

VIOLENCE AGAINST WOMEN LIVING WITH DISABILITIES IN SOUTH- EAST AND EASTERN EUROPE

UNFPA Evidence Brief based on OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe



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Acronyms

BiH	Bosnia and Herzegovina
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
EE	Eastern Europe
EIGE	European Institute for Gender Equality
EU	European Union
ICF	International Classification of Functioning, Disability and Health
ICPD	International Conference on Population and Development
N/A	Not available
NAP	National Action Plan
OSCE	Organization for Security and Cooperation in Europe
SEE	South-East Europe
UNFPA	United Nations Population Fund
UNSCR	United Nations Security Council Resolution
VAWG	Violence against women and girls

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Executive summary

Violence against women is widespread in the region of the Western Balkans and Eastern Europe as evidenced by the OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe conducted in eight of the region's countries/territories in 2018. Women living with disabilities are exposed to even higher risks of various forms of violence than women without disabilities.

Prevalence of violence. Lifetime prevalence (since the age of 15) of any form of gender-based violence (including physical, sexual, psychological, sexual harassment and stalking), committed by any perpetrator (including current or former partner, family members, friends, acquaintances or unknown persons) is higher among women living with disabilities than among women without disabilities. Both non-partner and partner violence are more prevalent among women with disabilities, since the age of 15 and during the 12 months preceding the survey. The prevalence of sexual harassment is also higher among women with disabilities.

Factors increasing risks of violence. Higher exposure to violence starts earlier in childhood, as women and girls with disabilities report higher prevalence of violence experienced before the age of 15. This is the strongest factor increasing the risks of experiencing violence in adulthood. However, there are also other factors contributing to higher risks of violence, such as adherence to norms and values promoting and maintaining the subservient role of women and considering violence as a private matter; economic dependence and material deprivation; and displacement or other form of vulnerability. High-risk partners include those who have secondary education, who are unemployed or inactive, who have alcohol-drinking habits and who participated in armed conflicts.

Consequences of violence are severe, and the impact is more prevalent among women with disabilities. They more frequently reported physical injuries as a consequence of the most serious incident of violence, including bruises, scratches, internal injuries, impact on sexual and reproductive health (e.g. infections, sexually transmitted infections, unwanted pregnancy), while also more frequently reporting long-term psychological consequences such as anxiety, difficulties in relationships, panic attacks, difficulties with concentration or in sleeping, and loss of self-confidence.

Reporting violence is very low among women who experienced violence in general, and among women with disabilities as well. Police are contacted by one in four women after experiencing the most serious incident of violence. Only hospitals are more often contacted, while other services such as health centres, legal services, social protection agencies, women's shelters or organizations for victim support were contacted by a very small number of women with disabilities. The reasons for not reporting are lack of trust, lack of services, lack of information about services, distant services and physical barriers in access to services.

Need for support. Women with disabilities indicated that their most-needed forms of support are psychosocial support, protection from further victimization, financial support, medical support, practical help, assistance in reporting and dealing with police, and more information from the police. This clearly indicates a high need for integrated and well-coordinated services.

Recommendations for improving the prevention of violence and protection of women with disabilities in line with UNFPA standards include adopting a systematic and systemic approach, better collection of data and evidence, improved multisectoral response ensuring more accessible and better-quality services, more appropriate resource allocation, improvement of sexual and reproductive health rights (SRHR) and services, and more widespread and effective prevention programmes. The programs and services should be designed with participation of women and girls with disabilities.

I. Objectives

Prepared by UNFPA's Eastern Europe and Central Asia Regional Office, this evidence brief aims to provide information on the prevalence, causes and consequences of violence against women with disabilities, and on the access to services of women with disabilities who have been experiencing different forms of partner and non-partner gender-based violence. The brief is based on data from an [OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe](#) which provided valuable evidence, rationale and validation of worldwide findings on the greater exposure of women and girls with disabilities to gender-based violence. At the same time, it provides regionally specific guidelines for policies on how to achieve more effective response to and prevention of violence against women and girls living with disabilities in order to fulfil the principle of leaving no one behind.

The significantly higher exposure of women and girls with disabilities (in comparison to women without disabilities) to gender-based violence and the need for their better protection is recognized in key international documents. The Convention on the Rights of Persons with Disabilities (CRPD) emphasizes that women and girls with disabilities face multiple and intersecting forms of discrimination and draws attention to their particular susceptibility to violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation.¹ The World Programme of Action Concerning Disabled Persons recognized women with disabilities as a "special group" and addresses the "specific barriers they face in accessing health care, education and employment."² The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence urges the States Parties to take measures to protect the rights of victims, including persons with disabilities.³ The 2030 Agenda for Sustainable Development reflects the international community's commitment to the empowerment and advancement of women and girls with disabilities.

Lack of data on the exposure of women and girls with disabilities to gender-based violence, particularly data on prevalence and access to protection services, is one of the key challenges in providing better response to violence against women and girls with disabilities. The particular value of the OSCE-led survey lies in the fact that the data can be used for secondary analysis that may provide insights into the prevalence, causes and consequences of different forms of violence against women and girls living with disabilities as well as their reporting habits and access to protection services. This brief presents the results of this secondary analysis.

On the principle of "leaving no one behind," the 2030 Agenda explicitly recognizes gender equality and disability as cross-cutting issues. In addition to a stand-alone goal to achieve gender equality and empower all women and girls (Sustainable Development Goal 5), the 2030 Agenda requires the systematic mainstreaming of a gender perspective in its implementation. While disability is not addressed in a stand-alone goal, it is specifically included in the Goals related to education, growth and employment, inequality, accessibility of human settlements, and data, monitoring and accountability.

United Nations General Assembly, Report of the Secretary-General, Situation of women and girls with disabilities and the Status of the Convention on the Rights of Persons with Disabilities and the Optional Protocol, 28 July 2017

1 United Nations General Assembly, Report of the Secretary-General, Situation of women and girls with disabilities and the Status of the Convention on the Rights of Persons with Disabilities and the Optional Protocol, 28 July 2017, available at <https://www.un.org/development/desa/disabilities/news/dspd/women-and-girls-with-disabilities-crpd.html>

2 Ibid., para. 4

3 Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, Article 4, para. 3

II. Methodology and limitations

The OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe was not designed to measure prevalence of exposure to violence among women with disabilities; it rather allowed insights into the experiences of these women to the extent they were included in the general sample. Therefore, the representation of women with different types of disabilities is probably not fully adequate as women who live with a mental disability or some forms of sensory disability (such as deaf women) were not included. The instrument for identifying disability enabled more a proxy measure than full identification of disability according to international standards. Within this brief, women with disabilities are identified in the OSCE-led survey as those women aged 18 to 74 who answered “Severely limited” to the survey question “For at least the past six months, to what extent have you been limited because of a health problem in activities people usually do?” This category includes 1,002 women, or 5.2% of the total sample, out of which 402 became disabled during an armed conflict.⁴

The decision to define the category of disabled women using a narrower definition (those who replied with “Severely limited” instead of “Somewhat limited”) was made taking into account data with global estimates on disability prevalence. The group of women who answered the above question with “Limited but not severely” included 25% of the sample, which when combined with those in the “Severely limited” category would include over 30% of women in the sample. This would be too large a category in comparison to global estimates, according to which about 15% of the world’s population lives with some form of disability – 2% to 4% of whom experience significant difficulties in functioning (WHO, World Bank, 2011).

It is important to note the advantages and disadvantages of such a decision. The disadvantages are related to the limits on disaggregating the analysis by country or by characteristics of the women due to the relatively small number of women in the disabled category. The advantage is a clearer picture on women with disabilities, with a higher certainty that women with a temporary illness or injury are not counted among those who live with disability. Focusing on a narrower group gives a more contrasting picture in comparison to women without disabilities, thus providing clearer policy guidelines.

In more general observations on violence against women and girls with disabilities in this report the category of “girls” refers to female persons younger than 18 years. All calculations presented in this brief were carried out by IPSOS Belgrade Office.

OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe

The survey was conducted with methodology used by the European Union Fundamental Rights Agency (FRA) for its EU-wide survey on violence against women.⁵ The survey was conducted in seven OSCE participating States: Albania, Bosnia and Herzegovina, Moldova, Montenegro, North Macedonia, Serbia and Ukraine, as well as Kosovo (UNSCR 1244)⁶.



⁴ Conflict-affected women are identified as those who have lived in a situation where there was an active armed conflict for a period of at least one week and who answered “yes” to at least one of the questions related to conflict experiences (see more in OSCE, 2019: 53).

⁵ FRA (2014) Violence against Women: An EU-wide survey. Main results. Accessed on 03.03.2019 at <https://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report>

⁶ All references to Kosovo should be understood in the context of United Nations Security Council Resolution 1244 (1999).

III. What is gender-based violence against women and girls living with disabilities?

Violence against women and girls (VAWG) is a violation of the rights and fundamental freedoms of women and a manifestation of historically unequal power relations between men and women.⁷ It is embedded in social structures marked by unequal access of women and men to diverse resources and positions, and unequal responsibilities in the family, community and in private and public life. It is rooted in culture marked by norms and values promoting stereotyped roles and placing different expectations on women and men, influencing their segregation in terms of roles and obligations. VAWG is a form of control over women exercised through various means that result in restricting choices of women and girls and reducing their chances to realize their full human potential.

Definitions of gender-based violence against women

...gender-based violence against women is one of the fundamental social, political and economic means by which the subordinate position of women with respect to men and their stereotyped roles are perpetuated... such violence is a critical obstacle to the achievement of substantive equality between women and men and to the enjoyment by women of their human rights and fundamental freedoms, as enshrined in the Convention... This violence takes multiple forms, including acts or omissions intended or likely to cause or result in death or physical, sexual, psychological or economic harm or suffering to women, threats of such acts, harassment, coercion and arbitrary deprivation of liberty.

Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating General recommendation No. 19

Violence against women is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, 2011: 3

Globally, women are more likely to experience physical, sexual, psychological and economic violence than men, and women and girls with disabilities experience gender-based violence at disproportionately higher rates and in unique forms owing to discrimination and stigma based on both gender and disability. For instance, women and girls with disabilities are thought to experience domestic violence at twice the rate globally of other women⁸ and they also experience forms of violence specifically because of their disability, including isolation, violence in institutions and the withholding of medication and mobility, vision and hearing aids.⁹ According to the UNFPA guidance note on the rights of women with disabilities they are up to 10 times more

7 United Nations Declaration on the Elimination of Violence against Women, 1994, accessed 03.03.2019 at <http://www.un.org/documents/ga/res/48/a48r104.htm>

8 Hughes, Karen, Mark Bellis, Lisa Jones, Sara Wood, Geoff Bates, Lindsay Eckley, Ellie McCoy, Christopher Mikton, Tom Shakespeare and Alana Officer. 2012. "Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies." *Lancet* 379:1621-29

Krnjacki, Lauren, Eric Emerson E, Gwynnyth Llewellyn and Anne Kavanagh. 2015. "Prevalence and risk of violence against people with and without disabilities: findings from an Australian population-based study." *Australian and New Zealand Journal of Public Health* doi:10.1111/1753-6405.12498

9 UN General Assembly, Sexual and reproductive health and rights of girls and young women with disabilities, Report of the special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, submitted in accordance with Human Rights Council resolution 35/6, Seventy-second session, para. 34.

likely to experience sexual violence.¹⁰ Where disability affects the individual's ability to communicate, the risk of violence may be even higher as abusers can take advantage of the person's inability to disclose the abuse.¹¹

Forms of violence defined by asking women if they experienced some of the behavioural acts representing such violence:

1. **Physical violence:** pushing, shoving, slapping, throwing object, grabbing or pulling hair, punching, beating, kicking, burning, suffocating, strangling, cutting, stabbing, shooting, beating head against something
2. **Sexual violence:** forcing or attempting to force sexual intercourse by holding woman down or hurting her in some way, making woman take part in any form of sexual activity when she did not want to or was unable to refuse, participating in sexual activity out of fear
3. **Psychological violence** includes three forms of violence:
 - a) **Economic violence:** preventing a woman from making decisions about family finances, from shopping independently, from working outside the home
 - b) **Controlling behaviours:** keeping a woman from seeing her friends, restricting her use of social media or contacts with family or relatives, insisting on knowing where she is, getting angry if she speaks with another man, suspecting that she has been unfaithful, forbidding the use of contraception or restricting her decisions on family planning, preventing her from getting an education, deciding what clothes she can wear or expecting to be asked for permission so she can see a doctor
 - c) **Abusive behaviours:** forbidding a woman to leave the house, or to leave without being accompanied by a relative, locking her up, belittling or humiliating her in front of other people or in private, purposefully scaring or intimidating a woman, making her watch or look at pornographic material against her wishes, threatening to hurt or kill someone she cares about, threatening to hurt her physically or with violent sexual acts, using a women's children to blackmail her or abusing her children
4. **Sexual harassment:** unwelcome touching, hugging or kissing, sexually suggestive comments or jokes, inappropriate invitations, intrusive questions, comments about appearance, staring or leering, sending or showing sexually explicit pictures, photos or gifts, exposing themselves to a woman, inappropriate advances on social-networking websites
5. **Stalking:** offensive or threatening mails, text messages, letters or cards, threatening or silent phone calls, posting offensive comments about a woman on the Internet, sharing intimate photos or videos of a woman, loitering or waiting for a woman outside of her home, workplace or school without a legitimate reason, deliberately following a woman, interfering with her property or damaging it

OSCE (2019) Well-being and Safety of Women in South-East Europe and Eastern Europe, Main Report

Women with disabilities of reproductive age (15 to 49) are at higher risk of adverse pregnancy outcomes than women without disabilities.¹² However, as a result of inaccessibility and stereotyping, women and girls with disabilities – particularly those with intellectual disabilities – are persistently confronted

10 UNFPA, *Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*, p: 50, accessed on 27.02.2019 at <https://www.unfpa.org/featured-publication/women-and-young-persons-disabilities>; Management Sciences for Health & UNFPA, *We Decide Young Persons with Disabilities: Equal Rights and a Life Free of Violence* (May 2016), https://www.msh.org/sites/msh.org/files/we_decide_infographic.pdf, quoted from UNFPA, *Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*, p: 50

11 United Nations Children's Fund (UNICEF), *The State of the World's Children 2013: Children with Disabilities 45* (May 2013), https://www.unicef.org/publications/files/SWCR2013_ENG_Lo_res_24_Apr_2013.pdf, quoted from UNFPA, *Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*

12 UN General Assembly, *Sexual and reproductive health and rights of girls and young women with disabilities*, Report of the special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, submitted in accordance with Human Rights Council resolution 35/6, Seventy-second session, para. 34

with barriers to sexual and reproductive health services and to information on comprehensive sexuality education.¹³ Women with disabilities are also likely to have negative health indicators, such as mental distress, obesity and asthma, and less emotional support compared to women without disabilities.¹⁴

In addition to interpersonal violence, women and girls with disabilities are more exposed to structural violence, manifested as experience of poverty and social exclusion,¹⁵ even in countries with a higher living standard.

Data from the EU show that women with disabilities are likely to be poorer than men with disabilities.¹⁶ This is a consequence of their lower chances to be employed, and of lower incomes from the employment they can obtain. Women with disabilities are also less likely to access rehabilitation compared to men with disabilities and are more likely to experience sexual violence in relationships and in institutions. This can increase their vulnerability to economic violence and exacerbate financial barriers to leaving violent situations and accessing services.¹⁷

Risks of violence particularly increase in situations of conflicts and humanitarian emergencies due to stress and frustration, and loss of community and institutional support.¹⁸ Risks of disability increase with ageing and the prevalence of disability is higher among women in older stages of the life course. Higher risks of violence, therefore, should be monitored from the perspective of population ageing, a global demographic trend present in countries of the region. Although, generally, young women are more exposed to different forms of gender-based violence, as data on prevalence will show later, among women with disabilities the highest lifetime prevalence of intimate partner violence is among women aged 50 to 74. This urges attention to the need for adequate policy measures taking into account that women age 60+ significantly outnumber the population of men in that age group due to their longer life expectancy. However, women also live longer with health problems and disability which makes them particularly vulnerable to different forms of violence.

Defining women with disabilities

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

Convention on the Rights of Persons with Disabilities, Article 1

According to *International Classification of Functioning, Disability and Health (ICF)* disability arises from the interaction of health conditions with contextual factors. UNFPA applies a social and human-rights model of disability which focuses on the high barriers created by the environment (rather than bodily impairment), including physical, information and communication contexts, the attitudes and prejudices of society, policies and practices of governments, and the often exclusionary structures of health, welfare, education and other systems.¹⁹

UNFPA, *Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights.*

13 Lee K., Devine A., Marco MJ., Zayas J., Gill-Atkinson L., Vaughan C. 2015. Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines. *BMC Women's Health*, 15: 87, doi: 10.1186/s12905-015-0244-8

14 UN General Assembly, *Sexual and reproductive health and rights of girls and young women with disabilities*, Report of the special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, submitted in accordance with Human Rights Council resolution 35/6, Seventy-second session, para. 34.

15 EIGE (2017) *Gender equality needs to reach everyone: Gender equality and disability*, <https://eige.europa.eu/publications/gender-equality-needs-reach-everyone-gender-equality-and-disability>

16 European Parliament (2017), *Discrimination and Access to Employment for Female Workers with Disabilities*, Brussels, Directorate General for Internal Policies, Policy Department A: Economic and Scientific Policy, European Parliament; EIGE (2019) *Intersecting inequalities: Gender Equality Index*, <https://eige.europa.eu/publications/intersecting-inequalities-gender-equality-index>

17 UNFPA, *Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*, p. 50

18 WRC & IRC, "I See That It Is Possible," supra note 31, at 1., quoted from UNFPA, *Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*

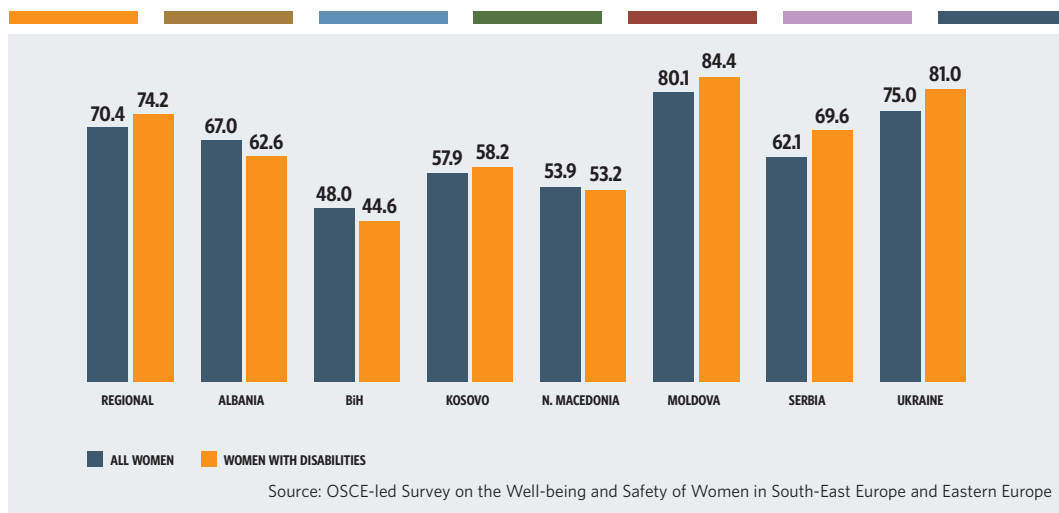
19 This definition served as a basis for the UNFPA Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights for Women and Young Persons with Disabilities. The definition is adopted from UNICEF, *Take Us Seriously! Engaging children with disabilities in decisions affecting their lives* 5 (2012). https://www.unicef.org/disabilities/files/Take_Us_Seriously.pdf

IV. How are women living with disabilities affected by gender-based violence in South-East and Eastern Europe?

The OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe data shows that in South-East and Eastern Europe women and girls with disabilities are systematically exposed to higher risks of violence. When the overall picture on violence women experience in their lifetime, since the age of 15, including all perpetrators (partners and non-partners) and all main forms of violence (physical, psychological and sexual violence, as well as sexual harassment and stalking) is taken into account, it is clear that the well-being of women with disabilities is severely undermined by violence and to a higher rate than among women without disabilities (74.2% vs. 70.4%; see Chart 1). The difference in prevalence rates between women with and without disabilities is probably even higher bearing in mind two limiting factors that could not be addressed by this survey. First, the violence disclosure rate might be lower among women living with disabilities, who may be more reluctant to report experiencing violence due to isolation, stigma, dependency on and fear of caregivers, lack of awareness and other obstacles related to their generally worse position and to the nature of their disability (i.e. a sensory disability that limits communication, or suffering from intellectual disabilities). Second, the OSCE-led survey was not specifically focused on women with disabilities and therefore, the sample was not fully representative of the population of such women in the region.

These limitations should be taken into account when the situation in individual countries is observed, since not only the willingness to disclose experiencing violence, but also the willingness to disclose a disability is culturally and socially sensitive, particularly in cultures in which women face high expectations to be “outstanding” in their roles, as is common in some parts of the region. Lower prevalence rates of violence are recorded among women and girls with disabilities than in the general population of women in Albania and Bosnia and Herzegovina (BiH), almost equal prevalence in Kosovo (UNSCR 1244)* and North Macedonia, and higher prevalence rates among women and girls with disabilities in Moldova, Serbia and Ukraine.

Chart 1: Prevalence (%) of any abuse in adulthood, since the age of 15, regional average and by country, among all women (N=13,826) and all women with disabilities (N=1,002)



Women and girls with disabilities “accumulate” more experience of non-partner and partner physical or sexual violence during their lifetime, since the age of 15, than women without disabilities.



Women and girls with disabilities report more prevalent experiences of non-partner physical violence during their lifetime and the past 12 months, and were more exposed to sexual harassment during the 12 months preceding the survey. Like with all women, the most prevalent forms of non-partner physical violence against women with disabilities are pushing or shoving, slapping and grabbing or pulling women’s hair. However, they more often experience partner violence, and particularly physical and psychological violence, than women without disability. The most prevalent forms of partner physical violence are the same as in the case of non-partner violence, but also include threats that the woman will be hurt physically, throwing objects at the woman, beating her with a fist or a hard object, and kicking. Psychological violence most commonly manifests as controlling behaviour preventing women from making their own choices and enjoying their own freedoms, then as abusive behaviour undermining women’s emotional well-being, dignity and self-confidence, and somewhat less commonly as economic violence and blackmail or abuse of women’s children. The research findings indicate that psychological violence in an intimate relationship happens on a continuum; rather than being an isolated incident, it repeats over time and often escalates or becomes coupled with physical violence.

Chart 2a: Any partner physical and sexual violence, sexual harassment and stalking since age of 15, and over past 12 months, regional prevalence, in %, among women without disabilities (N=12,824) and women with disabilities (N=1,002)

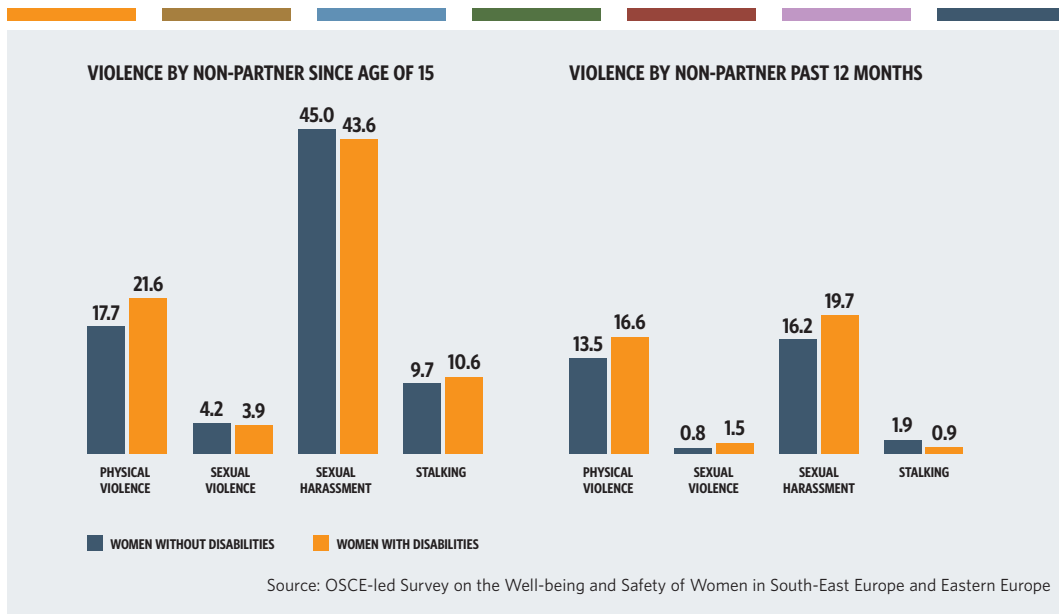
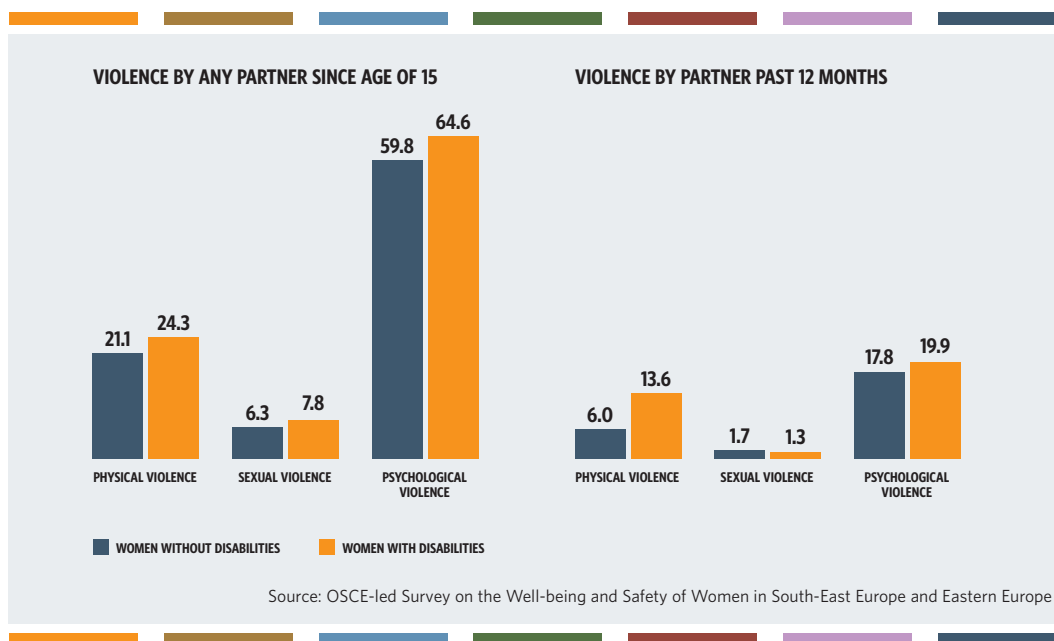


Chart 2b: Partner violence since age of 15 and over past 12 months, regional prevalence, in %, among women without and with disabilities



Again, as this was not a survey specifically focused on women with disabilities, insights are to some extent limited. Global data show not only higher prevalence of violence against women with disabilities (i.e. twice the rate of other women who experience domestic violence), but also that women with disabilities experience some specific forms of violence which women without disability do not face, such as isolation, withholding of medication and mobility, vision and hearing aids, or violence that occurs inside the institutions where women are meant to be accommodated with social protection and health support.²⁰ There is evidence that women and girls with disabilities are more likely to be subjected to forced medical treatments and reproductive health procedures without their consent.²¹ However, insights into these forms of violence are not available from the OSCE-led survey.

20 Ortoleva, S, Lewis, H. *Forgotten Sisters - A Report on Violence against Women and Disabilities*, UN General Assembly, Sexual and reproductive health and rights of girls and young women with disabilities, Report of the special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, submitted in accordance with Human Rights Council resolution 35/6, Seventy-second session, para. 21

21 Frohmader, C, Ortoleva, S. *The sexual and reproductive rights of women and girls with disabilities*, quoted from UN General Assembly, Sexual and reproductive health and rights of girls and young women with disabilities, Report of the special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, submitted in accordance with Human Rights Council resolution 35/6, Seventy-second session, para. 21

Higher exposure to violence starts earlier in childhood, as women and girls with disabilities report higher prevalence of violence experienced before the age of 15. Over a quarter of women (26.6%) with disabilities reported in the survey that they experienced violence during their childhoods (physical, sexual or psychological) which is higher than among women without disabilities (20.3%). International studies confirm findings on higher exposure to violence since early childhood.²² Girls and young women with disabilities are less likely than men and boys with disabilities to receive care and food in the home and are more likely to be left out of family interactions and activities; they are less likely to receive an education or vocational training important to find employment; and they are more likely than their male peers to think of themselves as disabled and hold a negative self-image. This makes them more vulnerable to harmful social interactions and abusive partner relations.²³

Findings of global study on young persons with disabilities

The prevalence of violence against women and girls with disabilities is much higher than usually recorded in surveys, not only because of the underreporting of violent experiences common among all women due to shame, fear or taboo, particularly around sexual violence, but also because violence against women and girls with disabilities can include very specific acts of harm that may not be part of surveys that do not specifically focus on their experiences. These forms of violence include:

- withholding of medication and assistive devices
- removal of a ramp or mobility devices
- refusal of caregiver to assist with daily living
- verbal abuse and ridicule relating to the disability
- removing or controlling communication aids
- forced sterilization and medical treatment

UNFPA, *Young Persons with Disabilities: Global Study on Ending Gender-Based Violence, and Realizing Sexual and Reproductive Health and Rights*, p. 33.

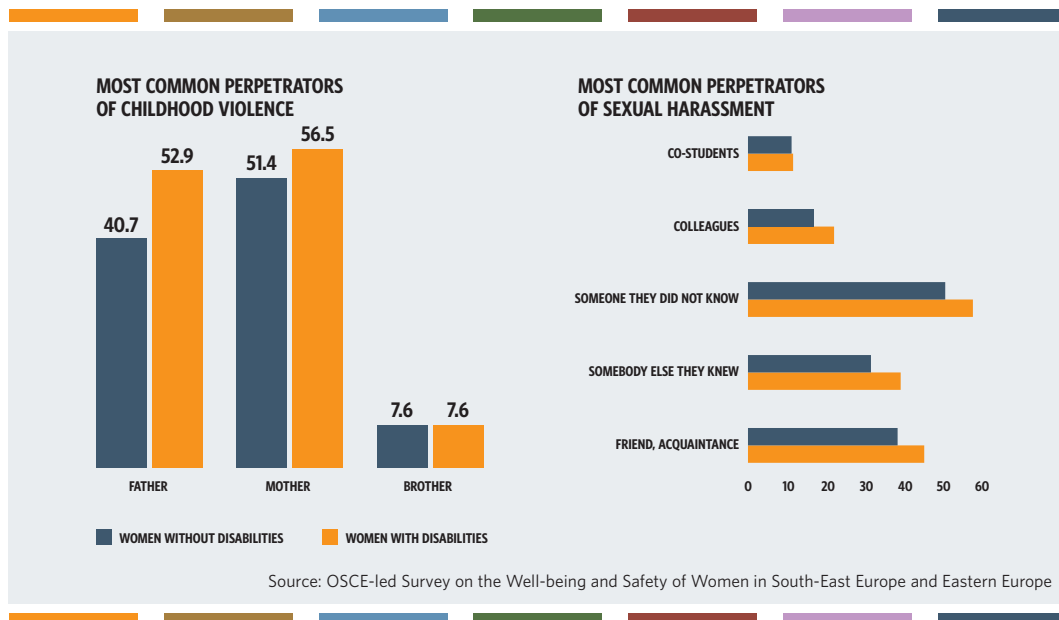
²² UNICEF (2013) *The State of World's Children 2013: Children with Disabilities*, https://www.unicef.org/sowc2013/files/SWCR2013_ENG_Lo_res_24_Apr_2013.pdf

²³ UNFPA, *Young Persons with Disabilities: Global Study on Ending Gender-Based Violence, and Realizing Sexual and Reproductive Health and Rights*, p: 24

V. Who are the perpetrators of violence against women with disabilities?

According to the survey data the most common perpetrators of childhood violence (which includes physical, sexual and psychological forms of violence) are the child’s mother and father. The most common perpetrators of sexual harassment are unknown persons, followed by friends and acquaintances, followed by other people known to the victim, colleagues and fellow students.

Chart 3: Women who experienced childhood violence and women who experienced sexual harassment, by disability and by perpetrators (women without disability N=2451, women with disability N=258)²⁴

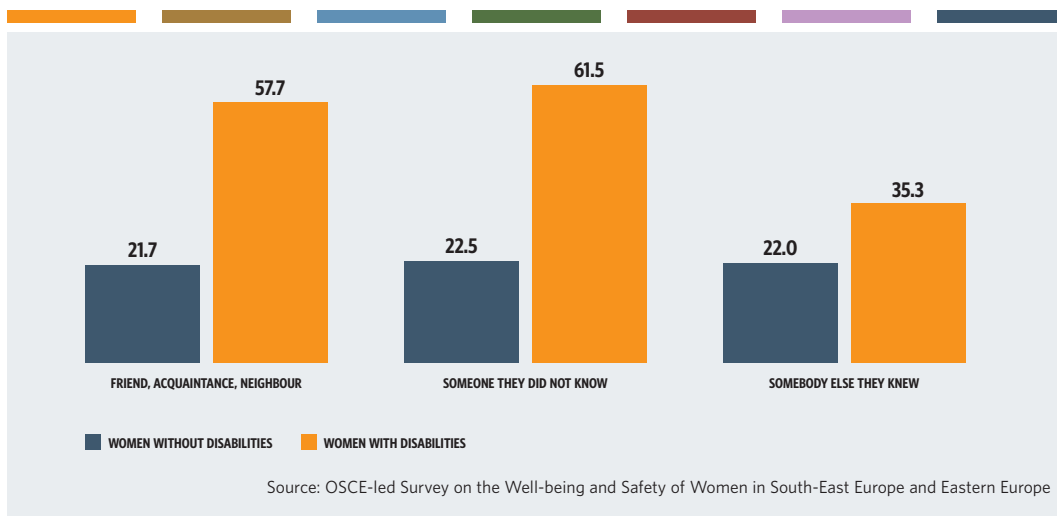


Perpetrators of non-partner physical violence are most commonly friends, acquaintances or neighbours, persons the women did not know, and relatives or family members. Among women who experienced physical violence by someone who is not their partner, women with disabilities are more likely than those without to be victims of friends, acquaintances or neighbours (30.2% vs. 25.2%) and to be victims of unknown persons (25.2% vs. 23.3%). On the other hand, they were less often victims of relatives (19.6% vs. 24.5%).

The picture on sexual violence is slightly different as the most common perpetrators of sexual violence towards women with disabilities are unknown persons. The percentage of women who experienced non-partner sexual violence perpetrated by friends, acquaintances or neighbours is also much higher among women with disabilities than among those without.

²⁴ Women could point to multiple perpetrators when applicable, so the total exceeds 100%.

Chart 4: Women who experienced non-partner sexual violence, by perpetrators and disability, in % (women without disability N=296, women with disability N=35)



Partners are more often than other persons to be perpetrators of physical and/or sexual violence. Unlike the situation in the EU, where, in the year previous to the survey, physical and/or sexual violence has more often been committed by persons who were not partners,²⁵ in the same period of time and in the Western Balkans region, Moldova and Ukraine, intimate partners have more often been perpetrators of violence than other persons.

Women with disabilities are also more often exposed to intimate partner violence than women without disabilities. Three quarters of women with disabilities have experienced intimate partner violence since the age of 15.

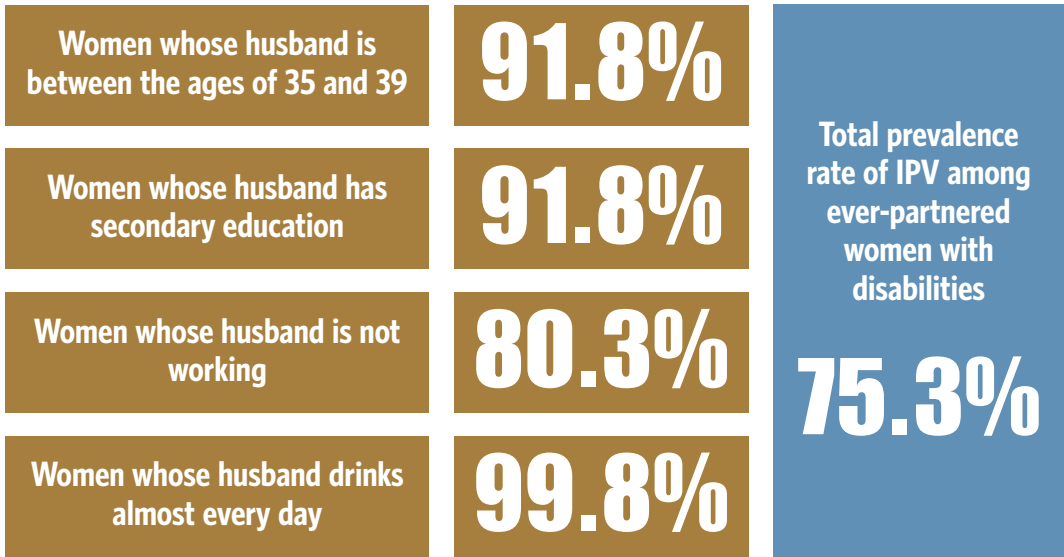


Source: OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe

Who are high-risk partners? For women with and without disabilities, high-risk partners share the same characteristics. The risk of experiencing violence increases among women with disabilities whose partners are between the ages of 35 and 39, and to a lesser extent (but still higher than average) when their partners are older, between the ages of 50 and 74. Women with husbands who do not work are under higher risk of intimate partner violence, as are those whose husbands are self-employed or employed in a family business, or who are students. Prevalence of violence is higher among women whose husbands have secondary education compared to those who have either primary or tertiary education, and the risks are highest among women whose husbands drink alcohol weekly or almost every day.

25 OSCE (2019), *Well-being and Safety of Women in South-East Europe and Eastern Europe, At a Glance Report*, p: 39

Prevalence rate of any violence (physical, sexual, psychological) by partner (current or former) among ever-partnered women with disabilities since the age of 15



Source: OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe

VI. Which factors increase the risk of violence against women with disabilities?

Disability by itself is the key factor that increases the risk of violence, as the data presented in previous sections reveal. However, there is a range of other factors that also contribute to the higher prevalence of violence among this group. The strongest predictor of experiencing violence (of any kind and by any perpetrator) in the 12 months prior to the survey was the same for women with disabilities and those without: having experienced childhood violence.

Among all women who did not experience violence in their childhood, 23% said they had experienced abuse during the past 12 months; among women who did experience violence in their childhood, that figure rises to 53%.²⁶ Among both women with disabilities and those without, the perpetrators of childhood violence are most often parents (mothers in 56.6% of reported cases, and fathers in 52.9% of reported cases). Other perpetrators include male acquaintances or neighbours, brothers, and less frequently, women from the victim's family or social networks.

Norms and values also influence the likelihood of experiencing violence. The survey data suggests that women who hold views of female subservience, spousal obedience and silence surrounding VAWG are more likely to say they have experienced violence, both since the age of 15 and in the 12 months prior to the survey. For example, while the overall prevalence rate of any type of partner violence since the age of 15 among women with disabilities is 74.2%, among those who agree with the statement "*Violence against women is often provoked by the victim*" the prevalence rate is 81.2%. This indicates that norms and attitudes that tolerate, if not promote, the submissive role of women increase the probability of staying in an abusive relationship.

Risks of violence are higher for women who have partners and children, and for women who live in financially deprived households. Rural women have a higher likelihood of being exposed to intimate partner violence, but urban women, and particularly younger women face higher risks of sexual harassment. Refugee or displacement status also increases risks of violence. These data on factors increasing risks of violence indicate that every aspect of the social position of women that makes them vulnerable increases the probability of experiencing violence. This sends a clear message on policymaking processes: effective policies and measures for combating violence against women should be developed within the broader framework of women's empowerment. This is particularly the case for women who face multiple vulnerabilities and exclusions, such as women living with different forms and degrees of disability. However, women with tertiary education are more likely to indicate that they experienced any form of abuse in the 12 months prior to the survey than women with secondary or primary education. Women who are students or working in a family business are also more likely to say they experienced abuse in the 12 months prior to the survey.²⁷ This may also indicate that more empowered women are more ready to disclose their experiences of violence.

Childhood violence

Measured in the OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe as experiencing before the age of 15 any acts of physical violence (being slapped or pulled by hair, hit, kicked, beaten – including with a stick or belt – stabbed, cut), sexual violence (being exposed to someone's genitals, being forced to pose naked in front of any person or in photographs, video or webcam, being touched on her genitals or breasts against her will, being forced to have sexual intercourse) or psychological violence (being told that she is not loved, wishing she was never born, being threatened to be abandoned or thrown out of the family home).

OSCE (2019) *Well-Being and Safety of Women*, Main report.

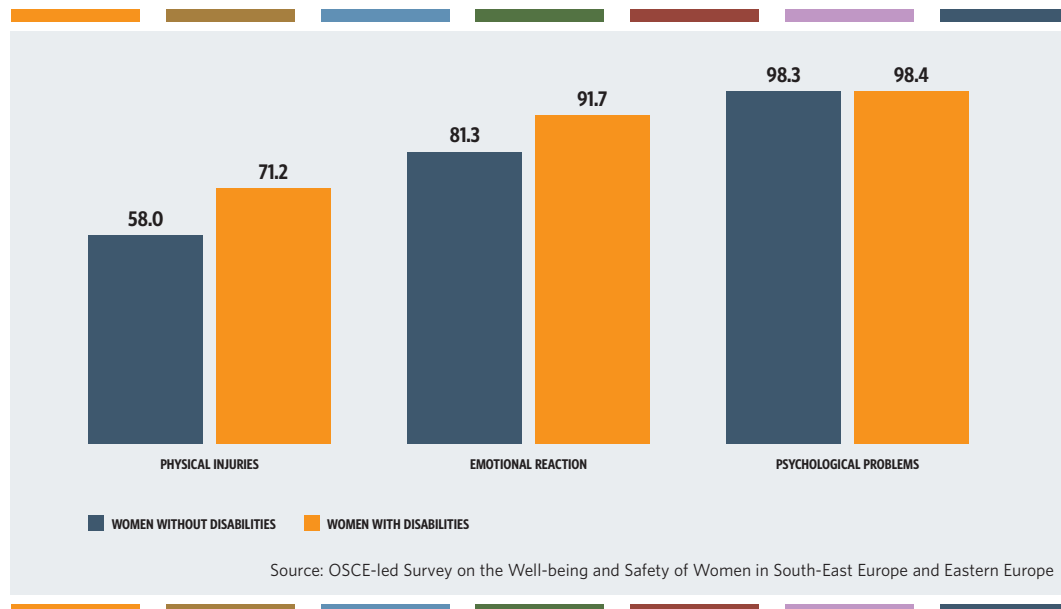
²⁶ OSCE (2019), *Well-being and Safety of Women in South-East Europe and Eastern Europe, Main Report*, pp: 118-120

²⁷ Ibid.

VII. What are the consequences of violence against women with disabilities?

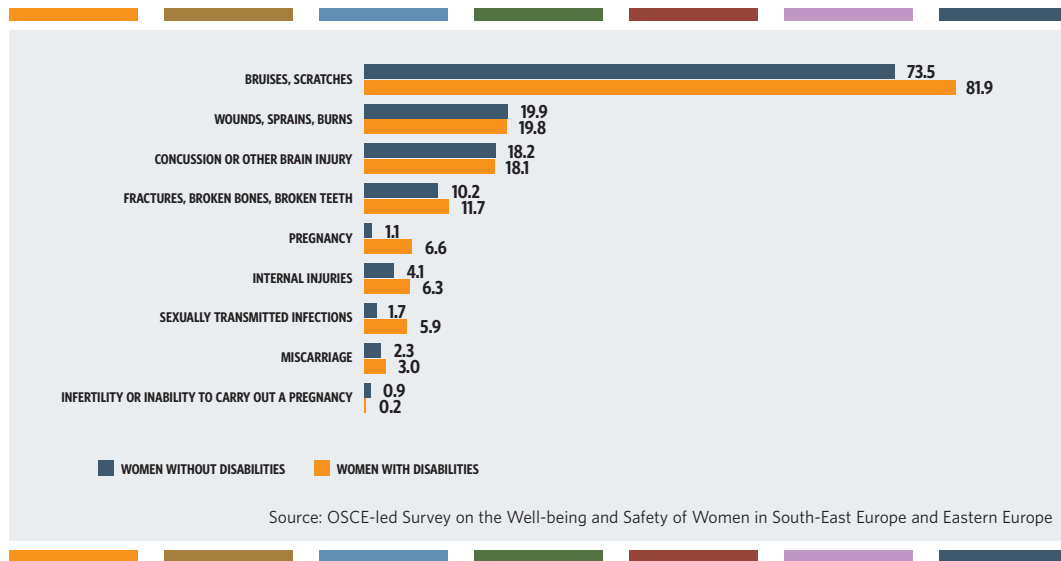
The survey measured the physical, emotional and psychological consequences of the most severe incident of violence that women had experienced. The findings indicate that the impact of the most serious incident of violence was greater for women with disabilities, both in terms of the percentage of women impacted and the severity of impact. Women with disabilities who reported the most serious incident of violence in higher percentages reported both physical injuries and emotional trauma, while there was no significant difference between women with and without disabilities in terms of reporting psychological problems as a result of violence.

Chart 5: Consequences of most serious incident of violence, among women who reported any type of violence (without disability N=7,866; with disability N=640)



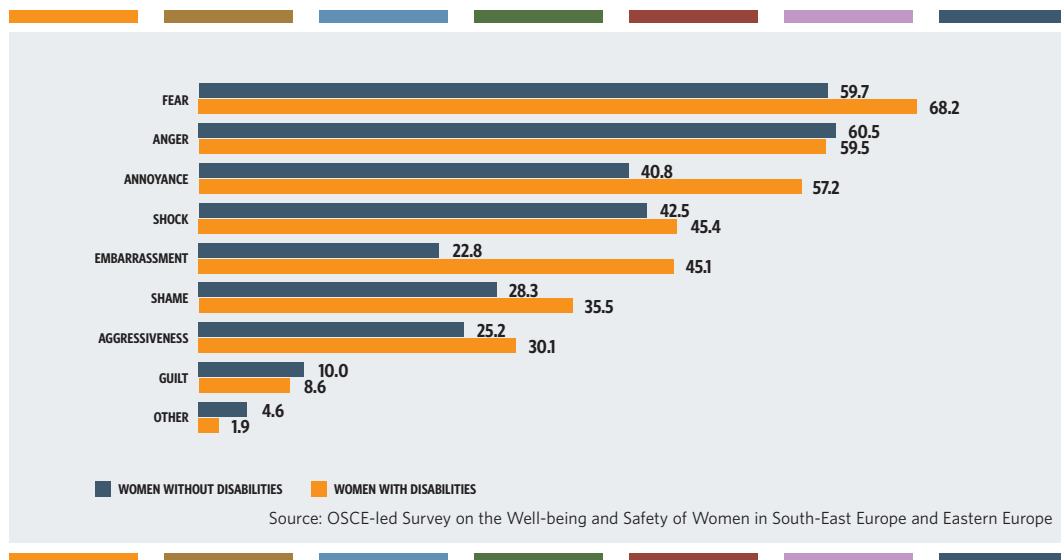
The most common physical injuries are bruises and scratches, which are more often experienced by women with disabilities, as well as fractures, broken bones and internal injuries. Women with disabilities also more often face sexual and reproductive health consequences, such as pregnancy, miscarriage, infections and sexually transmitted infections, which draws particular attention to the specific need for sexual and reproductive health support services within the systems of protection from violence.

Chart 6: Percentage of women with different physical injuries as a consequence of the most serious incident of violence, among women without (N=1,157) and with disability (N= 155) who reported injuries, multiple answers



In terms of emotional impact from the most serious incident of violence, women with disabilities more often reported feeling fear, annoyance, shock, shame, aggressiveness and much more often embarrassment than women without disabilities.

Chart 7: Percentage of women who experienced different emotional reactions to the most serious incident of violence, among women without (N=1,716) and with (N=211) disability who reported emotional reaction, multiple answers



Although there is no significant difference between women with disabilities and those without in the terms of the percentage of women who reported psychological problems as a consequence of the most serious incident of violence, there are differences in the types of psychological problems experienced after the most serious incident. Women with disabilities more often report anxiety, difficulties in relationships and in sleeping, panic attacks, difficulties with concentration and loss of self-confidence. The international research indicated not only that health consequences are more prevalent among women with disabilities but that health providers often assume these symptoms are related to their disability rather than exploring other causes, such as violence and abuse. Because women with disabilities are more likely to live with lower incomes and be unemployed, they are also exposed to higher risks of poverty and social exclusion, which makes them vulnerable to repeated victimization.²⁸

28 Curry et al. (2001) Abuse of Women With Disabilities, *Violence against Women: An Ecological Model and Review*, Vol. 7, Issue 1, pp: 60-79

VIII. Do women with disabilities report violence and access support services?

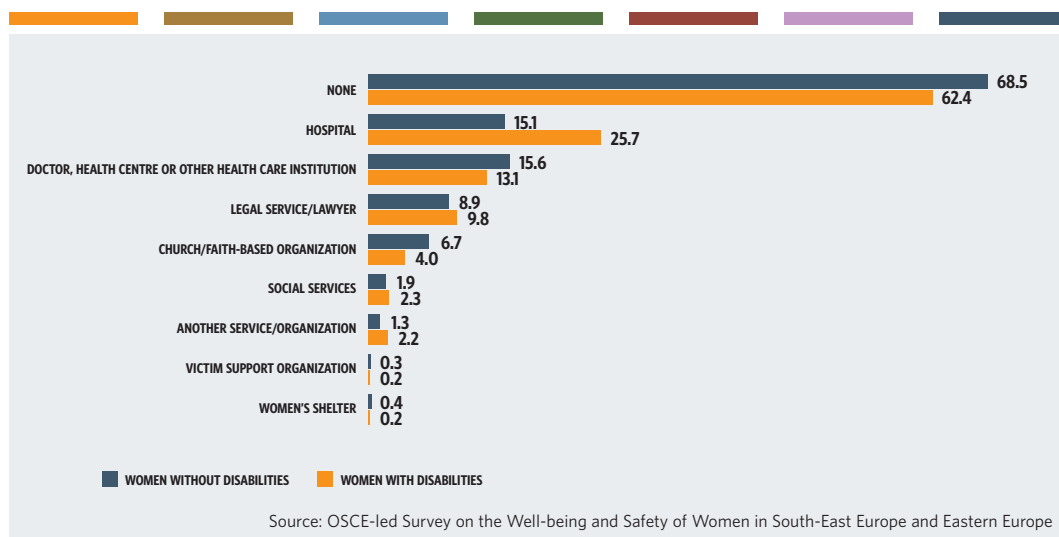
Only a small percentage of women living with disabilities report violence to police or health, social and other services. Nevertheless, compared to women without disabilities, they report more frequently to police and some other services. Among women with disabilities who do not report violence, the main reasons cited for not doing so are lack of services, lack of information or lack of trust. Among those who report violence the level of satisfaction with services ranges from relatively low (in the case of the police) to high (in the case of health care).

Reporting to police, health care and other services

After the most serious incident of violence, 22.6% of women with disabilities reported that incident to police, compared to 18.1% of women without disabilities.

Except for hospitals, women with disabilities contacted other services even less often than police. Hospitals were contacted by every fourth woman with disability after the most serious incident of violence, while other services, such as a doctor or health centre, legal service, social protection service, women’s shelter or organization for victim support, were contacted by a small minority of women with disabilities.

Chart 8: Services contacted by women after the most serious incident of violence, among women without (N=2,294) and with (N=258) disabilities, expressed as % of women mentioning these services



What were the barriers?

The reasons for not reporting the most serious incident of violence to police differ to a certain extent between women with and without disabilities. Women living with disabilities less frequently mentioned as the reason for not reporting that they “dealt by themselves” with the issue or involved a friend or family member. On the other hand, women with disabilities more often say they did not report because incident was “too minor” or cited a lack of trust, a wish to keep it private (and probably to avoid further stigmatization in the community) and fear of the offender and his retribution. They also more often said they were too emotionally upset to contact police or they went some other place for help.

Table 1: Reasons for not reporting violence to the police and/or other services, in % (multiple answers), among women without and with disabilities who did not report.

Reason	Reasons for not contacting police		Reasons for not contacting other services	
	Women without disabilities (N=1,818)	Women living with disabilities (N=198)	Women without disabilities (N=1,700)	Women living with disabilities (N=175)
Dealt with it myself/involved a friend/family member	53.4	38.4	62.2	58.8
Too minor/not serious enough	22.5	29.1	24.2	12.9
Did not think they would do anything	14.4	21.4	13.7	24.3
Didn't want anyone to know/kept it private	16.9	20.6	17.1	14.9
Fear of offender	13.4	17.4	7.5	11.6
Shame, embarrassment	14.1	13.3	9.7	11.5
Did not think they could do anything	8.5	7.3	-	-
Didn't want partner arrested or to get in trouble with police	7.9	6.2	-	-
Too emotionally upset to contact the police	5.2	9.8	4.2	9.8
Did not want the relationship to end	3.6	7.0	-	-
Did not know where to turn to	-	-	9.1	22.0
No services were available	-	-	5.4	13.7
Services were too far away or difficult to obtain	-	-	0.5	8.0

Source: OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe

Barriers to accessing services are much greater for women with disabilities. They more often indicate lack of trust, lack of services, lack of information about services, distant services and difficulty accessing services than women without disabilities.

As various research indicates, the health-care and social-protection systems — the very systems that should provide support to women with disabilities — often contribute to their higher vulnerability, including the risk of violence. Professionals working in different services within the protection system often have discriminatory attitudes and exhibit abusive behaviour towards women with disabilities. Dependence on caregivers is one more obstacle that women with disabilities face in regard to reporting violence and accessing support services.²⁹ Women with an intellectual disability or other forms of disability that make communication more difficult in an unsupportive environment have very limited opportunities to report any form of abuse and to access support services. Physical barriers, inappropriate facilities and equipment, and services that are not equipped with communication aid tools are very common problems for women with disabilities in the countries of South-East and Eastern Europe, where social services are still inadequately adjusted to persons with disabilities. Pervasive stereotypes — including those that create an image of women with disabilities as passive, asexual, dependent, not capable of performing roles in the public sphere (e.g. in employment, or in politics) but also in the private sphere — undermine their self-confidence, fostering negative self-image, social stigma and limited choices among these women.³⁰

Women's testimonies

A survivor of violence who has a disability described her experience of reporting to the police and social-welfare centre after her husband subjected her to severe psychological violence and aggressive behaviour, for example, through yelling and throwing objects across the house. She explained that the social-welfare centre told her they could not do anything until she filed for divorce. In turn, the police only reprimanded her husband verbally, telling him not to continue behaving in such a way. This woman also felt that the social-welfare centre treated him with disrespect because of her disability.

“Whenever I called police and told them what he was doing, police only warned him verbally, saying things like: ‘Don’t do it again.’ He would answer: ‘It wasn’t me, God knows who was kicking the door last night.’”

Female, aged 18-37, RS, BiH, in-depth interview

Satisfaction with services

Among women with disabilities who contacted police or other services, the level of satisfaction with different services varies significantly. The lowest level of satisfaction is with police. Less than half (46%) of women with disabilities who contacted police were very satisfied with the support provided, while 50.8% were dissatisfied. Women were more often satisfied with support provided in hospital (74.2% were very or fairly satisfied), and by a doctor or health centre (77.1%).³¹ The number of women with disabilities using and evaluating other services was too low to be statistically valid.

Women with disabilities in residential institutions for social protection and care are often under higher risks of various forms of violence, such as neglect, physical constraints and isolation, as well as exposure to physical, sexual, psychological, economic and social violence. They are also exposed to specific forms of violence related to sexual and reproductive health, such as forced delivery of contraceptive methods, forced sterilization and forced abortion. An additional problem comes from the fact that society does not perceive many of these manifestations of violence as abuse, but views them as an integral part of institutionalization and/or psychiatric treatments that protect the woman and are in her “best interest” because they see her as “unable to take care of herself.” When a woman is exposed to violence that is tolerated and socially acceptable, she becomes virtually helpless. In addition, an institutionalized woman has many fewer opportunities to defend herself against perpetrators and end the cycle of violence.³²

29 Ibid., p: 70

30 Ibid.

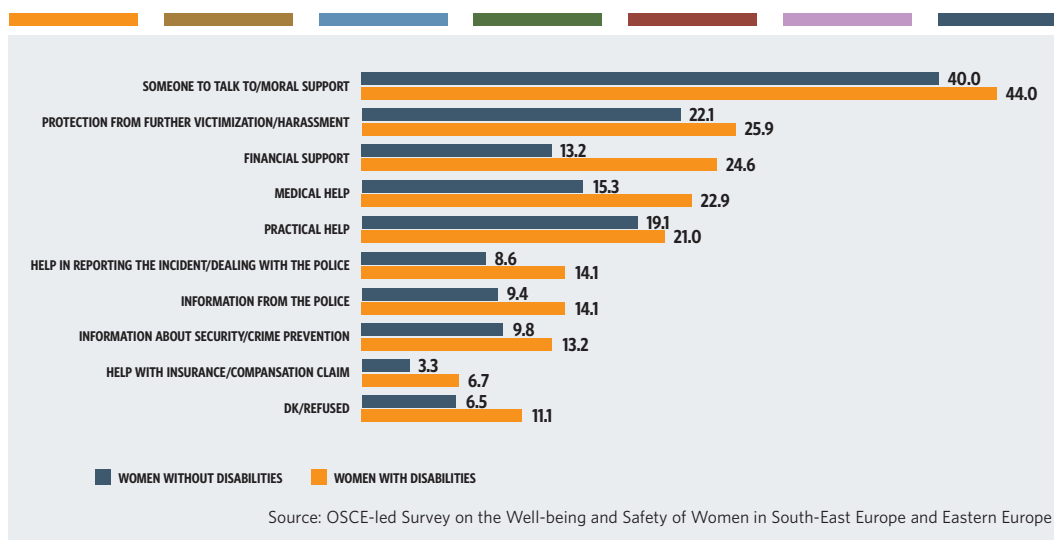
31 OSCE (2019), *Well-being and Safety of Women in South-East Europe and Eastern Europe, Main Report*, p: 109

32 Petrusic, N. (2017) *Smernice za sprečavanje nasilja prema ženama sa invaliditetom u uslugama/sluzbama podrške (Guidelines for prevention of violence against women with disability in services/institutions for support)* <https://www.mdri-s.org/wp-content/uploads/2018/02/Smernice-knjizni-blok.pdf>

Self-reported priority needs for support

Designing services to support victims of violence with disabilities should take into account a very important finding from the survey. Namely, women with disabilities expressed more needs for support across all categories than women without disabilities. They demonstrated more frequently a need for psychosocial support, for protection from further victimization, for financial and medical support, for practical help, for assistance in reporting and dealing with police, and for more information from the police. This clearly indicates a high need for integrated and well-coordinated services.

Chart 9: Most-needed support after the most serious incident of violence, reported by women (without disability N=2,254; with disability N=253) in %



IX. What are the international legal and national policy foundations for systems for protection of women with disabilities from VAWG?

The rights of women and girls with disabilities, and their protection from discrimination and gender-based violence, are guaranteed by key international conventions and policies. Countries in the region are committed to the protection of women with disabilities as signatories of or parties to key international conventions, including the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1981) and its Optional Protocol, the International Conference on Population and Development (ICPD), the Beijing Declaration and Platform for Action (1995), the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (the Istanbul Convention, 2011), the Victims' Rights Directive and the Convention on the Rights of the Child (CRC).³³

The **CRPD** adopts a rights-based approach that ensures the human rights of persons with disabilities in all areas of life, from their inherent dignity to their right to inclusion in social, economic and political life. The Convention recognizes the intersectional discrimination to which persons with disabilities are subject, and provides standards for the protection of rights of women and young persons with disabilities.

CEDAW General recommendation No. 18 calls on States Parties to provide information on disabled women in their periodic reports and on measures taken to address discrimination against women with disabilities, including special measures in the areas of education, employment, health services and social security.

The **Beijing Declaration and Platform for Action** recognizes the ways in which women and girls with disabilities may be subjected to multiple forms of discrimination both as a result of their gender and their disability.

The **CRC** adopts a "child-rights approach" and was the first human-rights convention to explicitly prohibit discrimination based on disability.

The **Vienna Declaration and Programme of Action** (1993) was crucial to the recognition of women's rights, including the right to accessible and adequate health care, family planning services and sexuality education, and to placing the elimination of VAWG at the top of the international agenda.

³³ The exception is Kosovo* which is unable to formally ratify the listed international conventions.

The **ICPD Programme of Action** identifies the advancement of gender equality and the elimination of violence against women as one of the “cornerstones” of international development (Principle 4). It affirms the right of all to “the highest attainable standard of physical and mental health” and calls on States to ensure universal access to health-care services, on an equal basis, for all women and men, including reproductive health-care services, family planning, and sexual health services (Principle 8). The ICPD directly addresses the needs of persons with disabilities and calls on governments to: consider the needs of persons with disabilities in terms of ethical and human rights; eliminate specific forms of discrimination that persons with disabilities may face regarding reproductive rights; and develop the infrastructure to address the needs of persons with disabilities in particular, regarding their education, training and rehabilitation.

The **Istanbul Convention** requires that victims receive adequate and timely information on available support services and legal measures in a language they understand, to have access to necessary services, including health care and social services, and safe accommodation. It mandates particular protections to children, particularly those who may need to serve as witness and/or require psycho-social counselling (Article 26).

The **Victims Rights' Directive** (2012) establishes minimum standards on the rights, support and protection of victims of crime, including violence against women.

UNSCR 1325 calls on all parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict (Article 10).

The **2030 Agenda for Sustainable Development** includes five goals that explicitly reference persons with disabilities, while two targets within the SDG 5 dedicated to the achievement of gender equality and empowerment of all women and girls define two targets related to the elimination of violence and harmful practices against women and girls and one target related to the achievement of universal access to sexual and reproductive health and rights of women in line with ICPD.

The **Council of Europe Disability Strategy 2017-2023: Human Rights: A Reality for All** recognizes that women and girls with disabilities are exposed to a high risk of gender-based violence and recommends to member States to mainstream the rights of persons with disabilities in their work related to the implementation of previously mentioned international conventions; to raise awareness and change legislation in order to make violence and abuse illegal, visible and unacceptable; to provide and promote disability-related training to professionals; and to support and empower persons with disabilities.³⁴

The national policy frameworks of the countries covered by this brief indicate that significant efforts have been invested in the promotion of gender equality, protection of women’s rights and improvement of the status of women. These efforts are manifested in the adoption of gender-equality laws and laws prohibiting discrimination, including on the grounds of gender and disability. Gender equality is promoted through overarching strategies and action plans, and most of the countries have adopted specific plans for tackling violence against women and domestic violence. At the same time, significant efforts are invested in the improvement of the position of persons with disabilities through specific policies. However, there is still room for improvement as a gender perspective is often not systematically mainstreamed into policies related to disability, or women with disabilities are not sufficiently made a focus of gender-equality policies as well as policies aimed at preventing and eliminating gender-based violence.

34 Council of Europe Disability Strategy 2017-2023, Human Rights: A Reality for All, pp. 28-29, accessed 01.03.2019 at <https://rm.coe.int/16806fe7d4>

National policies for gender equality, combating violence against women and improving position of persons with disabilities

	Gender equality	Violence against women	Disability
Albania	National Strategy and Action Plan on Gender Equality 2016–2020	Resolution on condemning violence against women and girls and increasing efficiency of legal mechanisms for its prevention	National Action Plan for Persons with Disabilities 2016–2020
Bosnia and Herzegovina	Gender Action Plan 2013–2017	Framework Strategy on Implementation of the Convention on Prevention and Combating of Violence against Women and Domestic Violence 2015–2018 <ul style="list-style-type: none"> • Strategy to Combat Domestic Violence of Republika Srpska 2014–2019; • Strategy on Preventing and Combating Domestic Violence of Federation of Bosnia and Herzegovina 2013–2017 	Strategy for the improvement of rights and position of persons with disabilities in Federation of Bosnia and Herzegovina 2016–2021 Strategy for the improvement of the social position of persons with disabilities in Republika Srpska 2017–2026
Montenegro	Action Plan for Achieving Gender Equality 2017–2021	Strategy on Protection from Domestic Violence 2016–2020	Strategy for the Integration of Persons with Disabilities 2016–2020
North Macedonia	National Equality and Non-Discrimination Strategy 2016–2020	National Action Plan for Implementation of the Istanbul Convention 2018–2023	National Equality and Non-Discrimination Strategy 2016–2020
Serbia	National Strategy for Gender Equality 2016–2020	N/A	Draft of the Strategy for the improvement of the position of persons with disabilities until 2020
Moldova	Moldova Country Gender Action Plan	National Strategy on prevention and combating violence against women and domestic violence for 2018–2023	Action Plan for inclusion of persons with disabilities 2017–2022
Ukraine	State Social Programme on Equal Rights and Opportunities of Women and Men until 2021	N/A	N/A
Kosovo (UNSCR 1244)*	Kosovo Programme for Gender Equality	Strategy on Protection from Domestic Violence 2016–2020	Law on Prevention and Protection against Domestic Violence

The Gender Equality Index³⁵ supported by the European Institute for Gender Equality (EIGE) enables not only the monitoring of the situation of women with disabilities in core domains (work, money, time, knowledge, power and health), due to its intersectionality, but also the measuring of prevalence of violence among this group of women, as well as the consequences and reporting of violence and accessing of protection systems. Until 2020, besides Serbia who developed two reports on Gender Equality Index, first Gender Equality Reports were launched by North Macedonia, Albania and Montenegro.

**Good-practice example:
Normative framework to improve social inclusion of persons with disabilities**

In 2010, the Republic of Moldova ratified the Convention on the Rights of Persons with Disabilities (CRPD). Subsequent to ratification, UN agencies have worked extensively on supporting the effective implementation of the CRPD and consequently, different reforms were implemented in line with the Convention. The Parliament adopted the Law on the Social Inclusion of Persons with Disabilities (2011); ministries responsible for health, justice and labour, social protection and family initiated a Working Group to amend the Civil Code and provide supported decision-making according to CRPD Article 12 requirements; the Government adopted a national mental-health programme with one of the objectives being to decentralize psychiatric care (Article 19); and the Government launched a national programme of inclusive education.³⁶

Consultations with experts and testimonies of women from the region during the survey indicated many positive processes in the development of systems for prevention and protection of women from violence, while also pointing to many areas in which further improvement is needed in order to achieve adequate systems for protection. A very important part of further improvement of national protection systems is specialized services with specific standards adjusted to the needs of women from vulnerable groups, including women and girls with disabilities who experience gender-based violence.

35 <https://eige.europa.eu/cooperation-eu-candidate-countries-and-potential-candidates>

36 UNCT Moldova Strategic Action Supporting CRPD Implementation, <http://mptf.undp.org/document/download/10076>

X. What is needed to achieve better systems for prevention of VAWG and protection of women and girls with disabilities?

The United Nations Population Fund (UNFPA) and Women Enabled International (WEI) jointly produced *Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights for Women and Young People with Disabilities*.³⁷ These comprehensive guidelines provide practical and concrete steps that policymakers, programme implementers, and service providers can take to ensure that young persons with disabilities, including young women and adolescent girls with disabilities, have equal access to and are fully included in GBV prevention and response and SRHR services. The guidelines also ensure that states, CSOs and other actors providing services have the necessary knowledge to develop targeted approaches to meet the disability-specific needs of women and young persons with disabilities. The majority of recommendations presented in this section are aligned with these guidelines.

Recommendation 1. Violence against women and girls with disabilities is part of complex structural inequalities – social exclusion, gender inequality and stigma related to disability – and should be addressed through systematic disability and gender-mainstreaming policymaking.

Violence against women and girls with disabilities is a consequence or part of the complex structural inequalities which multiply at the intersection of gender and disability. These inequalities are manifested through social exclusion of women and girls with disabilities from important spheres of social life and resources (education, employment, political life and decision-making at different levels, sports, culture, public spaces), and they are reinforced by patriarchal values and norms, coupled with stereotypes and stigma related to disability. Some countries in the region do not have laws, strategies, programmes or plans for the improvement of social inclusion of women and girls with disabilities, or specific plans for preventing and combating violence against women which will recognize the specific forms of violence and needs of women with disabilities for protection. Where such policies do exist, they are often not effectively implemented. Therefore, the following actions should be undertaken:

- Mainstream the disability aspect in development, social inclusion and sectoral strategies.
- Develop and implement gender-sensitive laws and policies for improvement of social inclusion of persons with disabilities where specific measures for women and girls will be designed.
- Develop specific strategies and action plans at different levels of governance to provide response to violence against women, carefully taking into consideration specific forms of violence to which women and girls with disabilities are exposed, as well as the specific needs and potentials of these women and girls.
- Engage women and girls with disabilities and families of persons with disabilities (where appropriate) in all stages of the review and development of laws and policies relating to GBV and SRHR service provision. Support and engage lawmakers with disabilities.
- Raise awareness on gender equality and equal rights of women with disabilities, while combatting the stereotypes and prejudices which stigmatize women and girls with disabilities as passive and incapable. Promote environmental understanding of disability as inappropriate environment and empower women and girls with disabilities so they are perceived as agents and not objects.

³⁷ UNFPA, Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights

Recommendation 2. Evidences on violence against women with disabilities should be significantly improved through regular surveys and administrative data in order to adequately design policies and measures and to monitor the effectiveness of their implementation and impact.

The OSCE-led Survey on the Well-being and Safety of Women in South-East Europe and Eastern Europe provided crucial comprehensive and comparable insights into the prevalence, characteristics, causes and consequences of violence among different groups of women, as well as their reporting and access to services, though the main study did not look specifically into the special situation of women with disabilities. The importance of prevalence surveys is clear when data on reporting are the area of focus, as only a small proportion of women who experienced violence reported these incidents and reached out for support. Qualitative findings indicate many gaps in official evidences on violence against women, including lack of synchronized data between different institutions, fragmented and/or incomplete data and lack of disaggregation, including by disability. Keeping in mind these findings, it is recommended to:

- Provide regular prevalence surveys on VAWG with standardized and comparable instruments in certain time intervals and provide disaggregation of data by disability in line with CRPD definitions. For that purpose internationally agreed instruments could be used, such as the Washington Group short set.
- Introduce in national monitoring mechanisms indicators that are comparable with other countries in the EECA region, preferably the indicators developed by EIGE in EU Member States, including:
 - » The Gender Equality Index which provides disaggregation by disability as one of the key intersecting aspects of gender equality. Although presently indicators measuring violence against women are not disaggregated by disability, future developments of the Index should enable for disaggregation in the domain of violence, as it is already enabled in six core domains of gender equality.³⁸
 - » Specific set of 13 indicators on intimate partner violence for the police and the justice sectors.³⁹
- Improve official evidences in order to provide better systems for tracking violence, but also in order to enable monitoring of the effectiveness of these systems in responding to violence. The process of the improvement of administrative data can be guided by the good practices examples and by EIGE's recommendations for the EU, which include sets of measures related to the improvement of overall quality and reliability of data, availability, comparability and accessibility of data.⁴⁰
- Develop national and local data-collection systems disaggregated by gender, disability, age, sexual orientation, socioeconomic status and living environment. A coordinated mechanism should be in place for regular data review and analysis to improve services.
- Ensure that monitoring and evaluation of services is regular, internal and independent, based on solid data-collection systems and in collaboration with women with disabilities.
- Advocate for mandatory minimum standards of accessibility to ensure that all services have a minimum level of accessibility, including those from private service providers.

Recommendation 3. Adequate resources and financing should be allocated to build and sustain each sector as well as an integrated coordinated system that has the capacity and capability to provide services that effectively and efficiently respond to violence against women and girls with disabilities.

Services for disabled persons subject to violence or adaptation of existing services to their needs are closely linked to the willingness and ability of governments and society to allocate resources. When resources are not sufficient to prevent or identify violence against women and girls with disabilities, it is very difficult to meet the need for supportive services among the disabled population. Sharing resources at all levels, not omitting rural or remote areas, could be of major significance to disabled persons by resulting in expanded community services. Service providers and the national and subnational governments responsible for providing services must consider and budget for accessible services for women and girls with disabilities starting from the programme-development stage. The following actions should be undertaken:

³⁸ Available indicators disaggregated by disability are presented on this EIGE internet page <https://eige.europa.eu/gender-equality-index/domain/intersecting-inequalities/disability/health/3>

³⁹ <https://eige.europa.eu/publications/indicators-intimate-partner-violence-and-rape-police-and-justice-sectors>

⁴⁰ EIGE (2018) *Recommendations for the EU to improve data collection on intimate partner violence*, <https://eige.europa.eu/publications/recommendations-eu-improve-data-collection-intimate-partner-violence>

- Raise awareness for the planning, coordination and financing of national strategies for prevention and provision of quality services for women and girls with disabilities who are subject to violence.
- Design a range of financing mechanisms of adapted programmes on prevention and response to violence against women and girls with disabilities.
- Provide adequate financial resources to ensure the provision of quality support services.
- Allocate sufficient resources for disability issues and rights training and supportive supervision for service providers and support staff, as well as accessibility mechanisms for government-funded programmes.
- Remove barriers to financing and affordability to ensure that women and girls with disabilities can afford and get the support they need, by compensating transportation, offering subsidies and social-protection plans, and conducting public information campaigns.

Recommendation 4. Quality services should be delivered in a coordinated multi-sectoral manner to provide comprehensive, accessible, acceptable and adaptable support to women and girls with disabilities who are subject to violence.

Women and girls with disabilities who experience violence are confronted with barriers to accessing services that support victims of violence for various reasons, including lack of services in their area, physical barriers, fragmentation of services and limited coordination between them, lack of trust in effectiveness of the institutions and organizations that are service providers, lack of information and/or knowledge, dependency on caregivers or isolation within the family or institution, and limited possibility to communicate with services not equipped with aiding equipment needed for women with sensory impairments. These specific obstacles should be considered when designing support systems and general and specialized support services.

As the data indicates, many women with disabilities do not approach institutions and organizations due to a lack of trust which is partly the consequence of inappropriate treatment by service providers due to stereotypes and prejudice. Inappropriate treatment, stigma and repeated victimization by uncoordinated services (health, policy, social sector) undermine beneficiaries' dignity, and do not respond to their needs defined based on their age, type of disability, socioeconomic status or cultural differences.

The findings of the OSCE report showed that women who reported violence and asked institutions and/or organizations for support were not very often satisfied with the services they received, particularly with the response of police and with legal support. Findings from the qualitative survey component indicated many problems in delivery of services as a consequence of poor quality of services. To provide better protection and empowerment of women and girls with disabilities who experience different forms of gender-based violence, quality of services should be improved in line with standards defined in UNFPA guidelines:

Keeping in mind *UNFPA Guidelines for Providing Rights-Based and Gender-Responsive Services to Women and Girls with Disabilities* and the package on *Global Essential Services for Women and Girls Subject to Violence*, the following actions are recommended for provision of more accessible, multisectoral coordinated services:

- Design and deliver all services following the basic principles of essential services: a rights-based approach, advancing gender equality and women's empowerment, that is culturally and age-appropriate and sensitive, taking a victim/survivor-centred approach, while ensuring victim/survivor safety and perpetrator accountability.
- Address multiple vulnerabilities of specific groups of women with disabilities, including minority women, Roma women, women from remote and/or rural areas, and older women.
- Adapt services to better respond to the specific needs of women and girls with disabilities.
- Develop protocols/guidelines for multisectoral service provision to deliver quality and comprehensive support, which will include: identification, evaluation and validation, case management, referral, risk assessment and safety planning, and follow-up.
- Educate and train service providers and support staff who encounter women and young persons with disabilities.
- Ensure that services effectively hold perpetrators accountable, including by supporting victim and survivor participation in the justice process and fostering victim and survivor agency.

- Develop accessible public information campaigns that address the rights of women and girls with disabilities, and remove attitudinal and information barriers deriving from widespread stereotypes and prejudice on women with disabilities as well as from social norms.
- Create education programmes for family members, partners and caregivers who may act as gatekeepers to essential services to help them to better understand the importance of accessing support services in cases of gender-based violence against women and girls with disabilities.
- Provide adequate multisectoral response with clear referral procedures and responsibilities of all stakeholders.

Recommendation 5. Sexual and reproductive health rights and services should be improved for women and girls with disabilities in order to prevent risks of violence and to provide adequate support when their sexual and reproductive health are impacted by violence.

Sexual and reproductive health services are of particular importance for women and girls with disabilities. Accessing those services is challenging for girls and young women with disabilities, since the attitudes of service providers are often marked by stigmas attached to premarital sex and sexuality of women with disabilities. Reproductive health providers, who often assume persons with disabilities are not sexually active, systematically do not screen them for sexually transmitted infections or provide access to contraceptives. Another critical issue is forced sterilization, which is prohibited by the CRPD, the CEDAW and the CRC, and represents a violation of the human rights of young women and girls with disabilities. Yet it remains widespread, with women and girls with disabilities disproportionately subjected to forced and involuntary sterilization for a number of reasons. Sterilization is often justified by caregivers as a mean to reduce the added care burden caused by management of menstruation and as an effort to prevent pregnancy. Contraception without the free and informed consent of girls and young women with disabilities is also widespread, as is forced or coerced abortion.⁴¹ The guide to risk assessment and management of intimate partner violence in EU, as well as the Guide to risk assessment and risk management of IPV against women for police recognize the specific and increased risks of women with disabilities and could be taken into account when improving SRH services. Therefore, it is recommended to:

- Increase an awareness among service providers on the sexual and reproductive rights of women and girls with disabilities.
- Provide comprehensive sexuality education for girls and boys, young women and men with disabilities.⁴²
- Incorporate supported decision-making and informed consent, crucial mechanisms that guarantee that the will of a disabled person will be respected in providing services. This not only refers to measures such as acquiring a signature for a procedure, but also to the entire process of communication between a service provider and beneficiary that results in the giving, withdrawing or refusing to give permission for a procedure based on full knowledge of what it entails. In this way the will, preferences and human rights of women and girls with disabilities are fully respected by service providers.⁴³
- Ensure accessible emergency medical care is available for women and girls with disabilities, including essential medicines, such as emergency contraception and STI prophylaxis, pregnancy and STI testing, abortion services for free or at a low cost to women with disabilities who are victims of GBV.

For women with disabilities, disability inclusion and gender equality cannot be achieved without addressing their sexual and reproductive health and rights... Girls and young women with disabilities are able to develop their own identities and realize their full potential when their sexual and reproductive health needs and rights are met. That contributes to ensuring their health and well-being, reducing the existing gaps in their access to education and employment and achieving their empowerment.

Special Rapporteur on the Rights of Persons with Disabilities

41 Ibid.

42 UNFPA, *Young Persons with Disabilities: Global Study on Ending Gender-Based Violence, and Realizing Sexual and Reproductive Health and Rights*, p: 46

43 Guidelines developed by the International Federation of Gynecology and Obstetrics (FIGO), in UNFPA, *Young Persons with Disabilities: Global Study on Ending Gender-Based Violence, and Realizing Sexual and Reproductive Health and Rights*, p: 46

Recommendation 6. Prevention programmes should be designed and implemented more systematically and on a larger scale in order to achieve a thorough change in the causes and contexts that increase risks of violence against women and girls with disabilities.

In order to increase preventive action, in line with the Istanbul Convention, it is necessary to:

- Support women and girls with disabilities to take active roles in advocacy and other prevention activities. Prevention should include men and boys as active allies for change in the transformation of gender roles.
- Dismantle harmful stereotypes and practices that justify and reproduce the violence against women and girls with disabilities.
- Create effective GBV trainings for professionals about the rights of women and young persons with disabilities, including detailed guidance on how to detect and report violence against women and young persons with disabilities.
- Create training programmes to promote safe, stable and nurturing relationships between persons with disabilities and their family members, romantic partners, community members and caregivers.
- Develop educational programmes about the right to be free from gender-based violence, how to recognize violence and how to report it, in order to reduce the isolation of women and young persons with disabilities, to connect them with services, and to make persons with disabilities more visible in their communities.
- Develop volunteer-led, community-based education and training programmes on preventing, recognizing and responding to GBV as a low-cost alternative to more formalized education programmes.
- Ensure that public information and awareness-raising campaigns address the forms and manifestations of violence against women and young persons with disabilities, sexual harassment, and available services.
- Ensure that prevention programmes target isolated settings to provide information about GBV, rights and how to report violence to the most vulnerable women and young persons with disabilities.

Good-practice example in support services: Centres for victims of sexual violence in Vojvodina

Within the project Stop-Care-Cure, implemented by the Secretariat for Health of the Autonomous Province of Vojvodina in the Republic of Serbia in partnership with civil society organizations and with the support of the UN Trust Fund, seven centres to support women victims of sexual violence have been established in seven municipalities. These offer the first specialized services for victims of sexual violence in Serbia. They are innovative as they combine for the first time health-care support with forensics and psychosocial support. Women are supported in one place and tiring, traumatizing and often confusing referral mechanisms are replaced with combined services within one centre. These centres are established from the start with the specific needs of women with disabilities in mind. This includes physical accessibility, equipment adjusted to women with disabilities, and trained personnel who understand the needs of these women and are trained in how to communicate with women and girls with disabilities in a sensitive manner, avoiding stereotypes, stigmatization and secondary victimization.

Adequate systems for prevention of gender-based violence and protection of women and girls with disabilities must be comprehensive, providing the response in an effective way that addresses their specific needs. The promotion of such systems requires a high level of commitment at all levels of governance where policies, measures and services are created and shaped. Improvement of the system for protection needs to be built on a universal, accessible multisectoral approach, but also on innovative solutions and non-traditional partnerships, such as public, civil and private sector joint initiatives, and on engagement of influential public persons from different areas of social life who can help break stereotypes and increase overall motivation to end violence against women in general, and particularly against women with disabilities.

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