and inclusion in society.

The approach now more broadly adopted in international development is the **social model** of disability, which is reflected in the UN Convention on the Rights of Persons with Disabilities (CRPD).[ii] This model views disability as a social construct characterised by physical, institutional and attitudinal barriers that inhibit a person with an impairment. It seeks to address the way society is organised and remove barriers to participation, inclusion and the full enjoyment of rights. The **human rights model,** which is closely linked to the social model, recognises disability as a social construct but goes further by advocating for the rights of persons with disabilities, the obligations of the state and other actors to uphold them and the essential role of persons with disabilities in holding duty bearers to account.[iii]

With the social and human rights based models in mind, a twin-track approach (mirroring that for gender mainstreaming) calls for mainstreaming of disability inclusion into all policies and programmes alongside specific, targeted interventions for persons with disabilities to meet their specific needs.[iv] This approach is a step along the process to full and effective participation and inclusion of persons with disabilities in society, based on the principles of universal design.

The CRPD stipulates that persons with disabilities should be at the heart of decisions made about them, regardless of type of impairment or level of support required, in keeping with the ethos of "*nothing about us without us*"[17] or more recently, *"nothing without us".* This is not only good practice for international development in general but also addresses the historical denial of autonomy, independence and decision-making that persons with disabilities have faced.

3. Disability-disaggregated data

The availability of high-quality, comparable data on persons with disabilities is very inconsistent, and data on the intersection between disability and gender is even

[ii] For the full text of the convention and optional protocol, visit: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

[iii] There are a number of other models that refine our understanding of disability, such as the identity model, the economic model and critical disability studies. See Berghs, M., K. Atkin, H. Graham, C. Hatton and C. Thomas. 2016. *Implications for public health research of models and theories of disability: a scoping study and evidence synthesis.* Public Health Research no. 4.8. https://www.ncbi.nlm.nih.gov/books/NBK378941/

[iv] CRPD defines "universal design" as "the design of products, environments, programmes, and services to be usable by all people, to the greatest extent possible without the need for adaptation or specialized design [but] shall not exclude assistive devices for particular groups of persons with disabilities where this is needed". See UNGA 2006, art 2.

scarcer. Reliable disability-disaggregated data on most global development metrics does not yet exist, even though data collection is a significant part of Agenda 2030.[18] One reason is that recent surveys to collect disability data have asked closed questions (requiring "yes" or "no" answers) to elicit whether or not the respondent had a disability, resulting in inaccurate, lower figures on disability. This happens for a variety of reasons: respondents may not self-identify as having disabilities or prefer to be identified otherwise (for example, by their gender, profession or level of education); impairments may be hidden or invisible, or associated with older age rather than disability as such; or stigma may prevent respondents from indicating that they or someone in their household has a disability.

In an attempt to address this issue, the Washington Group on Disability Statistics, established by the UN, devised two sets of questions (short and extended) that can be added to national census and other data collection tools in order to disaggregate data by disability more accurately.[v] The UN's Sustainable Development Goals (SDG) indicator framework includes commitments to disaggregate data by both gender and disability, offering the potential for much greater insights into the situation of women with disabilities.[19] This potential will only be realised, however, if matched by political will to invest in national statistical capacity.

This investment will need to be extended to building the capacities of all potential users of the Washington Group's sets of questions – from national agencies and bilateral and multilateral donors to civil society organisation – so that the data is not used purely as a medical registry. Rather, the data should be cross-referenced with other data such as age, sex, location, and social background and levels of access in order to achieve a better understanding of the barriers to inclusion faced by persons with disabilities.

Quantitative data alone cannot fully capture the diversity of women with disabilities and their lived experiences, however. The collection of qualitative data is particularly important so that the voices of women with disabilities are heard, sharing their experiences of exclusion or empowerment throughout their life course and ensuring programmes that address their distinct social and environmental situations.

4. Areas of discrimination and exclusion

This section outlines the spheres where women and girls with disabilities face particular discriminations and exclusions across the life course, while also highlighting the relevant commitments made in the UN Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and related agreements and conventions.

Education

Disability is one of the primary reasons for educational disadvantage and exclusion.[20] Half of the world's 65 million school-age children with disabilities are currently out of

[v] For more on the Washington Group on Disability Statistics, visit: http://www.washingtongroup-disability.com

school, making them the largest single group who are not in education.[21] Achieving universal access to quality education will require a significant increase in enrolment and, consequently, a focus on girls with disabilities. As a background paper for the Oslo Summit on Education for Development explains,

> *In spite of [persistent] inequality and repeated commitments from policymakers, strategies targeting girls seldom refer to girls with disabilities, thus making girls with disabilities invisible in plans, monitoring reports and statistics.*[22]

Similarly, disability-focused strategies commonly fail to differentiate between boys and girls in their analyses and reporting, which also makes girls with disabilities invisible.[23] Particular barriers to education for girls with disabilities include the risk of violence in and around school, harmful stereotypes in the curriculum and inadequate teaching methodology and material. The lack of inclusive or accessible WASH facilities in schools also affects both health and dignity, particularly for adolescent girls. For example, girls with physical disabilities may have to crawl on a dirty floor, and girls with visual impairments may have to feel their way to the toilet. The World Report on Disability cites data from 51 countries showing that girls with disabilities, particularly those with intellectual or developmental disabilities, were less likely to have completed primary school compared to both girls without disabilities and boys with disabilities.[24]

Box 2: Education and rights

- CEDAW recognises women and girls' right to education on an equal basis with men (article 10).
- CRPD recognises the right to inclusive education for all persons with disabilities (article 24).
- SDG 4 on quality education also seeks to "eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable[vi], including persons with disabilities".[25]

Lack of education affects these girls for their whole lives, leaving them with fewer opportunities for economic activity and independent living, reinforcing stereotypes around the limited capacities of persons with disabilities and often leading to low self-confidence. Lack of sex education also limits these girls' ability to make informed choices and lead a healthy life. These are not simply resourcing constraints – they reflect a lack of political will, stereotyping and discrimination at multiple levels. National and local government officials do not prioritise investment and research on how to reach girls with disabilities and keep them in education. Schools do not prioritise differentiation in learning and often replicate stereotypes around gender and disability. They may see the girls with disabilities as potentially putting the non-disabled children's

[vi] Many international disability advocates avoid reference to persons with disabilities as inherently "vulnerable", as such reference is seen to reflect ongoing disability-related stigma and conflicts with the social model of disability. The term "at risk" is preferred so as to shift perception of weakness and responsibility from the person to the social environment.

academic attainments at risk. Communities and parents may disregard the educational potential of girls with disabilities, perceiving them as unable to be educated and only suitable as wives, mothers and domestic workers in the future.[26]

Sexual and reproductive health and rights

Women and girls with disabilities face a number of barriers to exercising their sexual and reproductive health rights (SRHR). Health facilities, services and information may be unavailable or inaccessible, and girls with disabilities are less likely to receive any form of sex education as they their access to school is also restricted.[27] Access to basic health services related to SRHR, such as immunisations, screening for chronic health conditions such as cervical or breast cancer, and medication such as antiretroviral drugs, are often restricted for women and girls with disabilities.[28] Barriers relating to communication or a lack of training and experience on the part of health professionals increases the risks facing women and girls with disabilities of premature death due to non-detection and non-treatment of disease.[29] Women and girls with disabilities are also less likely to receive support with menstruation management due to stereotypes linked to sex and disability.

Box 3: SRHR

- CEDAW recognises equal access to health services related to family planning (article 12) and to marriage and family relations (article 16).
- CRPD has several provisions applicable to SRHR, including those related to legal capacity and decision-making (article 12), freedom from cruel or degrading treatment (article 15), freedom from violence, exploitation and abuse (article 16), protecting the integrity of the person (article 17), respect for home and family life (article 23), right to health (article 25).

Stereotyping at the family, community and national levels can affect women and girls' ability to make their own decisions, legally and medically, and can often lead to forced or coerced sterilisation or contraception, particularly for women with intellectual impairments and psychosocial disabilities.[30]

In many cultures, the menstruation cycle is a taboo subject and something to be ashamed of. Women and girls receive little information about menstruation and may even be isolated during the days of bleeding. Women and girls with disabilities are less likely to receive support with menstruation management due to stereotypes linked to sex and disability. Women with disabilities are often not included in outreach around sexually transmitted infections (including HIV) due to the perception that they are asexual, leaving them at greater risk. Women with certain impairments, particularly intellectual impairments, may also be less able to negotiate the use of condoms, especially where men regard having sex with these women as "doing them a favour". Women and girls with communication barriers, such as sensory or intellectual impairments, are at a higher risk of sexual violence and may struggle to understand and process sexual violence after it takes place. Dangerous myths, such as that having

sex with a woman with a disability can cure HIV/AIDs, circulate in some communities: "Some hearing men think that when they rape a sick deaf woman, they can be healed or cured of HIV… So they infect [the] deaf woman with diseases".[31]

Where women and girls with disabilities are able to access health care facilities, practitioners and workers often lack knowledge of disability as a social construct and view them purely through the lens of their impairments. A lack of sensitivity, respect and responsiveness can also cause traumatic experiences. For example, a deaf woman in northern Uganda, who was not aware that she was having twins, stopped pushing after the birth of the first child because the nurse could not communicate with her: "She was very rude to me, and she didn't know sign language. She couldn't even tell me to push. She wasn't guiding me. One of my children died".[32]

Water, sanitation and hygiene (WASH)

Access to WASH facilities is especially important for persons with disabilities and they must always be consulted in the design and development of accessible water structures. However, wells and toilets are often not accessible to persons with specific impairments, such as wheelchair users or women of smaller stature, and can be difficult and even dangerous to navigate for persons with visual impairments. Toilets can be a serious health hazard for persons with physical disabilities who enter on their hands and knees.

The risks are greater for women and girls with disabilities who are usually in charge of fetching water for the household and other livelihood activities. Additionally, lack of access to water for agricultural purposes has an impact on livelihoods, nutritional status and general health.[33] A dearth of safe, dignified WASH facilities in schools is also a significant barrier to education for girls with disabilities, especially during menstruation.[34] Women with disabilities are also at greater risk of incontinence, particularly those with intellectual or psychosocial disabilities, and so have a significantly increased need for a consistent water supply and for accessible, private WASH facilities.[35]

The specific needs of women and girls with disabilities are often not recognised or acknowledged because women are rarely considered able to provide constructive or valuable input into construction or engineering decisions. The WASH facilities thus remain inaccessible, often when minimal adaptation to the design would benefit the whole community including pregnant women, children, and older people. The unwillingness to consult and adapt is often justified by the lack of funds to cover the additional costs of adapting the design.[36]

Violence against women and girls

Women and girls with disabilities face up to three times greater risk of violence and abuse, including emotional, sexual and physical violence, than non-disabled women. This includes intimate partner violence and all forms of violence perpetrated by family members, including other women.[37] This can be partly explained by the congruence of patriarchal norms with the pervasive stigma associated with disabilities at the family,

community and national levels. A UNICEF report in Thailand stated that deaf girls and adolescents were specifically sought out for forced prostitution because they were expected to be less able to communicate their distress or find their way home, as customers, brothel proprietors and fellow sex workers were unlikely to know sign language.[38]

Box 4: VAWG and rights

- CRPD protects the right to liberty and security of the person (article 14), the right to freedom from torture and cruel, inhuman or degrading treatment or punishment (article 15), and the right to freedom from exploitation, violence and abuse (article 16), as well as the integrity of persons with disabilities (article 17).

- CEDAW views violence against women and girls as discrimination (article 1) and places obligations on states to take all appropriate means to eliminate all forms of discrimination.

The experiences of women and girls with disabilities, and older women, are often underreported and understudied, even within the VAWG field, such that exclusions become more entrenched. Interventions to protect and support women facing violence thus rarely provide adequate measures to address the specific experiences of those with disabilities, even though women with disabilities face a complex and pervasive set of risk factors for VAWG, including:

- a perceived lack of agency or capacity to report violence, contributing to the belief by the perpetrators of violence or abuse that women and girls with disabilities are easy targets
- limited personal or social support networks due to neglect or social isolation
- restricted access to information and services, including legal protection against VAWG, as well as education programmes for self-defence or self-protection
- barriers to understanding or communicating incidents of abuse, particularly for women and girls with intellectual disabilities who may not fully comprehend their experience as abuse
- low self-confidence and self-belief, reinforced by negative attitudes in communities and leading to belief that their reports will not be believed or taken seriously
- dependence on a family member or other carer who is the perpetrator of the abuse or otherwise complicit.

Women and girls with disabilities are much less likely to be able to report violence because of communication barriers, the physical inaccessibility of police stations and other institutions, and their financial or physical dependence on their abuser. Even when able to report violence, women and girls with disabilities face considerable obstacles in accessing support, justice, reparations and health or rehabilitation services. In pursuing access to justice, they are often not perceived as credible in describing the assault or even the perpetrator, particularly if they have sensory and intellectual impairments. As noted above, women and girls with disabilities are often stripped of their decision-making power, so justice processes may not take a shape that benefits the survivor.

Economic empowerment

Women with disabilities face many of the same economic inequalities as other women, but these are compounded by disability-related stigma and discrimination. Studies across a number of countries show that women with disabilities are at greater risk of poverty than men with disabilities, linked to limited educational and skills development opportunities.[39] Many are able to work, often with very minor accessibility adjustments or reasonable accommodations, or indeed none at all – yet women with disabilities have lower employment rates than both women without disabilities and men with disabilities, and they earn less than men with disabilities.[40]

The *World report on disability* cites data from 51 countries showing that being a woman is the common factor shaping disadvantage across a range of demographics: in 2011 the employment rate for women with disabilities was 19.6 per cent, compared with 29.9 per cent for women without disabilities. In contrast, the employment rate for men with disabilities was 52.8 per cent, compared with 64.9 per cent for men without disabilities.[41] To date, limited research has been done on employment conditions of women with disabilities in low- and middle-income countries, but the available evidence suggests that they have particularly low access to decent work; that women are underrepresented in higher-paid, formal-sector employment; and that both women and men with disabilities are known to be disproportionately excluded from such employment.[42] Therefore, it can be inferred that women with disabilities are among those most prone to low-paid and precarious work.

Box 5: Economic empowerment and rights

- CRPD asserts the right to work for persons with disabilities (article 27) and the right to an adequate standard of living and social protection (article 28).
- CEDAW recognises women's right to work (article 11), the right to access economic and social life (article 13) and the right to social protection, particularly for rural women, on an equal basis with men (article 14).

For many persons with disabilities, livelihood opportunities are limited to self-employment, small businesses and subsistence farming, although they are often denied access to land and other assets. Inheritance laws remain strongly biased against women and are compounded by the denial of legal capacities to persons with disabilities. Children born with impairments may not be registered at birth, placing them at greater risk of neglect, institutionalization and even death, although there is limited evidence that this differs between boys and girls.[43] The lack of a birth certificate and other identification creates difficulties in opening a bank account, securing loans or microcredit, which is then compounded by the physical inaccessibility of banks and savings groups, inaccessible information (especially for those denied education or with sensory impairments), prejudice on the part of lenders and discrimination by customers, who may perceive their goods and services as low quality, dirty or even contagious.[44] Women with disabilities are rarely included in market-led development

initiatives, even those specifically targeting women, putting them at a disadvantage in in selling their goods and services.

Social protection

Social protection programmes such as pensions, unemployment benefits and disability support are critically important for persons with disabilities, as they have additional pressures on their incomes. Living with an impairment or mental health condition entails costs such as treatment and rehabilitation, personal assistance, assistive technologies such as wheelchairs or screen-reading technology, or specialised transport.[45] Households that include a person with disabilities therefore do not have the same spending capacity as households with a similar income which do not include a person with disabilities. Likewise, poor households that include a person with disabilities are less likely to develop coping strategies to get out of poverty. For example, women with disabilities in Uganda reported being repeatedly faced with abandonment after conceiving children and therefore being left to care for them without material support.[46]

Many women with multiple or complex impairments lack access to adequate social protection and, further still, paid work is not a realistic possibility. Research by the International Disability Alliance in the Asia-Pacific Region indicates that budget allocations to support persons with disabilities, including through social protection, could be as low as zero to 0.5 per cent of GDP.[47] In addition to the under-funding of these programmes, considerable administrative barriers may exist, such as in registering for programmes or obtaining a disability identity card, which make social protection benefits inaccessible. Conversely, non-contributory social protection systems, or social assistance programmes, have been shown to benefit women in particular and in some cases reduce gender disparities in income such as pensions.[48]

Unpaid care

Many women and girls with disabilities have unpaid caring responsibilities, which may be even greater than those of women without disabilities. For example, women with disabilities are at particularly high risk of being abandoned by their spouses and left with multiple dependents, as evidenced by research in Uganda, Tanzania and Bangladesh.[49] This challenge is compounded if a woman's impairment makes everyday caring responsibilities more time consuming.[50] The recognition and redistribution of unpaid care work is a particularly pressing issue for women with disabilities, as well as for carers for persons with disabilities, who are also more likely to be women.[vii] A recent study in South Africa estimated that the average earned income of households with children with disabilities were only around 70 per cent of the average earned income of households with children without disabilities.[51]

[vii] The majority of people who care for persons with disabilities are women. One project found that 80 per cent of carers for persons with intellectual disabilities were women. See Cordier, S. 2014. 'Caring for people with intellectual disabilities in poor rural communities in Cambodia: experience from ADD International', *Gender and Development* 22.3, 549–561; see also World Bank 2012.

Macroeconomic and employment policies

Because women with disabilities experience unequal economic outcomes, they are particularly hard hit by the regressive macroeconomic policies that shape national and international economies in areas such as government borrowing, taxation, budgetary spending, inflation and the calculation of GDP.[52] Where budgets do not include dedicated resources to target and benefit these women – for example, for non-contributory social protection, inclusive and gender-transformative public services, or reasonable accommodations that enable access to employment and other opportunities – existing economic inequalities are likely to become even more entrenched. Where governments favour indirect taxation policies that impose the heaviest burden on those with the lowest incomes, these women are likely to be among the most acutely affected.

When governments fail to ensure public sector jobs are accessible or require private sector employers adhere to human rights standards, or when they impose policies that actively restrict labour rights, women with disabilities are particularly exposed. Even when women with disabilities have reasonable access to employment, it is often informal work with few protections – a situation that could be improved by governments extending legal protections to the informal sector and adherence to International Labour Organization standards on decent work.[53] In short, the experiences of women with disabilities is a kind of acid test for how far governments and international financial institutions really seek to foster an economy that serves society “rather than vice versa”.[54]

Participation, decision-making and leadership

From the household to the international level, discriminatory social norms around gender and disability have a major and mutually reinforcing impact on women’s participation and involvement in decision-making.[55] Stereotype-based perceptions of capacity have a negative impact on how women with disabilities are perceived as decision-makers, especially when combined with gendered discrimination. Their exclusion from social activities, education and employment on the grounds of their impairment has a further impact on their self-confidence and visibility as active and valuable members of society.

If an impairment exists from birth, girls will rarely have the opportunity to participate in family, social or school activities, and will often not be allowed to contribute to household or community decision-making. If the impairment is acquired later in life, women with disabilities reported feeling stripped of their decision-making power and value. For example, in some societies a young woman with disabilities cannot make her own decisions regarding education and marriage and “is even at risk of serious violence if she attempts to”.[56] Her disability becomes an excuse to apply conservative, infantilising and patriarchal restrictions, purportedly for her own good – a logic applied much less frequently to boys or men with disabilities.

Box 6: Participation and rights

- CRPD asserts the right to participation in political and public life for persons with disabilities (article 29).
- CEDAW protects the right of women to participation in political and public life (article 7) and to representation in government and international organisations (article 8).

Situations of risk and humanitarian crises

Data on the impact of humanitarian crises, such as those related to climate change, disasters, conflict and large-scale health emergencies, are limited. The available evidence, however, indicates that the multiple and intersecting forms and discrimination routinely faced by women and girls with disabilities is further complicated and exacerbated in these contexts.

Box 7: Crises and rights

- CRPD calls on states to protect persons with disabilities in situations of risk and humanitarian crises (article 11).
- The Charter on Inclusion of Persons with Disabilities in Humanitarian Action provides a policy framework for inclusive humanitarian response, with particular attention to women and girls with disabilities.[57]
- The Humanitarian Inclusion Standards for older people and people with disabilities provides an operational framework.[58]
- The IASC guidelines on inclusion of persons with disabilities in humanitarian action provides detailed guidance.[59]

According to the International Rescue Committee's toolkit for gender-based violence programming in humanitarian settings:

> People with disabilities and older people are frequently excluded from humanitarian assistance and protection even though they are among the most at risk, vulnerable, and marginalised during and after humanitarian crises. Their knowledge, agency, and capacities are rarely considered in humanitarian responses. Their access to and participation in humanitarian responses is limited by cultural, attitudinal, physical, communication, and legal/policy barriers… Women and girls with disabilities are even more likely to face physical and sexual violence, abuse and exploitation and are less likely to be able to access services due to a variety of physical, societal, and communication barriers.[60]

In crisis settings, exposure to gender-related threats arises from a combination of discrimination and stigma based on gender, age and/or disability as well as

socioeconomic stress, separation from carers and support networks, inaccessibility of safe shelters or the fact that many are simply left behind.[61]

In 2015, a global consultation found that 85 per cent of humanitarian actors recognise the risks and threats to persons with disabilities in situations of risk and humanitarian crisis, and 92 per cent indicate that humanitarian responses fail to consider persons with disabilities adequately.[62] Three-quarters of respondents with disabilities confirmed that they did not have adequate access to basic services such as water, food, shelter or health care. A third of female respondents with disabilities reported experiencing abuse, whether psychological, physical or sexual. Sexual abuse accounted for 16 per cent of the responses in both natural disasters and conflicts.[63] Women with disabilities are also believed to be amongst the most at risk for sexual violence in conflict settings, including repeated attacks by the same perpetrators, because of existing social disadvantage, poverty and structural exclusion that paint them as easy targets and less likely to report abuse or achieve redress.[64] Girls with disabilities are also at increased risk of child marriage in protracted refugee contexts.[65]

Barriers to inclusion persist in humanitarian gender-based violence programming, including in access to services and meaningfully participation in needs assessments, programme design, implementation and evaluation. A rapid review conducted in 2019 found that very few gender-based violence programmes in humanitarian settings integrate women and girls with disabilities into their assessments – for example, by including them in focus group discussions or adding specific gendered questions on disability into focus group topic guides. Where such assessments do happen, they rarely identify the skills and capacities of women and girls with disabilities, which is a missed opportunity to capture their contributions to community programming.[66]

5. Intersecting movements

The multiple forms of discrimination experienced by women with disabilities have resulted in fewer opportunities for them to join or establish organisations representative of their rights, experiences and needs, when compared to opportunities for women without disabilities and men with disabilities.[67] Women's rights movements have also been criticised for being overly focused on issues such as equal pay and access to abortion, while neglecting discrimination facing women and girls with disabilities and the intersections of gender with race, disability, age and sexuality, amongst other identities. As Ekaete Umoh, the founder of the Family Centred Initiative for Challenged Persons in Nigeria, explains:

> *The issue of women with disabilities is excluded in two areas; there is a great oversight of disabled women's issues within the women's movement, they think it is a matter for [the] disability movement, while the disability movement think[s] it is [a] matter for [the] women's movement. So, we are at [a] crossroad and sometimes I am almost tempted to think that we are beginning to lose our gender because of a disability.*[68]

Some of the barriers that women with disabilities face in participating in wider women's movements are physical: inaccessible buildings for meetings, inaccessibility of certain forms of action (such as protest), the costs of personal assistant or specialised transport to attend events, and the lack of accessible information and communications such as easy-to-read formats and sign language interpretation. Some of these issues can be addressed by developing accessibility guidelines for such events. Women with disabilities frequently have lower levels of education, which also impacts on their ability to participate on an equal basis with others. Stigma associated with disability acts to cement this exclusion from women's groups by giving rise to the belief that persons with disabilities are unable to participate.

More fundamentally, the identity of women with disabilities *as women* is often ignored by women's movement.[69] When disability has been considered by women's movements, arguably, it has often been from entrenched medical, charity or welfare perspectives. Yet while, on the one hand, women with disabilities are widely seen as unqualified to contribute to feminist thinking because they are perceived as needy, dependent and passive – traits associated with femininity across many cultures – on the other, they are often assumed to be incapable of assuming traditionally "feminine" roles such as that of carer. Discrimination faced by women with disabilities in their communities is often replicated in women's organisations, where a lack of information and awareness means the issues faced by women with disabilities can be erroneously deemed unrelated to gender inequality. Such beliefs span the spectrum of impairments but particularly affect persons with deaf-blindness and those with intellectual and psychosocial disabilities. Disability specialist María Laura Serra argues that the lack of focus on disability in feminist movements, as well as women's rights movements, means women with disabilities are forgotten in this discourse.[70]

The absence of women with disabilities and their concerns from women's movements further highlights the need for their voices to be heard these in such spaces. During focus group discussions organised by ADD International with organisations of people with disabilities, women with disabilities came to realise that many barriers to inclusion are not only linked to their impairment but also to patriarchal societies where disability is used as an excuse to discriminate and exploit.[71] Similar discussions within women's movements would likely bring about similar revelations about the ways that disability compounds and complicates gendered exclusions, discrimination and prejudice.

Parallel criticisms can be applied to the disability movement, which has replicated the patriarchal societal model: men tend to dominate in leadership roles, particularly in low- and middle-income countries. For example, the 2017–18 UN Committee on the Rights of Persons with Disabilities – the body tasked with monitoring the CRPD – comprised 17 men and only one woman.[72] In these situations, specific issues that affect women with disabilities, such as reproductive rights, tend to be side-lined even in broader discussions around self-determination.

Nonetheless, there are signs of incremental change. The number of organisations of women with disabilities is increasing, and women with disabilities are becoming more visible in mainstream women's spaces.[73] In some countries, organisations of persons

with disabilities are setting up women's branches with links to the national umbrella group and starting to take these issues into account. No doubt the focus on gender equality in development frameworks has started to filter through the movement, with the realisation that, in line with the CRPD, the human rights of persons with disabilities can only be achieved if the rights of women with disabilities are also respected.

6. Conclusion

Women and people with disabilities are both still viewed as a kind of deviation from the norm of the able-bodied male – and in this respect, there is great synergy between the concerns of both groups. Understanding the unique discriminations, inequalities and exclusions that arise at the intersection of gender and disability, and the capacities and coping mechanisms of the people experiencing them, is essential for any effective development or humanitarian intervention. Women with disabilities, in particular, are at risk of being left behind due to patriarchal power structures combined with disability-related stigma and discrimination. To counter these systemic inequalities, inclusive development and humanitarian action require the systematic engagement of women with disabilities in planning, implementation, monitoring and evaluation.

There remain significant gaps in knowledge and evidence around gender and disability in international development and humanitarian crises – gaps that will only be filled through greater collaboration between women-led organisations and organisations of persons with disabilities; improved representation of women with disabilities in leadership positions; increased resources allocated to addressing stigma and discrimination; and mainstreaming of gender justice and disability inclusion in accountability mechanisms.

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