

**DISABILITY INCLUSION IN CHILD PROTECTION AND GENDER-
BASED VIOLENCE PROGRAMS**

**Guidance on Disability Inclusion for GBV Partners in Lebanon:
Case Management of Survivors &
At-risk Women, Children and Youth with Disabilities**

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This resource is a product of a partnership project between the Women’s Refugee Commission (WRC) and UNICEF Lebanon entitled **“Strengthening child protection and gender-based violence prevention and response for women, children, and youth with disabilities”**. The overall goal of the project is to improve violence prevention and response programming for at-risk groups of women, girls, and boys with disabilities. It builds on existing initiatives of gender-based violence (GBV) and child protection (CP) actors to systematically advance disability inclusion across the CP and GBV prevention and response sectors in Lebanon.

This resource has been developed based on the findings of a needs assessment conducted in 2017 which:

- Assessed and analyzed existing guidance, tools and training resources related to GBV, CP and psychosocial support (PSS) for disability inclusion;
- Identified gaps and opportunities to strengthen the inclusion of women, children and youth with disabilities in community-based PSS and Focused PSS initiatives, and GBV prevention and response activities; and,
- Defined the capacity development needs and priorities of selected GBV and PSS actors on disability inclusion.

Other resources developed in the project include:

- Disability Inclusion in Gender-Based Violence Programs: Guidance for GBV Partners in Lebanon – Outreach, Safe Identification, and Referral of Women, Children and Youth with Disabilities
- Disability Inclusion in Psychosocial Support Programs in Lebanon: Guidance for Psychosocial Support Facilitators

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1. INTRODUCTION

Approximately 15 per cent of any community may be persons with disabilities.¹ There may be even higher rates of disability in communities affected by crisis or conflict,² as people acquire new impairments from injuries and/or have reduced access to health care. In Lebanon, it is estimated that 900,000 persons are living with disabilities.³ Persons with disabilities are one of the most vulnerable and socially excluded groups in any crisis-affected community. They may be hidden in homes, overlooked during needs assessments and not consulted in the design of programs.⁴ While gender-based violence (GBV) affects women, girls, men and boys, the vast majority of survivors globally are women and girls.⁵ Persons with disabilities have difficulty accessing GBV programs, due to a variety of societal, environmental and communication barriers, increasing their risk of violence, abuse and exploitation.⁶

The Lebanon Crisis Response Plan (LCRP) 2017 – 2020 recognizes that children with disabilities are at a higher risk of violence, abuse and exploitation, both inside the home and in the wider community, with women and girls with disabilities being among the most vulnerable to GBV. Both the LCRP and the Ministry of Social Affairs National Plan to Safeguard Children and Women in Lebanon 2014 – 2015 highlight commitments to strengthening national protection, child protection (CP) and GBV systems ensuring that women, girls and boys at risk and survivors of violence, exploitation and abuse have access to improved and equitable prevention and response services.^{7 8}

A needs assessment conducted in 2017 confirmed that women, children and youth with disabilities in Lebanon and their caregivers are facing a range of GBV-related risks including:

- **Child marriage among girls with disabilities:** GBV actors, women with disabilities and caregivers report that girls with minor disabilities are more likely to be pressured into an early marriage before they are perceived as *“less desirable”* due to both their age and disability.
- **Exploitation of women and adolescent girls with disabilities and female caregivers:** Women and adolescent girls with disabilities report examples where family members have forced them to engage in begging on the street, which exposes them to the risk of sexual abuse. Additionally, female caregivers (mothers and wives of persons with disabilities) may be seen as *“easy targets”* for exploitation due to either shifting gender roles (e.g. wives are working out of home in place of husband with a disability) or due to growing economic stress in the household.
- **Intimate partner violence (IPV) against women with disabilities:** IPV was a pervasive problem for women with and without disabilities. Women with disabilities may be more likely to experience IPV because of extreme disempowerment in their relationship.
- **Sexual harassment by male community members:** Women with disabilities report facing constant harassment in the community, often by male taxi drivers or street vendors. They attribute this type of harassment to these men assuming that they did not have husbands or males to protect them, and that *“there would be less repercussions”*.⁹

Despite these increased risks, women, children and youth with disabilities report a lack of information and awareness on GBV-related activities and how to access case management services, due to both physical and attitudinal barriers to accessing such services.¹⁰

GBV Case workers and Supervisors play a critical role in ensuring that women, children, and youth with disabilities who are at-risk of GBV, and/or have experienced GBV receive appropriate support and follow-up.

1.1 Purpose of the Resource

Guidance on Disability Inclusion for GBV Partners in Lebanon: Case Management for Survivors & At-risk Women, Children and Youth with Disabilities is designed to support GBV Case Workers and GBV Supervisors to strengthen case management services for survivors and at-risk women, children and youth with disabilities, and to uphold GBV guiding principles while working with these individuals. It includes guidance, key actions and tools to improve accessibility and inclusiveness of existing case management processes and activities.

1.2 How to use this Resource

This resource complements, and should not be used in isolation to, existing GBV prevention and response procedures, guidance and training in Lebanon, including:

- Inter-Agency Standard Operating Procedures (SOPs) for SGBV Prevention & Response in Lebanon (2014)
- Standard Operating Procedures (SOPs) for the Protection of Juveniles in Lebanon – Operational toolkit (2015)
- SGBV Case Management – Minimum standards and tools for Lebanon (2014/2015)
- Interagency Gender-Based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-Based Violence Survivors in Humanitarian Settings (2017)
- ABAAD Gender-Based Violence Case Management in Emergency Settings: Online Learning Course
- IRC Case Management Training, Peer-to-Peer Coaching Program for GBV Caseworkers and Supervisors
- IRC Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings (2012)

The material presented in this guidance should be adapted and integrated into existing guidance, tools and trainings. It features boxes to inform case managers and supervisors of key actions they should take, as well as to direct them to sample tools and suggested training materials.

2. UNDERSTANDING DISABILITY

It is important for all GBV actors to recognize persons with disabilities, and to understand different approaches that can be applied when working with persons with disabilities in the community.

2.1 Concept of Disability

The definition of disability continues to evolve over time. It is important to remember that persons with disabilities are not a homogenous group; they have different capacities and needs and contribute in different ways to their communities.¹¹

The national Lebanese Law 220/2000 defines a person with a disability as *“a person whose capacity to perform one or more vital functions, independently secure his personal existential needs, participate in social activities on an equal basis with others, and live a personal life that is normal by existing social standards, is reduced or non-existent because of partial or complete, permanent or temporary, bodily, sensory or intellectual functional loss or incapacity, that is the outcome of a congenital or acquired illness or from a pathological condition that has been prolonged beyond normal medical expectations.”*¹²

Article 1 of the UN Convention on the Rights of Persons with Disabilities (CRPD) states:

*“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.”*¹³

An impairment is a problem in the body’s structure or function.¹⁴ Impairments may be physical, intellectual, psychosocial and sensory.

- **Physical Impairments:** This includes individuals who are difficulty moving. Some individuals with physical disabilities will use assistive devices, such as a wheelchair or crutches, to conduct daily living activities.
- **Sensory Impairments:** This includes individuals who are deaf or have difficulty hearing, as well as individuals who are blind or have low vision (finding it hard to see even when wearing glasses).
- **Intellectual Impairments:** This includes individuals who have difficulty understanding, learning and remembering new things. For example, people with cognitive or developmental disabilities.
- **Psychosocial Disabilities:** This includes individuals who experience mental health difficulties which, in interaction with discrimination and other societal barriers, prevent their participation in community on an equal basis with others.¹⁵

Disability, however, is not just a health problem or impairment. Societal attitudes and a person’s environment have a huge impact on their experience of disability and their access to our activities.

- **Attitudinal Barriers:** Negative stereotyping, social stigma, and discrimination by staff, families and community members all affect a person with disabilities access and inclusion in society.
- **Communication Barriers:** Information may be presented in formats that are not accessible for persons with disabilities, including those with visual, hearing and intellectual/ psychosocial disabilities.
- **Environmental or Physical Barriers:** Buildings, roads and transport may not be accessible for persons with disabilities.
- **Policy & Administrative Barriers:** Rules, polices, systems and other norms may disadvantage persons with disabilities, particularly women and girls.

Improving access and inclusion for people with disabilities requires interventions to remove these different types of barriers in our GBV activities.

2.2 Models of Disability

There are different ways in which society may view or interact with persons with disabilities that can result in their exclusion or inclusion in our society. There are four different approaches or “models” that describe how members of society view or interact with persons with disabilities:

- **Charitable Model:** People may look at persons with disabilities as not having any capacity to help themselves and so must be “cared for” or “protected”.
- **Medical Model:** People may think that persons with disabilities need to be cured through medical interventions before they can actively participate in the community.
- **Social Model:** In this model, people instead look at the barriers in the community and remove these so that persons with disabilities can participate like others.
- **Rights-based Model:** In this model, persons with disabilities have the right to equal opportunities and participation in society. It also emphasizes that we all have a responsibility to promote, protect and ensure this right, and that persons with disabilities should have capacity to claim these rights.

Both the charitable and medical models result in other people making decisions for persons with disabilities and keeping them separate from society. The social and rights-based models, however, are aligned with the guiding principles for GBV prevention and response and should therefore guide the work of development and humanitarian actors, as well as governmental entities, with persons with disabilities, their families and communities.

Previous needs assessments in Lebanon have highlighted that family members, communities and service providers often view persons with disabilities through medical or charitable models, failing to recognize social factors, such as age and gender, that may increase their vulnerability to gender-based violence, requiring inclusion in prevention and empowerment efforts, and / or referral to case management agencies for appropriate follow-up.¹⁶

2.3 Rights of Persons with Disabilities

The move towards a rights-based approach for working with persons with disabilities has gained significant international momentum over the past decade with adoption of the United Nations Convention of the Rights of Persons with Disabilities (CRPD). Persons with disabilities have a right to protection in situations of risk or in humanitarian crisis and should be able to both access services and participate in GBV programs and activities on an equal basis with others.¹⁷ Persons with disabilities have a long history of discrimination and disempowerment by family members, caregivers, partners, and even service providers. GBV actors can play a central role in supporting women, children and youth with disabilities to make their own decisions and addressing the barriers they experience in their relationships, households and communities. GBV actors must use a rights-based approach when working with persons with disabilities, ensuring women, children and youth, with or without disabilities, have the same access to their programs, services and support.

Understanding Disability

Key Actions

- GBV actors should use the social and rights-based models to improve access and inclusion of women, children and youth with disabilities in GBV programs and services.
- Trainers and supervisors should focus on discussing the types of barriers that prevent women, children and youth with disabilities from accessing GBV services and activities – not impairments.
- GBV agencies are encouraged to develop training collaborations with local and national DPOs, as they are the in-country experts on the rights of persons with disabilities in Lebanon.

Useful Tools

- *Tool 1: Organizations of Persons with Disabilities (DPO) Contact List*

3. ADDRESSING EXISTING ATTITUDES & ASSUMPTIONS RELATED TO PERSONS WITH DISABILITIES

Social norms discriminate against and stigmatize people with disabilities. They may be ostracized or neglected in their communities and fear seeking support from family and community members. Service providers may also exclude persons with disabilities based on beliefs that GBV prevention and response services are not relevant to or appropriate for persons with disabilities, or out of fear of engaging with persons with disabilities.

Below are some common assumptions that are often made by service providers, caregivers, and community members about persons with disabilities, along with the facts and findings that challenge these assumptions.

Common Assumptions	Findings & Facts
<p>A person's disability defines their identity as an individual.</p>	<p>Persons with disabilities are women, girls, sisters, brothers, cousins and parents. They have unique skills and capacities and many roles that they play in their families and communities. It is important to let persons with disabilities define which group or characteristic they identify with the most.</p> <p><i>“I always want to tell new people that I am more than my disability and that I have many characteristics that define me better than just my disability. For example, nationality, my religion, the fact that I am a woman and a wife and someone who teaches religious lessons to children – all of these things make up my identity.” - Women with a sensory disability in Lebanon</i></p>
<p>You can tell if someone has a disability by looking at them.</p>	<p>Some disabilities are visible – for example if a person uses a wheelchair. Many disabilities, such as psychosocial and intellectual disabilities, may not be visible. However, people with these types of disabilities may still be stigmatized in communities and experience discrimination.</p>
<p>Persons with disabilities can't make their own decisions.</p>	<p>Adults with disabilities have the right to make their own decisions and know what the best option is for them. Even people with more profound communication difficulties may understand everything that is being said to them, and with appropriate support, may be able to indicate their wishes and preferences to others.</p> <p><i>“They started to yell at my family for bringing me and making me ‘suffer’. I got very defensive and told them ‘I am the one who wanted to go, they didn’t want to take me, and I convinced them to. This was my choice because I wanted the chance to meet other people and learn from the training.’” - Older woman with a physical disability in Lebanon</i></p>
<p>Women, children, and youth with intellectual disabilities do not need knowledge and awareness about GBV.</p>	<p>Persons with intellectual disabilities need knowledge and awareness of GBV, as they are at higher risk of experiencing sexual abuse than their non-disabled peers.¹⁸ They also have the right to safe and healthy sexual relationships.¹⁹</p> <p>Persons with intellectual disabilities can learn new things and participate in our activities, with just some small changes to the</p>

	<p>way we work and share information. For example, pictures can also be used to communicate messages to people with intellectual impairments – these are sometimes called “Easy to Read” documents.</p>
<p>Persons with disabilities need a lot of additional support and adaptations to participate in our activities.</p>	<p>Most persons with disabilities require very few adaptations to participate in our activities. They just need to be invited and given the chance to participate. Individuals with disabilities are the experts in the type of support and adaptations needed and can advise you appropriately.</p> <p><i>“I tell people not to feel badly for me and not to baby me ... I go to the park and do things on my own – sometimes I need help with my wheelchair, but that’s about it.” – Young woman with multiple disabilities in Lebanon</i></p>
<p>Persons with disabilities are safer in residential facilities.</p>	<p>Globally, research demonstrates that persons with disabilities who are living in residential institutions are at higher risk of sexual violence than those living in the community.²⁰</p>
<p>Persons with disabilities will be harmed or get sick from coming to our activities or services.</p>	<p>Most persons with disabilities are not sick or in pain. During the needs assessment in Lebanon, none of the people consulted reported harm from attending GBV prevention and response activities. Instead, they shared that attending these activities had a positive impact on their mental and physical health and helped them to expand their peer networks.</p> <p><i>“Sometimes parents or staff get are worried about keeping these people safe – however, we have never had anyone get sick or injured while they are here – most are really happy to be invited and the parents are seeing the benefits.” – Staff member from SDC in Mount Lebanon</i></p> <p>Concerns that staff may have about the health or harm can be directly addressed with the person with the disability - they can share strategies that they use to avoid injuries in their everyday life.</p>

It is important that all GBV staff engage in learning activities that reflect on their attitudes and assumptions about persons with disabilities. Supervisors can encourage this process by having staff engage in an initial activity to assess their attitudes and assumptions, and from there start open conversations about their ideas and beliefs in relation to persons with disabilities.

Addressing Attitudes & Assumptions

Key Actions

- Supervisors should conduct learning activities with GBV staff to reflect on attitudes and assumptions about persons with disabilities.

Useful Tools

- *Tool 2: Case Worker Attitudes Relating to Disability & GBV* can be used by supervisors to assess the existing attitudes and assumptions on disability, and to start an open conversation with staff around working with persons with disabilities.

4. GUIDING PRINCIPLES FOR WORKING WITH SURVIVORS WITH DISABILITIES

All interventions aimed at preventing and responding to GBV are guided by the principles of safety, confidentiality, respect, and non-discrimination – also known as the survivor-centered approach. These principles help to promote the survivor’s recovery, strengthening their ability to identify and express their needs and wishes, and reinforcing their capacity to make decisions about possible interventions.²¹ Case Workers must ensure these guiding principles are implemented when working with survivors with disabilities.

PRINCIPLE 1. Ensure Safety

Case workers should start by getting to know the individual with disabilities – the things they like and dislike, and the ways they behave and communicate when comfortable, happy or distressed. This will help the case worker to better understand when a survivor does and does not feel safe talking to the case worker. Watch for signs of agitation, anger or distress that may indicate the individual is not happy to proceed at this time, and respect this, especially if you are talking with the caregiver.

Some persons with disabilities may require assistance to communicate effectively with case workers. The decision about who to involve and when should be made in partnership with the survivor and include an analysis of risks to the survivor’s safety if they choose to involve another person. Case workers should be aware that caregivers of persons with disabilities may also be perpetrators of violence. Case workers should discuss with the survivor their relationships with family members and both primary and secondary caregivers – this will help to identify appropriate risk mitigation strategies

where a caregiver is a perpetrator, as well as protective relationships that may support the survivor's recovery.

Case workers must also ensure that the space in which they speak to the survivor feels safe and should follow existing guidance on selecting counseling and meeting spaces. Given the environmental context in Lebanon, it will not always be possible for GBV service providers to have fully accessible counseling spaces. Hence it is recommended that GBV program staff conduct a small mapping in each region to identify at least one accessible counseling space or mobile safe space per district with safe and confidential transportation arrangements for those survivors who will require it. Ideally an accessible counseling space should be a location where GBV counselling already takes place and meets the following guidance:

- Safe ramp access (recommended ramp gradient is 1:20 / 5% and ramp should have handrails)
- Counseling room is located ground floor and/or in building with fully functioning elevator
- Doors should be at least 90 cm wide, in order for wheelchair to pass through
- Space in counseling room is wide enough for wheelchair used to complete a full turn

Case workers and supervisors should work together to develop options to ensure that all survivors can receive case management. This may require developing new strategies for reaching those who may be unable to attend a service facility, such as adults with more profound disabilities who are unable to leave their homes or those who face severe risk of harassment or abuse when in the community. Home visits should be considered as a last resort, when there is no other option for the survivor to receive appropriate support. Case workers and supervisors should decide together if a home visit is the only option to provide case management services, and develop a thorough risk assessment with appropriate mitigations strategies. Some options to mitigate risks associated with home visits to survivors with disabilities include:

- Developing a mobile strategy for visiting multiple households at a time in a small geographic area to provide information or some other type of service not related to GBV. The case worker can then visit a survivor's household in that area during this time, which should not draw attention.²²
- Identifying if the survivor is receiving any other services in their home already – e.g. medical or rehabilitation visits – if so, a GBV case worker could consider conducting a joint visit with another allied health professional – in order to minimize speculation that the individual is receiving GBV responses services.
- Making a plan with the survivor and / or a protective caregiver to have a code or signal that they can use to let you know that it is no longer safe for you to come to their house. This could be a message sent through a mobile phone, or another system developed between the case worker and the survivor which will let you will know that it is not safe to speak with the person.²³

PRINCIPLE 2. Respect Confidentiality

Any support persons engaged in the case management process, family members, caregivers and/or sign language interpreters, should be briefed on the principles of confidentiality. The case worker should also provide appropriate caregivers and family members with information about how to be supportive of the

healing process (e.g., by maintaining confidentiality; by not judging or blaming the survivor; and by not pushing them to take a particular action or service). Participatory activities may also be useful to assist persons with intellectual disabilities to better understand the principles of confidentiality; decide who they may and may not want to share information with; and to explore different strategies or ways to respond to questions from others.

Describing confidentiality to persons with intellectual disabilities

Confidentiality means that when we tell someone something private or personal about ourselves, they can't tell anyone else unless they have our permission. If someone respects you, they won't share your personal information. (Expand or simplify as necessary.) The professionals we go to when we have concerns about our bodies (like doctors or nurses) or our feelings (counselors or social workers) must keep things confidential ... I want you to feel safe talking about your feelings, so we have a rule that all of us (point to self and support people) will keep what we discuss CONFIDENTIAL. If family members, friends, parents or others ask what we talked about, we say "That's confidential."

Adapted from Arc of Maryland (n.d.) Personal SPACE – A Violence Prevention Program for Women http://www.ncdsv.org/images/Arc_PersonalSpace-AViolencePreventionProgramForWomen.pdf

PRINCIPLE 3. Respect their Wishes, Rights and Dignity

Persons with disabilities have the right to make their own decisions and it is the job of the case worker to assist in upholding this right. In situations where a protective caregiver is involved, the case worker can still empower the survivor by: directing the conversation to the survivor first; asking permission from the survivor to consult with the caregiver from the very beginning and throughout the conversation; and checking back in with the survivor throughout the process.

In the past, the survivor with disabilities may have been dismissed by others when trying to communicate their feelings and experiences. As such, the case worker should reassure them that they are believed, validating any experiences and emotions that they share. The case worker can validate a survivor's feelings and convey empowering messages through both verbal and non-verbal techniques, i.e. using drawing, pictures or body language, particularly facial expressions. It may take some time to establish ways of communicating with the survivor that allows the case worker to convey these important messages –throughout this process case workers should remain thoughtful and creative.

PRINCIPLE 4. Non-discrimination

The guiding principle of non-discrimination means that case workers provide the same quality and range of service options to every survivor. It is important to present all available options to survivors with disabilities, even if it is not yet clear how they will participate in these activities. Present all the options in a way that the survivor will understand. Be prepared to try several different ways of communicating these options (e.g., if there is an English class in your women's center, support the survivor to visit the class to show them what it involves). Give the survivor time to think about these

options and to ask questions. If the survivor expresses interest in a particular service or activity, then discuss together the potential barriers and strategies to address these.

Guiding Principles

Key Actions

- **Ensure Safety:** Discuss with survivors with disabilities to determine protective or perpetrating relationships with family members, caregivers and community members.
- **Respect Confidentiality:** Brief all support persons engaged in process – family members, caregivers and/or sign language interpreters – on the principles of confidentiality.
- **Respect Wishes, Rights & Dignity:** Direct conversation to the survivor first, always asking permission from the survivor to consult with others (including caregivers).
- **Non-Discrimination:** Provide information about the full range services to all survivors, including persons with complex, severe or multiple disabilities – don't make assumptions about which ones are appropriate for them.

5. DECISION-MAKING AND SELF DETERMINATION

“Informed consent” is when permission is granted with full knowledge of the possible consequences, risks, and benefits, and choice is free and voluntary. The CRPD highlights that adults with disabilities have the same rights as everyone else to make their own decisions, and that where appropriate measures must be taken to support them to make their own decisions.²⁴ An adult cannot lose their legal capacity to make their own decisions because they have a disability.²⁵

5.1 Informed consent process²⁶

The informed consent process has three key components:

1. providing all possible information and options to a survivor in a way they can understand;
2. determining if they can understand this information and/or their decisions; and
3. ensuring that the decisions of the survivor are voluntary and not coerced by others (e.g., family members, caregivers or even service providers).

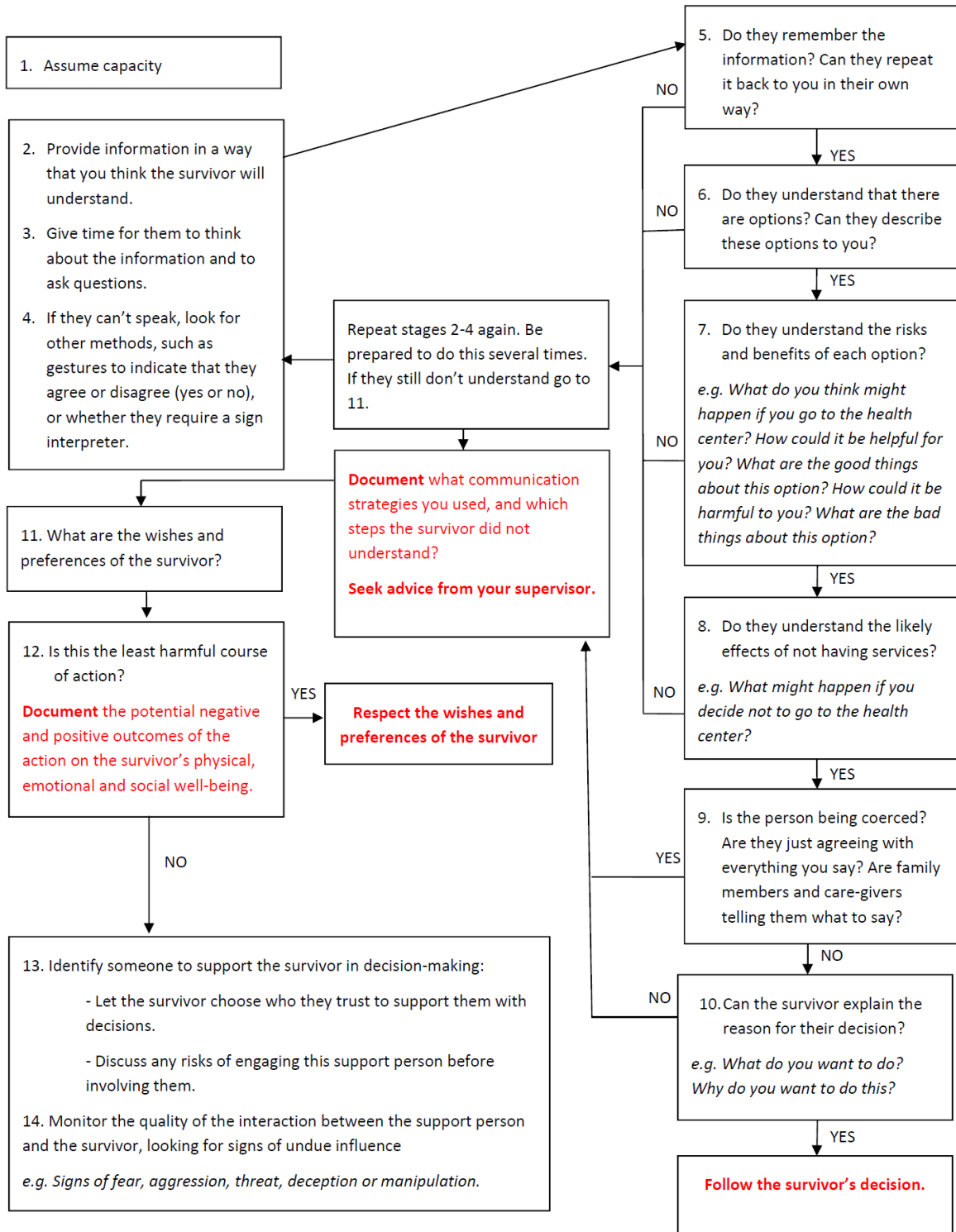
When conducting the informed consent process, it is important for case workers to remember the following:

- ***Assume capacity – All adults have capacity to make their own decisions unless demonstrated otherwise.*** This applies to people with all types of impairments, including those with intellectual impairments. GBV case workers should assume that all adult survivors with a disability have the capacity to provide informed consent independently.
- ***Understanding can vary according to the way we communicate information.*** For example, Maria has an intellectual disability. She may initially decline or accept referral to an economic empowerment activity. But have we conveyed the information in a way that she can understand it and use it in making her decision? If we discuss her goals, describe the activities to her, explore what she likes and doesn't like about these activities, and support her to visit the class without having to make any commitment to participating, then Maria will understand better the activity, and the possible positive and negative outcomes for her, enabling her to make a more informed decision.
- ***Understanding may vary over time.*** In some circumstances, it can be more helpful to seek consent for smaller steps in a longer process, so that survivors are in control of every part of a process and can stop it at any time. It is also important to revisit options that survivors may have declined at later stages in their case management process. For example, Maria may not understand the purpose of psychosocial support activities when she was first meeting the case worker, but later she notices that talking to others makes her feel less frustrated and angry.
- ***Understanding may vary according to the complexity of the decision.*** Understanding can change over time, but also according to the nature and complexity of a decision. Maria may have the capacity to understand and consent to HIV post-exposure prophylaxis, because she understands the concept of taking medicine as a treatment and has taken medicines before to prevent other illnesses. She may, however, find it more difficult to understand what legal assistance means and therefore would not be able to consent to a referral to legal assistance.

Consent is an ongoing process and not a one-time event. It is important that we never assume that a survivor's consent to one service means that they consent to everything.

A Note About Children with Disabilities: In accordance with the Inter-Agency Standard Operating Procedures (SOPs) for SGBV Prevention and Response in Lebanon, children with disabilities above 15 years of age are able to participate in the informed consent process as individuals. However, their parent or a trusted adult should be included with the child's permission, unless they are involved in the abuse. Children under 15 years of age can participate in an informed assent process, but require the permission of a non-perpetrating parent or caregiver as well.²⁷ For additional information, please see the Standard Operating Procedures for the Protection of Juveniles in Lebanon (and the annexed guidance on working with children with disabilities).

5.2 Informed Consent Flow Chart²⁸



5.3 Involving a trusted support person in the informed consent process

After trying multiple communication approaches, if the case worker is still unsure that a survivor understands the information, they should involve a supervisor to help determine whether there is a need to provide additional support for informed consent. The survivor may wish to involve a trusted support person.

Family members, caregivers and peers of persons with disabilities can be a valuable resource in facilitating understanding and communication with the survivor. If you determine that it is safe to do so, ask the survivor's permission to include someone they trust in your discussion as a way of supporting communication and enhancing the survivor's ability to provide informed consent. Let the survivor identify who they would like to involve and watch for any signs that they agree or disagree with the suggestions being made by the support person. The decision to engage a caregiver must always be reached by analyzing the survivor's situation with respect to safety.

If caregivers or others are involved, it is important to ensure that the survivor's wishes and needs remain the focus, and that the survivor feels safe. Be sure to observe the survivor's interactions with the caregiver. If the case worker feels the power dynamic and relationship between the caregiver and the survivor is affecting the right of the survivor to participate in decision-making and/or if decisions are not aligned with their wishes and preferences, they should consult with a supervisor on how to proceed.

5.4 Ensuring the rights, wishes and preferences of survivors with disabilities

When involving others in the informed consent and decision-making process, remember:

- **Always talk directly to the individual, even when a caregiver is present.** If a case worker is still establishing communication methods with the survivor and needs to ask for advice from the caregiver, make sure to have these conversations in front of the individual, so they can hear what is being said and participate in any way possible. Remember that people who cannot speak or move may still understand what is happening around them and what people are saying about them.²⁹ Please see more detailed information on communicating with persons with disabilities in Section 8.
- **Even survivors who lack capacity to consent have a right to information and should play a role in decision-making.**³⁰ Case workers should continue to share information, listen to their ideas and opinions, and explain how and why decisions have been made. This interaction will also assist in the monitoring of changes in capacity to consent over time and with different types of decisions.
- **Always seek informed assent from the survivor.** We must always seek to obtain informed assent, which is the survivor's expressed willingness to participate in the services or activities proposed, from all survivors of any age. Use pictures, hand gestures or symbols to ask if someone is willing to participate in an activity or to access a service. Also watch for signs of agitation, anger or distress that may indicate that the individual is not happy with something that is being discussed or an activity that is being undertaken.

- **Take measures to ensure that decisions reflect the rights, will and preferences** of the individual, are tailored and appropriate to the person’s circumstances and are reviewed on a regular basis to ensure that all opportunities to exercise capacity are optimized.³¹

Decision-making and self determination

Key Actions

- Assume survivors with disabilities have capacity to make their own decision.
- Use a range of methods to convey information in a way that the survivor can understand – take time to explain process and concepts.
- Let the survivor chose any support people they wish to include in the decision-making process.

6. ENGAGING CAREGIVERS AND FAMILY MEMBERS OF PERSONS WITH DISABILITIES

It can be very useful and in some cases necessary to work with the survivor’s caregiver(s) and/or family members. However, doing so can also complicate efforts to promote the safety, confidentiality and the interests of the survivor. Persons with disabilities should always be consulted on the involvement of caregivers and family members, as would be the case with all survivors.

6.1 Maintaining a survivor-centered approach

It is paramount that case workers always **focus on the survivor**. The survivor is the individual seeking services and all actions should be guided by their will and preferences. The interests of family members and caregivers may or may not be linked to the will and preferences of the survivor. For example, caregivers may want to pursue justice options. If the survivor does not understand the legal processes involved, then it is unlikely to promote healing and recovery, and may even expose them to further emotional harm, as they will have to recount their experiences to others. If the referral is not in the interest of the survivor, the case worker should not proceed, even if requested by caregivers. It is essential that the case worker explain to caregivers the importance of respecting the survivor’s wishes, and any possible harm that could be caused to the survivor by certain actions. Exploring the reasons why caregivers think certain actions are in the best interest of the survivor can help to come to decisions that respect the needs and interests of the individual, and identify support that caregivers may require for themselves.³²

It is also important to **maintain confidentiality** when working with survivors with disabilities. If the survivor discloses information that they do not wish to be shared with their caregiver, the case worker

must respect and maintain the survivor's confidentiality and not share information with the caregiver. When sharing information, always think about why the caregiver needs that information and only share what is necessary to facilitate support for the survivor. For example, you may do a joint session with a survivor and their caregiver to review a case action plan, because it requires the caregiver or family member's action. In that case, they only need to know what is relevant for facilitating that part of the survivor's care.³³

6.2 Fostering positive power dynamics³⁴

It is important to pay attention to the dynamic between the survivor and their caregiver. The following questions can assist case workers to better understand the power dynamics at play in the relationship between the survivor and caregiver:

- *What are the strengths of this relationship?*
- *What do both people have confidence in and what is this relationship built on?*
- *What are the mutual expectations and assumptions? How do these interact?*
- *What tensions can you see? What do you think is contributing to these tensions?*

Thinking through the perspectives and needs of both the survivor and the caregiver, and the intersections and relationships between each individual and the case worker, can help to shape the process of case management in a way that ensures that the needs of both individuals are met, and that their relationship is strengthened. Providing caregivers with accurate information about the risks and impacts GBV can help them understand what the survivor may be experiencing and how to best support them. Caregivers may be inclined to blame the survivor, so be sure to communicate that what happened was not the survivor's fault. Caregivers may also blame themselves for not being able to protect the survivor from violence. Providing messages to caregivers that are supportive, non-blaming and non-judgmental may be important for them to hear. By supporting them, the case worker is also enhancing their ability to support the survivor.

6.3 Identifying and responding to caregiver needs³⁵

Caregivers are people first and foremost with their own perspective, needs and feelings. Care-giving is a complex role, and caregivers may have conflicting feelings — they may feel guilty, resentful, angry, afraid, concerned, and as though they have failed. They may prioritize the person they are caring for above everything else, including themselves, which can be difficult for others in the household. They may also have unmet needs of their own, particularly if they carry the full responsibility for care with no one to support them. For female caregivers, caring for a person with disabilities comes in addition to the many other responsibilities and duties expected of them at home.

Caregivers are also exposed to the threat and reality of GBV, and case workers have to pay attention to their safety concerns and their opportunities to have more control over their lives. Caregivers are most often women and adolescent girls, meaning they already experience disadvantage within the household and community, and are likely over-burdened with domestic responsibilities, including the care of children and the elderly, and household chores. Caregiving can be a very isolating experience, and more so for women who are already less likely to have access to opportunities outside the home. This is also

an opportunity to talk about female caregivers' own exposure to and risk of violence, including violence from the people they care for or domestic violence, and work with them to plan for safety and access to services.

Providing good support for caregivers is one of the most effective ways to improve the safety and well-being of those they care for. It may be useful to work separately with caregivers (in addition to working with survivors and caregivers together). This can serve a psychosocial intervention in and of itself by creating a safe space for caregivers to talk about the issues that affect them, their own emotions – positive and negative – without feeling that they are being demanding or selfish, or that they are not properly heard. It is also important to recognize that feelings about being a caregiver are complex, and it is normal to feel frustration, resentment and anger, along with love and concern. Helping caregivers to understand and manage these feelings can be very helpful in strengthening the core relationship between the caregiver and the person being cared for.

Engaging Caregivers

Key Actions

- Maintain primary communication and participation with the survivor.
- Ask for permission from the survivor to communicate with the caregiver or family member.

Useful Tools

- *Tool 3: Practical Tips for Supporting Caregivers*

7. CASE ASSESSMENT AND ACTION PLANNING

Case workers should follow all standards steps as they facilitate disclosure, gather background information, and support survivors to access appropriate services and assistance. Critical steps in the case management process for survivors and at-risk women, children, and youth with disabilities are assessing their needs; identifying skills and capacities and using this in case action planning; identifying appropriate services and assistance; and assisting and advocating for survivors to receive quality services.

7.1 Assessing needs of survivors and at-risk women, children, and youth with disabilities

The causes of GBV against persons with disabilities are rooted in the inequalities and power imbalances between women and men, the inequalities associated with disability, and in many cases in Lebanon – the displacement of the individual or family from their country of origin. GBV case workers should consider the following factors when undertaking assessment and intake processes, as they may increase the vulnerability of persons with disabilities to GBV, and provide valuable information for case action planning:

- **Lack of information about sex, healthy relationships and GBV.** Persons with intellectual disabilities are often assumed to be incapable of learning the same concepts or participating in the same activities as other people and are thus excluded from opportunities to learn about violence, sex and healthy relationships, and to develop new skills and strengthen peer networks.
- **Loss of familial and community support mechanisms.** During displacement, families and communities may become separated and traditional community support structures weakened, which disproportionately affects children with disabilities, and adults with disabilities who require assistance with daily care. They may rely on assistance from less familiar family or community members, which oftentimes adds to their risk of violence. They may also have fewer people they trust and can turn to for support if they experience violence.
- **Social isolation.** Depending on the level of stigma associated with disability in the community, families of persons with disabilities may hide or isolate the individual, which increases their risk and vulnerability to violence, particularly inside the home, and limits their options to report or seek outside assistance.³⁶
- **Exaggerated issues of power and control.** Issues of power and control may be more complex in relationships in which one person has a disability, particularly if the caregiver is also the intimate partner. Some of the dynamics and tactics of power and control that may be used against persons with disabilities (though not limited to intimate partners) are:
 - Abusers may threaten to not take care of the person, withhold basic care and support from them (food, money, hygiene) or leave the person unattended.
 - Abusers may threaten to or withhold, misuse, or delay specific support that helps the person to function independently (e.g. medication, equipment).
 - Abusers may use the person's money for themselves and/or make financial decisions for them without their consent.
 - Abusers may isolate the person from social networks.
 - Abusers may ridicule and embarrass the person because of their disability.
 - Abusers may blame the person with disabilities for their own stress (i.e. as a result of having to care for them).³⁷

As described earlier, women, children, and youth with disabilities may face added attitudinal, physical / environmental, communication and policy or administrative barriers when accessing services and assistance.

- **Attitudinal Barriers:** Service providers may exclude persons with disabilities based on beliefs that GBV prevention and response services are not relevant to or appropriate for them. For example, there is a common myth is that people with disabilities are asexual, and thus they may not receive adequate education about sexuality, healthy relationships and personal safety.
- **Communication Barriers:** Important information about GBV prevention and response may be presented in formats that are not accessible for persons with disabilities, including those with visual, hearing and intellectual disabilities. Furthermore, they may be isolated in the community and excluded from informal information networks, such as peer networks. As a result, persons with disabilities may not recognize abuse when it occurs or may not know where to access support.

- **Environmental or Physical Barriers:** For example, a GBV prevention and response service may be physically inaccessible due to long distances, a lack of accessible transportation or the costs associated with reaching facilities. Furthermore, health clinics and women’s centers may not be accessible for wheelchair users or those with other mobility challenges, which can also convey a message that services are not welcoming to persons with disabilities.
- **Policy & Administrative Barriers:** For example, survivors with disabilities may face greater difficulties returning to the facility to go through lengthy administrative processes, due to more limited resources, less independence and obstacles in accessing transportation.³⁸

It is important to discuss these barriers with the survivor, and identify appropriate strategies to address these, so that they will be able to access programs and services on an equal basis with others.

Assessing Needs

Key Actions

- Ask women, children and youth with disabilities about their daily lives – Do they need support from others for daily activities? Who do they trust to support them with these activities?
- Ask women, adolescents and youth with disabilities about sex and healthy relationships, as well as GBV – Do they have the same knowledge about these topics as others their own age? Where do they get information about these topics?
- Identify attitudinal, communication, physical / environmental, and policy or administrative barriers to accessing different types of services, and work with the survivor on strategies that address these barriers.

Useful Tools

- *Tool 4: Action Planning – Addressing Barriers to Care for Survivors with Disabilities* – This tool can be used in the case management process assist survivors with disabilities to develop actions that reduce barriers preventing them from reaching their goals.

7.2 Identifying skills, capacities and strengths/assets

A core component of GBV case management is collaborating with survivors to identify strengths and assets, then building off these specific strengths in action planning – this same approach should also be applied to working with survivors with disabilities. The following general principles are important to remember when working to assess the skills, capacities and assets of a survivor:

- Focus on the person first, not their disability or health condition.
- Assume capacity. Look at what they can do, not just what they cannot do. This gives the case worker many more options for communication and participation.
- Treat adults with disabilities as you would other adults, paying particular attention to gender issues.
- Take time, watch and listen. Identifying skills and capacities is a process, not a one-time event. During each meeting the case worker can learn something new that will help to better understand how the person communicates and what they can contribute to action planning.
- Pay attention to any way in which the individual wishes to communicate. This could be through gestures and sometimes their emotions. It is okay, however, to say “I don’t understand.”
- Some persons with intellectual and psychosocial disabilities can exhibit a wide range of behaviors. This is sometimes the way they communicate with others.
- Watch for signs of agitation, anger or distress that may indicate that the individual is not happy to proceed at this time, and respect this, even when talking with the caregiver. Try to plan another session to see if they are more comfortable and want to continue.
- Be sensitive to any negative language being used by family members towards the persons with a disability and rephrasing in positive language as appropriate.
- GBV case workers who are working with survivors with profound functional limitations in both communication and movement may need to consider using adapted communication styles and adding additional questions during the intake phase.³⁹

Identifying skills, capacities and strengths/assets

Key Actions

- Take time to listen, watch and learn about an individual’s skills and capacities, as well as what they like and dislike doing.

Useful Tools:

- *Tool 5: Identifying Skills and Capacities of Survivors with Disabilities* provides suggested questions to help case workers establish more effective communication with persons with profound communication impairments, as well as to identify skills and capacities that can be used in action planning.

7.3 Identifying safety concerns and developing a safety plan

As emphasized in other sections of this guidance, case workers should follow all standard operating procedures for case management when working with survivors with disabilities, including when identifying safety concerns and developing safety plans. Survivors with disabilities may have specific

safety concerns to take into consideration when developing safety plans with them. Safety plans for survivors with disabilities must be highly individualized and should take into account the following:

- The individual’s living situation and ways in which a perpetrator may try to exploit the survivor’s disability to isolate them, prevent them from leaving, or further harm them.
- How the survivor’s impairment may impact on the execution of their safety plan, and adjust the plan as necessary.
- What disability-specific items the person may need to implement their safety plan, such as medication, assistive devices or equipment, or relevant documentation for health or legal support.⁴⁰

Safety Planning

Key Actions

- Discuss with survivors with disabilities what strategies they already use to promote safety, and appropriate adaptations to safety planning actions.

Useful Tools

- *Tool 6: Developing Safety Plans with Survivors with Disabilities* provides additional guidance and questions to support safety planning processes with persons with disabilities.

7.4 Referral pathways for survivors with disabilities – Roles of different actors

In the case of survivors with disabilities, it is imperative, regardless of the type of disability of the survivor, that they have case management services provided by service providers who specialize in GBV. GBV case workers have a central role to play in identifying needs, discussing options with survivors, and then coordinating appropriate referral processes. GBV case workers should avoid deferring to disability-related needs first, as this engages a wider range of actors who are not necessarily able to respond to the survivor’s needs relating to violence and may threaten confidentiality.

ROLE OF DIFFERENT ACTORS IN REFERRAL PATHWAYS FOR SURVIVORS WITH DISABILITIES	
ACTOR	ROLES & RESPONSIBILITIES
GBV AGENCIES	<ul style="list-style-type: none"> ▪ Consult and involve persons with disabilities and their caregivers in GBV needs assessments and program design activities. ▪ Develop and adopt policies to ensure that actions and interventions do not contribute to discrimination or exclusion of persons with disabilities. ▪ Identify and address barriers to persons with disabilities accessing GBV prevention and response services. ▪ Train and develop capacity of GBV staff – at all levels – to better understand disability. ▪ Establish a system to monitor persons at heightened risk and integrate persons with disabilities throughout GBV prevention and response mechanisms. ▪ Inform and train persons with disabilities as well as their families and caregivers on how to recognize and report incidences of GBV. ▪ Provide accessible information about GBV and services that exist to prevent and respond to GBV.
GBV CASE WORKERS	<ul style="list-style-type: none"> ▪ Provide comprehensive GBV case management services to all survivors, including those with disabilities. ▪ Liaise with other actors to improve accessibility and make accommodations for survivors with disabilities during case management. ▪ Make referrals to disability and health specific services as needed, but not in lieu of providing full GBV case management services to those who are survivors of GBV.
DISABILITY SPECIFIC SERVICE PROVIDERS	<ul style="list-style-type: none"> ▪ Oversee the provision of disability-specific services (e.g. physical, occupational and speech therapy, prescribe and supply assistive devices). ▪ Provide community-based rehabilitation (CBR) and support persons with disabilities to develop skills to be more independent and autonomous. ▪ Refer cases of persons with disabilities who have been exposed to or are at risk of GBV to specialized GBV actors.

<p>ORGANIZATIONS OF PERSONS WITH DISABILITIES (DPOS)</p>	<ul style="list-style-type: none"> ▪ Raise awareness on the rights and needs of persons with disabilities. ▪ Advocate for GBV and other services providers to ensure survivors with disabilities have full and equal access to case management and other services. ▪ Advise mainstream actors on how to provide accommodations, accessibility and foster inclusion of persons with disabilities in services (e.g. technical assistance on adapted materials, provide referrals for sign language interpreters). ▪ Collaborate with other actors in community to promote the inclusion of women and girls with disabilities into existing activities which help to build peer networks and mitigate protection risks. ▪ Monitor inclusion of persons with disabilities and hold mainstream agencies and Government actors accountable to national and international standards on disability rights.
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Referral Pathways for Persons with Disabilities

Key Actions

- Case managers should continue to meet with and support survivors with disabilities, ensuring that referrals address the needs identified.
- Only refer to service providers who can address needs identified with the survivor in the case assessment.

Tool Suggestion:

- *Tool 7: Dos and Don'ts When Referring Survivors with Disabilities* for some quick tips when making referrals.

7.5 Advocating for survivors with disabilities

When working with survivors with disabilities, advocacy – speaking in support of survivors to access the care and services they need and want – often becomes an essential component in the case management process. GBV case workers will frequently need to play a role in educating service providers to ensure that survivors with disabilities are not turned away from services, and/or harmed by the interactions that they have with service providers. Based on the action plan developed, case workers may need to contact the relevant service providers to refer the survivor, explaining the adaptations required to address any barriers.

Advocating for Survivors with Disabilities

Key Actions

- Ensure that the views and opinions of the survivor are respected by family members, service providers, and any support people.
- Accompany survivors to service providers, and / or ensure they have appropriate and safe access to transportation.
- Educate police, security personnel and shelters on the rights of persons with disabilities, highlighting any discriminatory approaches.

8. TIPS FOR COMMUNICATING WITH PERSONS WITH DISABILITIES

In most cases, persons with disabilities can communicate directly with staff with no adaptations, or relatively small adaptations. In other cases, it may be more difficult to determine the best way to communicate with the individual, and additional steps may be required. It is important when working with persons with disabilities that you take time to watch and listen. Each time you meet the person you will learn something new about them and understand better how they communicate and what they mean.⁴¹

Below are some tips for frontline workers on ways to adapt verbal and non-verbal communication when interacting with persons with disabilities.⁴²

8.1 Use respectful language

Different language is used in different contexts to describe disability and to refer to persons with disabilities. Some words and terms may carry negative, disrespectful or discriminatory connotations and should be avoided in our communications. The *Convention on the Rights of Persons with Disabilities* is translated into many languages, including Arabic, and can be a useful guide to correct interpretation of different disability terms.⁴³

Organizations of persons with disabilities (DPOs) can also provide guidance on the terminology preferred by persons with disabilities in a given country. Additionally, the national Lebanese Law 220/2000 can provide additional helpful guidance proper terminology.

DPO leaders in Lebanon have suggested the following terms to be the most respectful and most commonly accepted terms in Arabic:

Person with disability	شخص ذو إعاقة
Person with physical disability	شخص ذو إعاقة حركية
Person with intellectual disability	الشخص ذو إعاقة ذهنية
Person with mental/psychosocial disability	الشخص ذو إعاقة فكرية
Person with hearing impairment	ذوي الإعاقة السمعية
Down syndrome	تثلث الصبغية 21 / متلازمة داون
Autism	التوحد
Person with autism	الشخص ذو توحد
Support person	الشخص الداعم
Person with visual impairment	شخص لديه إعاقة بصرية،
Blind Person	شخص كفيف أو مكفوف
Person with low vision	شخص ضعيف البصر

The table below also has some suggestions on tips for ensuring respectful language:

AVOID...	CONSIDER USING...
<p>Emphasizing the impairment or condition before the person</p> <p>For example: Disabled person</p>	<p>Focus on the person first, not their disability</p> <p>For example: Person with disabilities</p>
<p>Negative language about disability</p> <p>For example:</p> <ul style="list-style-type: none"> • “suffers” from polio • “in danger of” becoming blind • “confined to” a wheelchair • “crippled” 	<p>Instead use neutral language</p> <p>For example:</p> <ul style="list-style-type: none"> • “has polio” • “may become blind” • “uses a wheelchair” • “has a disability”

Referring to other people as “normal” or “healthy”	Try using “persons without disabilities”
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8.2 Use a strengths-based approach

Do not make assumptions about the skills and capacities of persons with disabilities – this can negatively affect the way we communicate and interact. Remember that persons with disabilities are people first and foremost. Just like all people, they have different opinions, skills and capacities. Look at what the person with a disability can do. This can often give us insight into how they can communicate and participate in your activities.

8.3 General guidance

Remember that you have many skills that you can use with persons with disabilities. Every day you are listening to, communicating with and supporting women, girls, boys and men who are all different in their own ways. All of us use speech, writing, pictures and posters, and activities, as well as emotions and gestures, to both convey and understand information. Different approaches may work better with each individual. Ask persons with disabilities and their caregivers for advice about their preferred communication method, and then try different things.

- Greet persons with disabilities in the same way you would with other people – For example, if culturally appropriate offer to shake hands, even if they have an arm impairment.
- Speak directly to the individual with disabilities, not to their interpreter or assistant/caregiver.
- When speaking for a length of time, try to place yourself at eye level with that person if they are not already at the same height (e.g., by sitting in a chair or on a mat).
- Treat adults with disabilities like you treat other adults – Discussions and activities should be age appropriate and then adapted for communication needs of the individual.
- Ask for advice. If you have questions about what to do, how to do it, what language to use or the assistance you should offer – ask them. The person you are working with is always your best resource.

Tips for Communicating with Persons with Disabilities

Key Actions

- Adapt communication strategies when working with persons with different types of disabilities – Ask persons with disabilities and their caregivers for advice and try different approaches.

Useful Tools

- *Tool 8: Tips for communicating with People with Different Types of Impairments*
- *Tool 9: Easy-To-Read Information about GBV*

9. SUPERVISION STRUCTURES: SUPPORTING GBV CASE WORKERS WITH COMPLEX CASES

Supervisors can play a critical role in ensuring the quality of care for survivors with disabilities. In complex cases where persons with disabilities are involved, supervisors should provide additional support case workers as needed. Supervisors should also be prepared to assist case workers as they navigate any complicated steps of the case management process, particularly as case workers are establishing informed consent with survivors with profound disabilities.

9.1 Caseload and Assignment System

Agencies are also strongly encouraged to consider disability when determining the complexity of cases and case assignments. Considering disability in case assignments is important to ensuring case workers who are working with survivors with disabilities have the time and capacity to provide quality care. The average time for each session could potentially double – particularly when working with a survivor with communication difficulties or those who are using sign language. Initial counseling sessions may also take longer with these survivors, as the processes of establishing effective communication, building trust, ensuring informed consent processes, and fostering their participation in decision making may move more slowly than in the case of survivors without disabilities.

9.2 Individual & Peer Supervision

In cases that involve persons with complex disabilities, it may be necessary for supervisors to provide ad hoc support to the case workers during the initial phases of the case management process – in addition to regular weekly supervision meetings. During both individual and peer supervision sessions, supervisors should provide ongoing opportunities for staff to reflect on their personal values, beliefs and behaviors and how these impact on their work with survivors with disabilities. Ensure standard group supervision sizes – no more than 6-7 case workers per group – so that there is ample time for peer

exchanges and learning. Encouraging case presentations relating to survivors with disabilities in peer supervision will provide opportunity for case workers to share ideas and strategies with each other.

Below are sample guiding questions that could be used in supervision with case workers:

Share some example of how have you built trust with the survivor with disabilities – How do you know that they trust you? How do they express this to you?

How you supported the survivor in decision-making processes? What strategies worked and why?

Has there been any interaction with a caregiver or trusted support person? How have you supported positive power dynamics between the caregiver or support person and the survivor?

Has this survivor discussed any specific barriers they are facing to accessing services? If yes, what strategies have you tried to address these barriers? If not, can you think through what some of the potential barriers maybe and how you would navigate them?

9.3 Supervision Tools

In addition to the supervision strategies mentioned above, case management supervisors can also create or adapt existing tools to assess staff attitudes, knowledge and skills that are important for providing survivor-centered care and case management services to persons with disabilities.

Supervisors should **assess attitudes** of case workers on working with persons with disabilities.

Supervisors can consider adding questions related to disability to the existing Survivor-Centered Attitude Scales, currently being used by many agencies to evaluate attitudes among staff providing direct support to survivors. Specific questions about survivors with disabilities and their caregivers can help the supervisor to assess a staff member's personal values and beliefs and to measure an individual's attitudinal readiness for working directly with survivors with disabilities, while also highlighting specific areas in which the staff member may require further education and training. See Tool 2: Case Worker Attitudes Relating to Disability and GBV for a list of questions that could be integrated into standard attitudinal questionnaires and tools.

Supervisors should also support case workers by providing experiential learning opportunities – creating space for them to practice using certain tools adapted to working with persons with disabilities – particularly tools related to seeking informed consent and establishing communication. Group discussions and participatory activities can also assist in reflective practices supporting case worker teams to identify and share positive changes in their knowledge, attitudes and practices relating to disability inclusion.

Supervision Tools

Key Actions

- Integrate questions on disability into existing Survivor-Centered Attitude Scales to measure and monitor an individual's attitudinal readiness for working directly with survivors with disabilities.

Useful Tools

- *Tool 2: Case Worker Attitudes Relating to Disability and GBV*
- *Tool 10: Reflection Tool for GBV Practitioners*

10. GUIDANCE FOR GBV TRAINERS

GBV trainers should integrate disability into existing training for GBV staff, facilitating discussions on the needs and rights of women, girls and youth with disabilities. Incorporating an analysis of both gender inequality, as well as disability-based discrimination, will assist GBV staff to better understanding the unique factors that contribute to GBV risks and vulnerability for women, children and youth with disabilities, and to identify more effective strategies for inclusion in GBV programs. It is recommended that content about persons with disabilities and their caregivers be integrated and mainstreamed throughout core GBV training packages, including through case studies and examples centered on women, children and youth with disabilities. Over time, GBV staff will increasingly recognize that responding to the needs of persons with disabilities is a core part of their work and that they have the skills to effectively do this with in their jobs.

Guidance for GBV Trainers

Key Actions

- Integrate case studies and examples of survivors and at-risk women, children and youth with disabilities into core GBV training packages.

Tool Suggestions

- *Tool 11: Sample Case Studies & Action Plans* can be integrated into existing training activities.

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- ¹ World Health Organization & World Bank (2011) World Report on Disability. http://www.who.int/disabilities/world_report/2011/en/
- ² Handicap International & HelpAge International (2014) Hidden Victims of the Syrian Crisis: Disabled, Injured and Older Refugees. http://d3n8a8pro7vhmx.cloudfront.net/handicapinternational/pages/454/attachments/original/1397045203/Hidden_Victims_of_the_Syrian_Crisis—disabled_injured_and_older_refugees.pdf?1397045203
- ³ This estimate is determined using a global estimate that 15% of any population will be persons with disabilities (WHO & World Bank, 2011), and that the population of Lebanon is approximately 6 million people (World Bank, 2016, <https://data.worldbank.org/indicator/SP.POP.TOTL?locations=LB>).
- ⁴ Women’s Refugee Commission (2014) Disability inclusion: Translating policy into practice in humanitarian action. <http://wrc.ms/disability-inclusion-translating-policy-into-practice>
- ⁵ International Rescue Committee (2014) GBV emergency response and preparedness: Participant handbook, page 7. <http://gbvresponders.org/wp-content/uploads/2014/04/GBV-ERP-Participant-Handbook-REVISED.pdf>
- ⁶ Women’s Refugee Commission & International Rescue Committee (2015) “I see that it is possible”: Building capacity for disability inclusion in gender-based violence programming in humanitarian settings. <http://wrc.ms/i-see-that-it-is-possible>
- ⁷ Government of Lebanon & the United Nations (2017) Lebanon Crisis Response Plan 2017-2020. <http://www.3rpsyriacrisis.org/wp-content/uploads/2017/01/Lebanon-Crisis-Response-Plan-2017-2020.pdf>
- ⁸ Building Resilience and Development Programme: The MoSA National Plan to Safeguard Children and Women in Lebanon 2014-2015.
- ⁹ Women’s Refugee Commission & UNICEF (2017) Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Gender-Based Violence (GBV) Programs, November 2017.
- ¹⁰ Women’s Refugee Commission & UNICEF (2017) Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Gender-Based Violence (GBV) Programs, November 2017.
- ¹¹ UNHCR. (2011). Working with persons with disabilities in forced displacement. <http://www.unhcr.org/publications/manuals/4ec3c81c9/working-persons-disabilities-forced-displacement.html>
- ¹² UNESCO (2013) Social Inclusion of Young Persons with Disabilities (PWD) in Lebanon. http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Beirut/images/SHS/Social_Inclusion_Young_Persons_with_Disabilities_Lebanon.pdf
- ¹³ The United Nations (2006) Convention on the Rights of Persons with Disabilities. <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>
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