03

Light for the World
LEARNING SERIES

Ensuring girls and women with disabilities are not left behind: recommendations from disability and gender analyses.

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LIGHT FOR THE WORLD

Contents

Foreword

Light for the World advocates for an inclusive society. Its programmes aim to achieve sustainable transformation through non-discriminatory and human centred approaches. Operating in Africa, Light for the World strives to bring tailored and contextualised solutions. Aware of the heterogeneity of women and men with (and without) disabilities, Light for the World wants to strengthen its knowledge on the issues and barriers that the people we work with face daily and how to overcome them. For the past five years, we have, therefore, consistently researched the intersectionality between gender and disabilities in our focus areas to uncover the roots of exclusion of women and girls with disabilities.

This publication consolidates the learning from the previous inclusive gender analyses conducted by or in partnership with Light for the World. While, it does not replace the initial reports, this publication is structured around thematic areas: Inclusive Education, Eye Health, Humanitarian Action, Economic Empowerment, and Disability Inclusion in Community Development. The document summarises and briefly describes identified issues as well as recommended solutions from various programmes and countries. At the same time, it is designed to be accessible, with each section able to be used independently.

Indeed, Light for the World and its partners have gained more understanding on what works in context, and will use it in both our current and future programmes. We encourage you to do so too, so that no woman or girl is left behind.

Marion Lieser
Chief Executive Officer
Light for the World International

Introduction

For women and girls[1] with disabilities, gender and disability intersect leading to great exclusion. In fact, women and girls with disabilities make up about 60% of the world population with disabilities, and they experience increased inequalities in all areas of life compared to women and girls without disabilities and men with disabilities. They experience higher levels of exclusion in education, in personal activities, in health, and in standard of living [1]. They are subject to multidimensional poverty, insecurity, and poor psychological well-being [2]. They are at higher risk of being sexually or physically abused than a women or girls without disabilities, and unfortunately, they are scarcely reached by interventions against gender-based violence, or able to access safe spaces and service providers [3]. Women and girls with disabilities are less likely to make major life decisions for themselves, and rarely get married [4]. In addition, both women's rights movements and disability rights movements have historically excluded women with disabilities [5].

Light for the World recognises that disabilities disproportionately affect women and girls more than men and boys globally on the one hand, and on the other hand, that gender norms and roles exacerbate the experiences of discrimination among women and girls with disabilities [6]. Unless policies and programmes of gender equality and women empowerment consider both gender and disability, it is unlikely that women and girls with disabilities will ever equally enjoy their rights or realise their full potential. Thus, Light for the World has deliberately adopted intersectional approaches in policies and programmes. Overall, it is striving to mainstream gender as well as to address the needs of women and girls with disabilities [7].

This publication presents a summary of the lessons on key issue as well as recommendations towards achieving gender equality and fostering empowerment of women and girls with disabilities in the focus areas: Inclusive Education, Eye Health, Economic Empowerment, Humanitarian Action, and Disability Inclusion in Community Development.

1 Although we acknowledge that there are also other genders for whom disability and gender intersect, the studies on which this report is based have solely used the binary analysis. Therefore this report also focuses only on women and girls with disabilities.

Methodology

This publication sums up the ‘lessons learned’ and recommendations given in nine gender analyses conducted by Light for the World in Eye Health, Inclusive Education, Humanitarian Action, Economic Empowerment, and Disability Inclusion in Community Development. Documents were chosen for inclusion in this report based on their focus on the intersectionality of gender and disability, focus on one or more of the thematic areas of Light for the World, and whether the original study was carried out by or funded by Light for the World International. A list of all the documents reviewed in this report is found in the annexe.

For each document, the authors reviewed the key issues as stated by the authors, as well as their recommendations, and organised those that were specifically relevant to the intersection of gender and disability, per theme. In the following sections, a summary of key factors of exclusion concerning the intersectionality of gender and disability per thematic area, as well as the recommendations is provided.

1. Inclusive Education

The complexity of gender and disability keeps women and girls with disabilities out of education

Women with disabilities achieve lower educational outcomes than women without disabilities and men with disabilities: they have less education and lower literacy rates [2]. From early childhood, girls with disabilities are less likely to attend early childhood education compared to their peers and boys with disabilities [8] and at all ages, they are more likely to be out of school than their peers without disabilities and boys with disabilities [8], [9].

Girls with disabilities are given less priority to attend school. Families prefer their child with a disability to stay at home to protect them: this happens more often for girls as they are considered more fragile [4]. Investing in girls, and particularly girls with disabilities, is considered 'useless' because, in some of the communities surveyed, girls are predestined for marriage [3], [10].

Accessibility barriers limit girls with disabilities from attending school. Physical and assistive device inaccessibility such as lack of ramps at school, unsuitable bathrooms and other inaccessible infrastructure, as well as difficult access to assistive devices results in children with disabilities, particularly girls and young women, never starting school or starting late, dropping out, or receiving poor quality education if they ever start [3], [4], [11]. Although boys with disabilities may face the same issues, their access needs are more likely to be met. For example, they are more likely to have access to a wheelchair [12].

Girls with disabilities lack support from family and community to complete schooling. Families may not be able to support their daughter with a disability to attend school because they are not capable of doing so. This is especially the case when the main carer is the mother or grandparents after the child has been abandoned by the father or both parents [10]. When the school is located far away from the families' homes, it has been challenging to find host families for teenagers and young girls with disabilities [10].

(Fear of) sexual and gender-based violence prevents girls with disabilities, especially adolescent girls with disabilities, from continuing their education. In Burkina Faso, for example, in regions hit by humanitarian crises, families keep their girls with disabilities home for fear that they may face rape or sexual assault on their way to and/or from school [10]. High rates of domestic and gender-based violence prevents them from starting and completing their schooling [10].

Children with disabilities tend to start school late, and girls likely drop out during puberty. As they are identified and enrolled late because of the reasons mentioned above, girls with disabilities tend to drop out of school when they hit puberty, often before finishing their primary education [10].

Recommendations: Deliberately targeting women and girls with disabilities in education

Work with the community to encourage, promote and inform on the importance and possibilities of education for girls with disabilities [3], [4], [10]. Ideally, such mobilisation sessions should be carried out by women with disabilities who have completed education, as their lived experiences can demonstrate that (educational) success is possible for others like them [3], [4], [10].

Invest in the parents of girls with disabilities. Supporting the parents of girls with disabilities, for example with food, employment, or other needs, can prove to be useful as a first step. Parents who are secure in their needs and who have positive self-esteem will be more likely to encourage and support their child to attend school [10].

Promote quality training and retention of teachers, including (female) teachers with disabilities in inclusive schools. Children are more motivated to attend school when their teacher encourages and accepts them to do so. Investing in teachers who are welcoming and inclusive of girls and boys with disabilities facilitates their attendance in school [10]. In addition, training female teachers and teachers with disabilities will increase the number of role models; this will also encourage parents to enrol their girls with disabilities in school, thus increasing the number of girls with disabilities' retention in school [4].

Build safe and accessible infrastructure to ensure that girls and boys with disabilities are physically able to attend school. This can include improving simply physical access by installing ramps, adapted bathrooms and setting up separate bathrooms for girls and boys [10] in addition to other girl child friendly schools' standards.

2. Eye Health

Women and girls with disabilities are still excluded in eye health for all

55% of people with vision loss are women and girls [13]. Women and girls also participate less in eye health services. And, when they do, it is often at primary eye care units or during outreaches. Where they do access primary consultations, they are less likely to subsequently receive surgeries [14].

Women and men encounter different types of eye problems and therefore need different types of eye health services. Women are, for example, 1.8 times more likely to have trachoma [14]. Women and girls, being most often responsible for taking care of the children, are more exposed and vulnerable to infection and inflammatory diseases due to the high rate of contact with small children [15].

Limited financial and decision-making powers delay women's access to eye health and increases the prevalence of blindness and chronic eye conditions among women. Women in general do not own any economic resources [4], and if they do, they lack control over the use. Therefore, their access to eye health depends on the male family leader's agreement to sponsor eye healthcare seeking costs: for transport and services [15]. In addition, because they often shoulder the burden of household chores, women and girls have less time available to attend (eye) health services [15].

Women are excluded from health promotion in eye health. Some eye health conditions like trachoma can easily be prevented through proper sanitation, hygiene and handwashing. Women, however, are often less aware and informed about eye health and disease prevention [15].

Women seek eye health care very late when they are already seriously ill. This is partly due to the gender roles which makes women responsible for the largest part of household chores, leaving them with no or little time for themselves and to seek health services. They tend to seek proper medical care when traditional remedies have failed [15].

Physical accessibility prevents women and men with disabilities from using health care services. The inaccessibility of service delivery venues and buildings, such as a lack of ramps for wheelchair users and limited size of rooms, hinders persons with physical disabilities from entering and freely navigating eye health centres, as well as accommodating both the health seeker and their assistant. Other accessibility issues include communication issues, such as the lack of sign language interpretation which limits access to information and effective communication between service providers and clients [3], [15].

Healthcare providers may not take women with disabilities seriously. Women with disabilities, specifically, are treated with less respect and are more often discriminated against by health service providers than people without disabilities [4]. As with other community members, health professionals may believe that women and girls with disabilities are useless, and may therefore discriminate against them in providing their services [12].

Recommendations: Considering women and men with disabilities as rightful users of eye health services

Improved physical accessibility through universal design will increase the utilisation of services by women and men with disabilities. It is equally important to create enough space for the persons seeking eye health services to bring an assistant into the waiting room or changing cabin. Other supports include assigning assistants to support persons with physical disabilities when they come to the health centre and giving people from distant places priority if necessary [14], [15].

Ensure the availability of sign language and other alternative communication methods. Assign sign language interpreters and/or provide sign language training for health workers. Use alternative communication methods, such as easy language information and communication tools. The Image Books developed by Light for the World is here mentioned as one example of alternative and inclusive communication method.

Use gender appropriate and inclusive communication channels and methods. It is recommended that awareness-raising activities for the general population should be implemented in the immediate neighbourhoods of women with and without disabilities. Ensure that information, education, and communication methods used are gender-sensitive, time-friendly, and content-specific to women, such as within families or through house-to-house visits [14], [15]. Find appropriate times based on

the context and keep the sessions short. Women and girls with disabilities, use inclusive communication tools like illustrations to reiterate key messages [15]. Deliberately use female community educators and female role models, such as women who have successfully had eye surgery [14], [15].

Support women and girls with disabilities financially in seeking eye health services. Providing them with affordable fees and or free meals and accommodation options as they seek services can motivate them to use the services [15].

Develop 'fast track' services for women with and without disabilities to ensure efficient use of time in seeking and receiving health care. For example, keeping the time spent in seeking health care as short as possible and running exclusive children and women outreach programmes or screening camps [15]. Another solution could be to set up two waiting systems, one for each gender, rather than working on a first-come first-serve basis [14].

Use community organisations including women and disability organisations and, male engagement in advocacy for inclusive eye health [14], [15]. Male engagement is key in bridging the gender gap. In eye health, men can be involved by asking married men to bring their wives and/or daughters when they come for consultation or treatment[14].

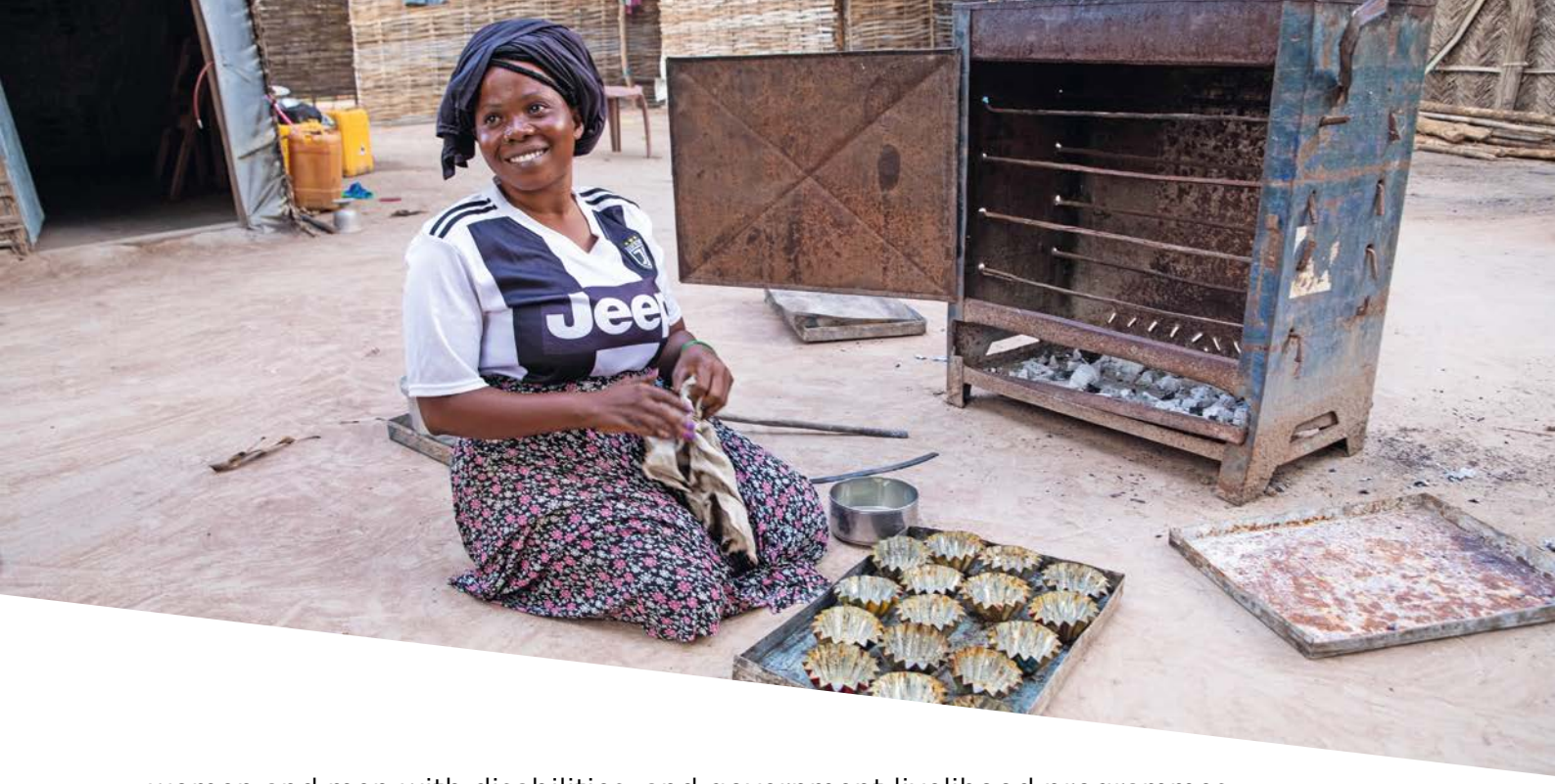
3. Economic Empowerment

Access to economic empowerment is compromised due to barriers for women with disabilities

Due to lower educational outcomes as well as barriers based on gender norms, women and girls with disabilities are less likely to have the professional skills necessary to enter employment, compared to men and boys [8]. They are less likely to be employed compared to men with disabilities and women and men without disabilities [16]. In addition, they are more likely to be engaged in unpaid work compared to women without disabilities [16].

Women with disabilities are considered unable to earn an income. Cultural and traditional gender roles and ideas about women having to take up unpaid work for the household prevent them from taking up paid opportunities outside of the household. On top of that, persons with disabilities have fewer opportunities for employment or business as they are considered 'slow' or unable to work because of disability [3], [17].

Livelihood or training programmes are often not accessible to women and men with disabilities. Skills training programmes are not designed to suit the abilities of



women and men with disabilities, and government livelihood programmes are not appropriate to the needs of women with disabilities [17]. Furthermore, lack of reasonable accommodations in the area makes it difficult for individuals with disabilities to participate [17].

Gender norms and patriarchal family relations prevent women with disabilities from accessing social security programmes. Wage employment and social security systems are closely related. In North-East India, women and men without disabilities are more likely to have benefited from the rural employment scheme. The scheme which issues employment opportunities per household, guarantees wage employment to adult members of a household who happen to be non-disabled [17].

Recommendations: Promote positive discrimination and social security for women with disabilities in economic empowerment

Broaden livelihood from employment to incorporate income security/social security. Women with disabilities may not have the educational qualifications and soft skills required to enter formal employment. Focusing on income security and access to social security can open up more opportunities for women with disabilities to gain an income. For example, including women in cash transfers or other public social security programmes [18], specifically supporting income projects for women and men with disabilities s [17] and ensure that livelihood programmes also focus on social security and income security, instead of only physical work-based activities [16].

Advocate consistently for improved access of women with disabilities to low-scale economic opportunities. For example, by advocating for their involvement in saving groups or (subsistence) agricultural programmes, can provide a start in challenging gender norms and provide additional income [4].

Create specific opportunities for women and girls (with disabilities) or use positive discrimination measures to ensure they gradually access employment. This will improve both their ability to support themselves, as well as improve their self-esteem [4], [18].

4. Humanitarian Action

Disability worsens the vulnerability of women in humanitarian situations

Women and men with disabilities are particularly vulnerable when it comes to conflicts and disasters. The disparities that women and girls with disabilities already experience, are exacerbated in such situations. As stated in the UN Flagship Report, "(...) women, children and older persons with disabilities, are more vulnerable to exploitation, violence, physical, sexual and emotional abuse in the aftermath of humanitarian crises" [19]. However, the experiences of women with disabilities generally do not inform the delivery of humanitarian services, as very few humanitarian actors set targets or indicators for the participation of women and girls with disabilities, and many do not include women with disabilities and their organisations in the programmes [20].

The needs of women and men with disabilities are neglected. Mainstream interventions and approaches in humanitarian action overlook the needs of women and men with disabilities from the start. As a result, women with disabilities do not access food rations as well as resettlement interventions like in agriculture. In addition, humanitarian agencies do not deliberately target women and men with disabilities nor do they actively engage with their organisations. Consequently, they are not reached out to or supported. Community leaders do not consider them while generating the beneficiary list for food aid [21].

Difficulties in accessing resources increases the risk of sexual and gender-based violence. It was found that community leaders coerced women with and without disabilities in sexual abuse in exchange for access to basic services, such as securing their name on the distribution list for food rations [21].

In resettlement settings, women, and girls (with and without disabilities) suffer from lack of access to basic gender specific services. This includes sexual and reproductive health services, menstrual hygiene management such as dignity kits and mental health services. The lack thereof can increase existing health conditions, or cause new health conditions [21].

Recommendations: Vulnerable women with disabilities should be given priority in humanitarian programmes

Make food distribution accessible to all, particularly to less visible people like women and men with disabilities. Where possible, the recommendation is that food rations for vulnerable groups, such as women and girls with disabilities, pregnant and breastfeeding women should be prioritised or supplemented [21].

Ensure accountable, inclusive, and transparent decision-making on food distribution and services provision. In addition, there should be proper oversight and feedback mechanisms in place to hold those who oversee food and other service distributions accountable. This is important to ensure that distribution and prioritisation mechanisms are not being used to subject women to sexual abuse and exploitation [21].

Promote services and partnerships which ensure that women and girls with disabilities can access menstrual health materials, as well as access mental health and psychosocial support [21].

5. Disability Inclusion in Community Development (DICD)

The intersection of disabilities and gender limits the participation of all women with disabilities in DICD

The representation of women with disabilities is low in national leadership and management of gender and disability related organisations [19]. In addition, rehabilitation services and organisations tend to be situated in urban and city centres, leaving many women and girls with disabilities who reside in remote areas deprived of knowledge about their existence and the services offered. Even if they hear about them, physical and financial barriers limit their access [3].

Women and girls with disabilities are excluded from community development initiatives. Women and girls with disabilities are often left out of community development meetings and initiatives due to patriarchal systems and societal barriers. If they do attend, the community suppresses their voice or simply ignores it. Subsequently, they are demotivated to try again [3], [17].

Women with disabilities are marginalised in organisations for persons with disabilities (OPDs) and/or they are underrepresented. Although, women and men are members of OPDs, prominent leadership roles are often taken up by men [17]. While OPDs are set up to advocate for the needs and rights of their members, women specific needs are neglected in OPDs' advocacy agenda and women do not feel fully represented by them [4].

Recommendations: Develop and innovate DICD programmes to become gender inclusive

Develop the capacity of DICD programmes and organisations of persons with disabilities on gender. Encourage DICD programmes as well as OPDs to partner with feminist and women's organisations. This will strengthen organisational capacity and abilities programmes to work with and for women and girls with disabilities and address gender needs and issues [17]. Particularly for OPDs, support their advocacy to gender and disability in budgets and policies. This can be done by developing the capacity of OPDs in understanding budgeting and local planning processes [17].

Consistently collect data on women and girls with disabilities in DICD programmes. This is useful for understanding whether and where women and girls with disabilities are being included or not in the projects set up by the DICD programme. It is also instrumental for monitoring, evaluating and improving access for women and girls with disabilities to those programmes.

Involve, encourage, and employ women and girls with disabilities. Build and promote opportunities for women and girls with disabilities to take up roles in OPDs and community activities. Identify women with disabilities already in leadership positions, empower them through training and mentorship to become as coaches for their peers [17]. Recruit and engage them as community activists, on local government committees, and as leaders in organisations of persons with disabilities [3], [4], [17].

Empower the agency of women with disabilities by investing in creating and enabling their groups, committees, and networks. Where possible, link their networks to national networks of women with and without disabilities. This will increase the visibility of women and girls with disabilities and strengthen their network for advocacy and lobbying [17].

6. Conclusion and outlook

Leaving no one behind, setting the case for women and girls with disabilities

Summarising the findings and recommendations of the gender and disability analyses confirms what we already know: women and girls with disabilities are not being seen and heard in women-related programmes, nor in disability-related programmes. Many do not have a voice of their own, meaning that they are less represented in communities, programmes, and organisations. Contextual and tailored solutions are important in addressing the issues of intersectionality.
The sections above have provided recommendations per thematic area of Light for the World's work. In conclusion, we highlight important cross cutting recommendations.

1. Collect and use sex-disaggregated data. Data about women and girls with disabilities in programmes and organisations are scarce, yet they are key for both organisational development and programmatic transformation. It is recommended to disaggregate data by sex and disability to improve current and future work and increase participation of women and girls with disabilities [3], [17].

2. Address and redress the impact of traditional gender roles. Encourage men with and without disabilities to participate equally in the care work and domestic chores in the household and at community level [4], [22], [3]. In the meantime, programme interventions should be adapted to the gender roles to allow greater participation of women and reasonably accommodate women and girls with disabilities, considering time, duration, and venue [22].

3. Genuinely engage and work with women with disabilities and support the development of their organisations. Work with organisations that promote the rights of women and girls with disabilities, where they exist, and/or support the creation of such organisations, if they do not [3]. In addition, develop their capacity for self-advocacy, effective engagement, and meaningful participation in programmes and organisations [4]. Promote specific activities for women and girls with disabilities, and target them in programmes [21], [23]. In order to achieve that, organisations should invest in developing the capacity and expertise of their staff and partners on the intersectionality of disability and gender, increase their 'know how' for understanding and dealing with gender and disability-specific barriers [15], [17]; Support staff and partners in developing gender and disability-inclusive policies [4]. In particular, provide them with the skills to address gender-based violence against women and girls with disabilities [3], [4].

Finally, it is important that the profile of women and girls with disabilities is improved, their voices are heard, and that their needs are being met in development, gender, and disability organisations such as Light for the World.

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Annexe: List of documents reviewed for this publication

Author	Title	Year	Research methods
Caritas India CBR, Choudhury, B.	Disability and Gender in the North-East of India: discrimination and barriers faced by women with disabilities.	2020	Literature review Personal interviews (20) Interaction with key stakeholders Community group discussions
Girl Child Rights, & Light for the World.	Disability Inclusive Rapid Gender Analysis	2022	Desk review Household survey (108 respondents) Focus group discussions (9 groups)
Girl Child Rights, & Light for the World.	Disability Inclusive Rapid Gender Analysis (DIRGA), Cabo Delgado	2022	Household survey (24 respondents) Key informants interviews (28 respondents) Focus group discussions (14 groups)
Kere, C., Kere, H. & Guinko-Bance, D.	Project Strengthening Inclusive Education in the Catholic Education Sector (SNEC): rapport d'étude genre	2022	Household questionnaire (167 respondents). Children's questionnaire (218 respondents). Semi-structured interviews (30 respondents). Group interviews (4 groups).
Light for the World	Gender and Disability in Sofala, Mozambique	2018	Desk review. Semi-structured interviews and focus group discussions with 57 women and 70 men.
Light for the World	Equitable, sustainable eye care for all! Lessons learned from a gender-sensitive pilot project in Burkina Faso, Ethiopia, and Mozambique.	2022	Literature review Key informant interviews Focus group discussions Service provision data Gender analysis in the three regions

Author	Title	Year	Research methods
STAT-DES Burkina	Etude Genre de projet “Renforcement de l’Autonomisation à Kaya pour L’inclusion Sociale” (RAKIS)	2021	Literature review. iews (43 respondents) Focus groups (34 groups)
WI-HER	Gender Audit: Sports Training Integration School, Artistic Expression and Work Development (EIFODEC).	2021	Desk review Key informant interviews (2 respondents) Focus groups (3 groups)
Yardinat Consultancy	Gender Analysis Report to Comprehensive Eye Health including Child Eye Health Projects in Arba Minch and Gondar	2021	Desk review. Key informants (13 respondents, all male). Focus group discussions (17 groups).

7. Want to know more?

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