Violence against Women and Girls with Disabilities

Latin America and the Caribbean

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Gender and Diversity Division
Social Sector

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Violence against Women and Girls with Disabilities: Latin America and the Caribbean

Gender and Diversity Division

Policy Brief No. IDB-PB-00302

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Women with disabilities are at higher risk of experiencing violence than men with disabilities as well as women without disabilities. Yet, in Latin America and the Caribbean (LAC), there is a significant gap in services to prevent violence against women and girls (VAWG) with disabilities in practice and in research alike. This technical note aims to: 1) bring to light the information that exists on the prevalence of and risk factors relating to VAWG who live with a disability in LAC, and 2) present various promising approaches for prevention in response to such violence. Given the challenges faced by LAC countries, recommendations are outlined for those wishing to develop and incorporate rigorous evaluation methodologies into their program planning, and implementation.

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Contents

Tables

Abbreviations

ASAP	Safety Awareness Program
DHS	Demographic and Health Surveys
ENDISC	National Study of Disability (Estudio Nacional de la Discapacidad), Chile
ESCAPE	Effective Strategy-Based Curriculum for Abuse Prevention and Empowerment for Adults
IDB	Inter-American Development Bank
LAC	Latin America and the Caribbean
PRONADIS	National Program on Disabilities (Programa Nacional de Discapacidad), Uruguay
SSP	Safer and Stronger Program
UN	United Nations
UNCRPD	Convention on the Rights of Persons with Disabilities of the United Nations
VAWG	violence against women and girls
WG	Washington Group on Disability Statistics
WHO	World Health Organization

1. Motivation

According to the *Global Report on Disabilities* (WHO and World Bank, 2011), approximately 15 percent of the world's population live with some form of disability. This percentage is slightly lower in Latin America and the Caribbean, at approximately 12.5 percent (CEPAL, 2014). While the estimates vary depending on their source, the variation is not significant. Differences, however, do increase when disaggregated by sex, age, and ethnicity.

Worldwide, women show a greater prevalence of disability than men although, again, statistics vary significantly. As the previously mentioned report states (WHO and World Bank, 2011), "At the global level, the Global Burden of Disease estimates of moderate and severe disability prevalence is 11% higher for females than males, while the World Health Survey estimates give a female prevalence of disability nearly 60% higher than that for males." A recent review of 2010 census round data from the Latin American and Caribbean (LAC) region, however, does not find a systematic difference by gender in the prevalence rate. In fact, of the eight countries for which data is available, four indicate a higher rate of disability among women, one shows no difference, and three demonstrate a higher prevalence in men (Berlinski et al., 2019).

Empirical evidence confirms that the experience of disability differs between women and men based on various scenarios. For example, job participation among women with disabilities is far lower than for men, at 20 percent versus 53 percent, respectively (LCD, 2014). As a result, women with disabilities are more likely to live in conditions of poverty, which, in turn, makes them more likely to be victims of violence and less able to escape the cycle of violence. Furthermore, women with disabilities in other vulnerable groups, such as the elderly, indigenous peoples, migrants, and other minorities (e.g. ethnic, religious, linguistic, among others), face additional risks of abuse and violence as a result of complex intersecting forms of discrimination.

The objective of this technical note is not only to bring to light the information that exists on the prevalence of and risk factors relating to violence against women and girls (VAWG) in LAC who live with a disability,[1] but also to present various promising approaches for prevention in response to such violence. This particular note uses quantitative secondary data, and forms part of a series of notes that explores the potential of disability-inclusive development, particularly within the realms of education, health, social protection, and employment.

First, the technical note provides a background to the forms of violence perpetrated against women and girls with disabilities, as well as the risk factors they may face. Second, it describes the extent to which they are exposed, supported by available data relating to LAC, and measures the prevalence of violence and the existing gaps in accessing protective and caring services. Third, in order to identify potential means of response to the issue at large, the paper presents various policies and programs at the national level in the LAC region, as well as global good

[1] The term "disability" in this note includes a disability that will likely increase vulnerability to abuse due to a physical, sensory, or mental impairment or a combination thereof.

practices. Finally, various recommendations are offered to address the key challenges that relate to inclusion and access to services.

2. Conceptual and Legal Framework

2.1 Convention on the Rights of Persons with Disabilities of the United Nations

The Convention on the Rights of Persons with Disabilities of the United Nations (UNCRPD) was approved on December 13, 2006. It represents the first human rights convention within the twenty-first century to address the rights of persons with disabilities on a global platform. Ratified by the member countries of the Inter-American Development Bank (IDB), the UNCRPD is the most relevant international instrument to hold countries to account in ensuring that every person with a disability is able to enjoy all rights and fundamental freedoms (Article 5: Equality and Non-Discrimination) (OHCHR, 2006).

According to the UNCRPD, disability is an evolving concept and results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. The UNCRPD framework recognizes that women and girls with disabilities are often at greater risk, and that disability adds another layer of discrimination and deprivation (Article 6: Women with Disabilities). Combined, disability and gender discrimination may lead to a greater likelihood of poverty, limited access to protective services and resources, and heightened risk of violence and abuse over a lifetime. Hence, VAWG with disabilities require specific legislation and policies (Article 16: Freedom from Exploitation, Violence and Abuse) to ensure that it is identified, investigated and, where appropriate, prosecuted. The UNCRPD also articulates the importance of access to health care services that are gender-sensitive and of quality reproductive health services for persons with disabilities (Article 25: Health).

2.2 Operational Policy of the Inter-American Development Bank to Promote Gender Equality

The IDB strives to strengthen its response to the goals and commitments of the region to promote gender equality and women's's empowerment. The IDB's Operational Policy on Gender Equality in Development (Gender Policy), approved in 2010 (IDB, 2010), calls for proactive actions in the form of direct investments and gender mainstreaming in country strategies, loans, technical cooperation, knowledge products, and outreach efforts. It also calls for preventive actions to prevent or mitigate gender-based exclusion and the potentially adverse impacts of IDB-financed projects on women.

The IDB's Gender Policy underscores that gender equality contributes to poverty reduction and higher levels of human capital for future generations. Empirical evidence indicates that equality

within the household, in the labor market, in terms of access to financial services and technology, and in terms of civic and political participation will contribute to effective development. Furthermore, the IDB's member governments have committed to support the equal rights of men and women as a result of their being signatories to various powerful human rights instruments relating to gender equality. These include, for example, the UN Convention on the Elimination of All Forms of Discrimination against Women, adopted in 1979, and the 1994 Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women. More recently, in 2015, a majority of the IDB's member countries signed on to the new 2030 Agenda for Sustainable Development of the UN, including its Sustainable Development Goals, which seek to end all forms of discrimination against women and ensure universal access to sexual and reproductive health as well as affording women equal rights to economic resources.

2.3 Forms of Violence Perpetrated against Persons with Disabilities

According to the literature, adults and children with disabilities are at increased risk of violence compared to those without disabilities (Jones et al., 2012; Hughes et al., 2012). Prevalence estimates of any type of violence (physical, sexual, or psychological) are highest among those with mental illnesses and those who are young. The implication is that although disability disproportionately affects older individuals, violence typically takes place in younger ages.

A number of broad categories of violence against persons with disabilities are identified in the literature. These may or may not include acts recognized as criminal in terms of violence or abuse; nevertheless, they cause profound effects on quality of life and the ability to develop one's full potential. Such forms of violence[2] include the following:

- **Psychological and emotional** violence or abuse includes the lack of love and affection, threats, verbal attacks, taunting, and shouting which lead to a victim's loss of confidence and self-esteem (Westcott, 1993). Psychological abuse frequently accompanies other forms of abuse, although it can occur independently (Sobsey, 1994). Psychological and emotional abuse can also manifest as the internalization of the attitudes of caregivers, personal assistants,[3] or family members toward people with disabilities and those unable to take care of or develop themselves .

- **Neglect and acts of omission** are described as ignoring the nutritional, medical, or other physical needs of people with disabilities (Williams, 1993). The failure to provide medical care or appropriate educational services also have been identified as forms of neglect to which people with disabilities may be particularly susceptible (Sobsey, 1994).

[2] These are the same forms of violence that are frequently cited as being perpetrated against elderly women who often acquire one or more disabilities in the aging process (UN, 2013).

[3] Article 12 of the UN Convention on the Rights of Persons with Disabilities states that people with disabilities have the right to exercise their legal right in accordance with international laws on human rights based on respect, will, and preference. Reference to personal assistant or assistant in this note relates to one who assists and offers a person with a disabilityto promote independence and autonomy.

- **Physical** violence or abuse involves an individual being physically hurt, injured, or killed. It may include inappropriate handling, inappropriate personal or medical care, over-use of restraint, or inappropriate behavior modification. Another form of physical abuse discussed in the literature—and to which people with disabilities may be particularly susceptible—is that of experimental treatment.

- **Sexual** violence or abuse includes any unwanted or forced sexual contact, such as rape or forced oral sex; unwanted touching or unwanted displays of sexual parts; and threats of harm or coercion in connection with sexual activity (Roeher Institute, 1993). Sexual abuse also may include having to undress or be naked in front of other people, or forced to watch other people be sexually abused. For people with disabilities, sexual abuse has been identified as including the denial of sexuality, denial of sexual information/education, or forced abortion or sterilization (GoC, 1993). Research shows evidence of the forced sterilization of women with disabilities, particularly in the case of intellectual disability, in several countries in Australasia, Asia, Europe, Latin America, and the Middle East. One study, for instance, indicates that in Orissa, India, 6 percent of women with a physical disability and 8 percent of women with an intellectual disability were sterilized against their will (Mohapatra and Mohanty, 2004).

- **Financial abuse or exploitation** includes the denial of access to and control over the funds of an individual and the misuse or appropriation of her/his financial resources. This may include removing or destroying a person's mobility devices (e.g., wheelchairs, scooters, walkers).

2.4 Risk Factors for Violence

According to the UN Declaration on the Elimination of Violence against Women, VAWG encompasses physical, sexual, and psychological violence that (i) occurs in the family, including battering, sexual abuse of female children, marital rape, non-spousal violence, among others; (ii) occurs within the general community, including rape, sexual abuse, sexual harassment at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; and (iii) is perpetrated or condoned by the state.

To better understand the interplay of personal, situational, and sociocultural factors that combine to cause abuse and violence, researchers are increasingly using an ecological model. According to Dahlberg and Krug (2002), violence or abuse is a harmful form of interaction between two individuals—the offender and the victim. The model can be best interpreted as four concentric circles. The innermost circle represents the biological and personal history that an individual brings to his or her behavior in relationships. The second circle represents the immediate context in which abuse takes place, frequently within the family or other intimate or acquaintance relationships. The third circle represents the institutions and social structures, formal and informal, in which relationships are embedded, such as neighborhoods, the workplace, social networks, and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms. The ecological model stresses that relationships exist with and are strongly

influenced by a unit of the social environment—a family, a group home, an institution—that is, in turn, strongly influenced by society or culture. Elements of the ecological model have been used to explain the victimization of people with disabilities (Sobsey, 1994).

Table 1 highlights some of the most salient factors encountered in the literature and empirical studies that contribute to the vulnerability of women and girls with disabilities to violence, including social isolation, reliance upon others for care, and lack of credibility. The elevated level of power and control an abuser has over such women with disabilities, especially abusers without disabilities, multiplies the vulnerability and isolation that they experience. Women and girls with physical disabilities are likely to be more dependent on the care and support of their abuser than other groups of women. Furthermore, law enforcement and legal agencies are more likely to question the credibility of the accounts provided by those with psychosocial and intellectual disabilities or disabilities that require assistive communication or reasonable accommodation in communication.

Table 1. Location, Perpetrators, and Risk Factors for Violence against Women and Girls with Disabilities

Location of Violence against Women and Girls with Disabilities	Perpetrator(s)	Specific Factors that Increase Vulnerability
Social groups such as family or other personal **relationships**	Family members	Negative public attitudes about disability
Residential settings such as the home, apartment, or boarding **home**	Paid caregiver/personal assistant	Social isolation of people with disabilities and their families
Service settings such as hospitals, group homes, **institutions**	Other people with disabilities, especially those clustered with their victims in service settings	Reliance of people with disabilities on others for care
Public **spaces**		Lack of support for family members who assist people with disabilities
		Lack of opportunities for people with disabilities to develop social skills through typical social interaction
		Nature of the disability
		Gender, particularly with reference to sexual abuse (where women face a very high risk of victimization)
		Poverty and other economic factors affecting people with disabilities
		Lack of control or choice of people with disabilities over their personal affairs

Location of Violence against Women and Girls with Disabilities	Perpetrator(s)	Specific Factors that Increase Vulnerability
		Perceived lack of credibility of people with disabilities when they report or disclose abuse
		Socialization of people with disabilities to be compliant; learned helplessness
		Alcohol and drug abuse by perpetrators
		Ineffective safeguards

Source: Table developed by the authors, using an adapted framework from Ticoll (1994).

Perpetrators often use forms of abuse that make use of, and exploit, a woman's impairment or condition so that the violence experienced is compounded. Most common perpetrators of VAWG with disabilities are family members and care givers, as well as other people with a disability in service settings. They also may be exposed, however, to other potential perpetrators that include intimate partners, service providers, and personal assistance workers, among others.

3. Empirical Data on Inclusion and Access

3.1 Data on Violence and Disability

The Committee on the Rights of Persons with Disabilities, at its 9th Session on April 17, 2013, underscored that VAWG with disabilities is four times more serious than violence in the general population. It concluded that this particular group suffers a situation of "global humanitarian disaster," and that it requires intervention without delay by State Parties.

Although there are some studies on the violence and victimization of women and girls with disabilities in Latin America and the Caribbean, no official statistics have been found to interrelate these variables within their measurement instruments. According to CEPAL (2011), LAC countries already collect data on people with disabilities in their censuses or household surveys. Most of the questionnaires contain questions designed for people on an individual basis and, in some cases, apply to the household. There are, however, only six countries in the region that have specific surveys on disability, updated since 2005. Of these, two include questions that relate to violence against women (VAW) (Colombia and Haiti), and only one (Colombia) allows for cross-tabulations of variables on disability and VAW due to its sample size (Table 2).

Table 2. Specific Surveys Relating to Disability that Include a Question on Violence, by Country

Country	Year	Name	Question Relating to Violence
Guatemala	2005	Encuesta Nacional de Discapacidad	No
Mexico	2010	Encuesta Nacional sobre Discriminación - Módulo Discapcidad	No
Peru	2012	Primera Encuesta Nacional Especializada sobre Discapacidad	No
Chile	2015	II Estudio Nacional de la Discapacidad	No
Colombia	2015	Demographic and Health Surveys Program	Yes
Haiti	2016	Demographic and Health Surveys Program	Yes

Source: Prepared with information from various population censuses and household surveys from the Latin American and Caribbean region.

3.2 Good Practices in Data Collection

The collection of data on VAW with disabilities must comply with ethical and safeguard guidelines to protect the safety and privacy of affected individuals. In addition to specific recommendations provided in the introductory note of this series, *Measuring Disability in LAC* (forthcoming), a specific set of guidelines should be followed to collect data.

As a best practice to measure the prevalence of such violence, countries have opted to either use the methodology applied in the multicountry study of the World Health Organization (WHO)[4] or the Domestic Violence Module of the Demographic and Health Surveys (DHS) Program. The former, which was originally designed as a standalone questionnaire for violence research (Ellsberg and Heise, 2005), has several advantages: (i) it collects detailed information about acts of physical, sexual, and emotional violence committed by partners and nonpartners; (ii) it includes information about the frequency and duration of violence, violence during pregnancy, health consequences for women and their children, women's responses to abuse, and access to services for battered women; and (iii) it explores related issues, such as social acceptance of violence, decision-making within the family, women's financial autonomy, and physical mobility. In LAC, very few countries have applied the WHO methodology, with most having embedded VAW questions in the DHS module, thereby excluding the experiences of older women and men.

[4] WHO worked with collaborating institutions on 15 sites in 10 countries between 1998 and 2004 to implement a multicountry study of domestic violence and women's health (WHO, 2005). The study was the first to produce comparable data on physical and sexual abuse across various settings. It sought to minimize the differences in methods by standardizing questionnaires and procedures, as well providing a common approach to interviewer training.

According to the DHS Program,[5] the main guidelines to ensure safety and privacy are the following:

- One eligible woman per household should randomly be selected.
- Members of the staff should receive special training on safety procedures relating to crisis situations and self-care.
- The introductory sentence in the violence module should be treated as an additional informed consent procedure. If more than one woman in the household is interviewed, the interviewer should informally explain that no one else in the household will be asked the same questions and that any discussions held will be maintained confidential.
- Informant should be guaranteed absolute privacy. If, despite repeated attempts, privacy cannot be obtained, the domestic violence module should not be implemented.
- An information sheet should be prepared and disseminated, listing the options and services available to women who experience domestic violence; legal aid and services should also be included.
- The use of translators should be avoided when collecting data on domestic violence, since it may make less effective the information provided and would violate the privacy of the interviewee.
- Quality assurance procedures should be developed for the domestic violence module, in line with those applied to the rest of the survey.
- It is critical that local women's groups be involved at inception, which will have the additional value of increasing data ownership.

It was announced in 2016 that a disability module would be introduced into the DHS, in collaboration with the United States Agency for International Development and the Washington Group on Disability Statistics (WG). The new disability module is based on WG disability questions that have been internationally tested and endorsed by the UN for use in population data gathering.

The tools are based on the WHO International Classification of Functioning, Disability and Health framework. The Disability Module in a survey enables the capture of disability data relating to all household occupiers from the age of five across six core functional domains: seeing, hearing, communication, cognition, walking, and self-care. DHS surveys that include this module include basic information on disability, comparable to that being gathered worldwide with the aid of WG disability tools. To date, of the LAC countries reporting,[6] only Colombia and Haiti have included the special Disability Module.

To undertake research on VAW is, in many ways, similar to research on other sensitive topics; they all involve issues of confidentiality, information disclosure, and the need to ensure adequate and informed consent. There are aspects of gender-based violence research that are particularly sensitive, given the potentially threatening and traumatic nature of the subject; the safety—and even the lives—of female interviewers and respondents are potentially at risk. Thus, VAWG questions should be incorporated into disability surveys only when ethical and safety

[5] These guidelines are adapted from WHO (2001).
[6] According to information on the DHS website, https://dhsprogram.com, accessed in October 2018.

requirements can be met. Table 3 provides a general overview of the advantages and disadvantages of this recommendation.

Table 3. Advantages and Disadvantages of Incorporating Questions into Disability Surveys that Relate to Violence against Women and Girls

Advantages	Disadvantages
Incorporating a set of questions relating to violence against women and girls (VAWG) in a preset disability survey may **offset survey costs.**	Lack of fieldworkers trained on issues of VAWG may put women at risk and/or distress them..
Countries may **reduce the time it takes to collect data on VAWG,** by gathering it concurrently with disability data.	Linking two issues of relatively low prevalence within a population may require larger samples.
Combining questions on both topics facilitates an **analysis of the experiences of VAWG with disabilities.**	Surveys with few questions on violence may lead to substantial underreporting.
	Fieldworkers and supervisors may be reluctant to report violence if it is not the main objective of the survey.
	Lack of preparedness to refer women who request assistance to available sources of support
	Informing the wider community: interviewing more than one woman per household in complete confidence (in the absence of the care giver) will safeguard lives. This may not be feasible, however, if the main objective of the survey is to measure only the disability.

Source: Table developed by the authors using Ellsberg and Heise (2005).

In order to assess the viability of incorporating VAWG questions into disability questionnaires or vice-versa, it is crucial to conduct power calculations regarding anticipated prevalence and to adjust sample sizes to ensure they can capture precise estimates of disability and violence prevalence alike. The goal is to statistically estimate significant variances in prevalence rates of violence across women with and without disabilities. If the overall sample is too small and/or the prevalence of disability in a country is too low, then it will be necessary to use larger samples to achieve precision and accuracy.

3.3 Prevalence of Violence among Women and Girls with Disabilities

The data analysis provided below on women, adolescents, and girls with disabilities who suffer violence in countries outside the LAC region is drawn from various international publications. With regard to LAC, data is primarily extracted from national disability survey reports. Only in the case of Colombia have the authors performed a statistical analysis using the publicly available DHS

database, since the sample size and prevalence rate of women with disability was sufficiently large to allow for a comparison of violence experiences.

3.3.1 Worldwide prevalence

Worldwide, one of every three women experiences physical or sexual violence in her lifetime. In the United States, the average is 36 percent (WHO, 2013). Hughes et al. (2012) found that women with disabilities are at a higher risk of experiencing any type of violence compared with women without disabilities and that women and girls with intellectual disabilities are at particularly high risk of violence, including sexual violence.

Research from several countries in Europe (la Riviére Zijdel, 2004) found that almost 80 percent of women with disabilities are victims of violence, and that they are four times more likely than other women to suffer sexual violence. Also, 80 percent of those who are living in institutions are exposed to violence from the people around them, whether health and service personnel, caregivers, or other people with disabilities (Ibid).

In Canada, a study using a representative sample of 7,027 Canadian women, who were married or living in a marital common-law union, found that women with disabilities were 40 percent more likely than other women to have experienced violence in the five years preceding the interview. In addition, these women were at particular risk for severe violence (Brownridge, 2006).

Similarly, a study of the United States found that women with a disability were significantly more likely to experience rape compared to women without a disability (1.7 vs 0.4),*[7] other forms of sexual violence (4.5 vs 1.8),* physical violence (7.1 vs 3.3),* stalking (21.0 vs 12.2),* and psychological aggression and control of reproductive or sexual health (2.4 vs 1.4) by an intimate partner (Breiding and Armour, 2015). These were found after controlling for age, family income, race or ethnicity, and education.

Lastly, in Australia, an analysis of the 2012 Personal Safety Survey data indicates that among women under age 50 with disabilities, 62 percent had experienced violence since the age of 15, and women with disabilities had experienced three times the rate of sexual violence in the past 12 months than women without disabilities (Dowse et al., 2016). These findings do not represent the full extent of VAW with disabilities in Australia, however, since the survey sample only includes women who reside in private dwellings and not those living in disability care settings.

3.3.2 Prevalence in Latin America

In Latin America and the Caribbean, the collection of data on VAWG with disabilities is scarce. As noted previously (Section 3.1), while most countries in the region measure the prevalence of disability, they do not pose specific questions about violence. Only Colombia's 2015 DHS contains statistically representative information on VAW with disabilities, and follows international guidelines for questions on disabilities and gender-based violence. Chile's disability survey

[7] Asteriscs* denote statistical significance.

represents a special case because prior to 2005, the survey included questions about violence but the variable was taken out in the most recent version of the survey (2015).

3.3.2.1 Data on disabilities: Chile

With respect to the collection of data and statistical indicators on disabilities in LAC, Chile's first National Study of Disability (Estudio Nacional de la Discapacidad, or ENDISC) in 2004 and its second in 2015 (ENDISC II) were pioneers in the region. According to 2015 preliminary results, Chile has a total of 2,606,914 people with disabilities (20 percent of the population) of which 11.7 percent are classified as mild to moderate and 8.3 percent as severe. This data, however, does not compare with that from the first study since only the second is based on the conceptualization and agreements relating to the way disabilities are measured according to the UNCRPD,.

Regarding the dimension of violence, only ENDISC 2004 included a question relating to it. According to ENDISC 2004,[8] 13.28 percent (274,599) of people with disabilities had ever been victims of acts of violence, and in the last 12 months, 1 of every 8 had suffered some kind of physical or verbal violence. Unfortunately this study does not offer a specific analysis of VAW.

3.3.2.2 Analysis of violence against women with disabilities: Colombia

According to Colombia's 2015 DHS Survey, 9.8 percent reported having a disability.[9] The prevalence of disability[10] also increases with age (from 2.7 percent among those aged 0−9 to 53 percent among those aged 80 or above).

When the data is disaggregated by sex, the prevalence of disability is higher for women (10.9 percent) compared to men (8.6 percent). Disabilities most prevalent among women are those relating to "seeing close, far, around" (7.4 percent); "moving around/walking/climbing stairs" (2.6 percent); and "doing daily chores without showing cardiac, respiratory or renal problems" (1.3 percent). The pattern is similar, although lower in each category, for men with disaiblities ("seeing close, far, around": 5.1 percent; "moving around/walk/climb stairs": 1.8 percent; and "to do daily chores without cardiac, respiratory, or renal problems": 1.2 percent).

Intimate partner violence. Colombia's survey also indicates that 67 percent of women who have either been married or live with a partner have experienced at least one type of violence

[8] The question was applied to a randomly picked person with a disability in the household selected. The questions were asked face to face, when the informant was able to answer by his/her own means. When the latter was not possible, the questionnaire was presented to another qualified informant.

[9] Colombia's 2015 DHS Survey included questions on the difficulties of (i) hearing voices or sounds; (ii) talking and communicating; (iii) seeing close, far, around; (iv) moving around/walking/climbing stairs; (v) holding, using arms/hands; (vi) understanding, remembering, taking decisions; (vii) eating, dressing, taking a shower, (viii) relating/interacting with others; and (ix) carrying out daily chores with no cardio/respiratory conditions. These questions were to be responded to based on the level of effort required: (i) No, cannot; (ii) Yes, can with a lot of difficulty; (iii) Yes, can with some difficulty; (iv) Yes, with no difficulty; and, (iv) Do not know. A person with a disability is defined as one who relates to the two first levels of difficulty ((i) and (ii)) to perform the activities stated.

[10] It is important to note that Colombia's 2015 DHS Survey data does not measure the total size of the population with disabilities; it does not, for example, include those who live in institutions, such as long-term care hospitals, nursing homes, and prisons.

(psychological, physical, sexual, or economic) from her husband or partner during her lifetime. In the case of women with disabilities in the same situations, the figure increases to 72 percent.

For all types of violence, women with disabilities show higher prevalence rates compared to those without (Table 4). The most prevalent type of violence is psychological, affecting 69 percent of women with disabilities and 63.9 percent of women without disabilities. Women with disabilities report being threatened of being abandoned by their husband or partner, the prevalence rate of which is 4.5 times that of women without disabilities. They also report feeling ignored (38.8 percent) and having been insulted (29.6 percent) at higher rates than women without disabilities (27.0 percent and 20.6 percent, respectively).

The second most prevalent type of violence is physical, overall affecting 31.9 percent of Colombian women against 42.2 percent of women with disabilities. Among the acts of violence, the most prevalent are "being pushed, shaken or having something thrown by husband/partner", (27.9 percent of women without disabilities and against 38.7 percent of women with disabilities, and "being slapped by husband/partner" (20.8 percent of women without disabilities and against 28.3% women with disabilities).

Economic violence is also an issue for Colombian women with disabilities, whereby one in every five women with disabilities who has been married or is in a relationship has suffered from at least one type of economic violence. This represents more than 9 percentage points higher than the prevalence of economic violence among women without disabilities, at 30.4 percent.

Table 4. Intimate Partner Violence and Disability

Type of Violence	Women (%)	Women without Disabilities (%)	Women with Disabilities (%)	Difference (percentage points)
Sexual	7.6	7.3	11.4	4.1**
Physical	31.9	31.0	42.2	11.2**
Psychological	64.1	63.6	69.0	5.4**
Economic	31.1	30.4	39.6	9.2**

Source: Estimates calculated by the Inter-American Development Bank, based on Colombia's 2015 Demographic and Health Survey (expanded Table A1 in Annex).
**Statistically significant at 95 percent of confidence; *statistically significant at 90 percent of confidence.

When the data is further disaggregated by type of impairment (Annex Table A2), there is evidence that the women most vulnerable to sexual violence are those with impairment Type 4 ("difficulty moving around, walking, climbing"). The prevalence of sexual VAW with impairment Type 4 is six percentage points higher than that of women without a disability, 13.6 percent vs. 7.6 percent, respectively.[11] For all other types of physical violence, women with impairment Type 1 ("hear

[11] This is a statistically significant difference.

sounds and voice"), 6 ("understand and remember") and 8 ("relating and interacting") have a considerably higher probability of being victims.

Violence perpetrated by another person. Women with disabilities also suffer violence at the hands of other people. The most frequent forms of violence perpetrated by someone other (henceforth "others") than a current spouse or intimate partner are psychological (25.8 percent), followed by physical (17.8 percent) and sexual (7.8 percent).

According to Colombia's 2015 DHS, 25.8 percent of women with disabilities fall victim to psychological violence perpetrated by others; this prevalence rate is three percentage points higher than that of women without disabilities. The most frequent type of psychological violence is being "insulted or made to feel bad about herself", which is also almost three points higher for women with disabilities than for women without disabilities (19.7 and 17.0, respectively).

Physical violence is the second most prevalent form of violence perpetrated by others, affecting 17.8 percent of women with disabilities compared to 12.6 percent of women without. The most common perpetrator of physical violence is "other relative different from mother or daughter" (5.2 percent).

Approximately 7.5 percent of women with disabilities have been a victim of sexual violence at least once in their lifetime; this prevalence rate is three percentage points higher than that of women without disabilities. When asked who the perpetrator was, women with disabilities answered that the most common perpetrators were male relatives independent from the father, step-father, and brothers (25.3 percent), a rate 12.6 percentage points higher than women without disabilities. In addition, women with disabilities reported a sexual harassment prevalence rate 4.5 percentage points higher than other women.

Table 5. Types of Violence Perpetrated by Others[1]

	Women (N=38,087) (%)	**Women without Disabilities (N=35,667) (%)**	**Women with Disabilities (N=2,420) (%)**	**Difference**
Sexual violence	**4.6**	**4.4**	**7.6**	**3.2****
Forced by someone/boyfriend to have sexual intercourse	4.5	4.3	7.5	3.2**
Forced to have sex to obtain money/benefits for others	0.3	0.2	0.5	0.3**
Physical violence	13.0	12.6	17.8	5.1**
Psychological violence	**22.8**	**22.6**	**25.6**	**3.1***
Someone/partner has addressed you in bad terms	17.2	17.0	19.7	2.7*
Someone/partner did not permit you to see friends	10.6	10.6	11.0	1.6
Someone/partner limits contact with family	2.6	2.6	3.1	0.5
Sexual harassment	**59.5**	**59.2**	**63.7**	**4.5****

Source: Estimates calculated by the Inter-American Development Bank, based on Colombia's 2015 Demographic and Health Survey.

**Statistically significant at 95 percent of confidence; *statistically significant at 90 percent of confidence.

[1]This paper considers domestic violence as one that occurs when the victim lives with her partner. As such, this table considers violence perpetrated by others that include a boyfriend or partner who does not live with the victim.

Violence reporting

Less than 50 percent of women who were victims of violence sought help (43.7 percent). In this case, there is no statistically significant difference between women with or without disabilities. The person from whom the victim most frequently sought help was the mother (50.3 percent) or another family member (35.6 percent).

On average, only 20 percent of Colombian women who were victims of violence reported it to an institution. The most common places where formal complaints were filed at a a family police station[12] (39.8 percent), public attorney's office (39.6 percent), and other police (24.4 percent).

Sexual and reproductive rights education

When questioned about sexual education, almost all women (95 percent) responded that they had received in their lifetime information on topics relating to sex or reproduction. While on average, the data shows that the same percentage of women with disabilities received information as women without disabilities, when it is disaggregated by topic, there is evidence of some variances (Table 6). Women with disabilities are less likely to have access to information about self-knowledge, with the highest difference relating to puberty; women without disabilities receive this information at a rate of 82.5 percent, which is five percentage points higher than women with disabilities (78.3 percent).

There are also differences in topics relating to sexual decision-making, where women with disabilities are less likely to receive information about sexual orientation (65.1 percent) and condom use (72.5 percent) compared to women without (70.7 percent and 77.7 percent, respectively).

Table 6. Access to Education on Sexual and Reproductive Rights and Disability

	Women (N=38,718) (%)	Women without Disabilities (N=36,245) (%)	Women with Disabilities (N=2,473) (%)	Difference
Self-knowledge				
Functioning of the sexual organs	77.8	78.1	75.9	-2.2**
Changes that appear in puberty	82.2	82.5	78.3	-4.2**
Changes that appear in the elderly	61.9	61.9	61.5	-0.4*

[12] A "comisaría de familia" is a district or municipal level pólice state that has the misión to guarantee, restablish or repair the rights of the members of a nuclear family in cases of violence.

	Women (N=38,718) (%)	Women without Disabilities (N=36,245) (%)	Women with Disabilities (N=2,473) (%)	Difference
Interpersonal relationships				
Affective relationships	63.5	63.7	60.6	-3.2%
Affective communication and conflict resolution	66.8	67.0	64.8	-2.2%
Gender equality	70.2	70.3	68.5	-1.8%
Sexual decision-making				
Pleasure and erotism	44.3	44.4	43.1	-1.3%
Sexual orientation	70.3%	70.7	65.1	-5.6**
Demand for condom use	77.3	77.7	72.5	-5.2**
Reproductive decision-making				
To have or not have kids	71.3	71.6	67.2	-4.4**
Use of contraceptives	90.1	90.0	90.6	0.5%
Right to voluntary interruption of pregnancy	61.4	61.2	62.8	1.6%
Self-, mutual, and social care				
Safe sexual practices	61.2	61.2	61.6	0.4%
Gender violence	74.1	74.2	71.8	-2.4%
Sexual and reproductive human rights (SRH)				
From whom to request information about sexuality	52.7	52.8	51.7	-1.1%
What SRH services and resources are available?	42.1	42.4	39.0	-3.4%
What are the mechanisms to denounce infringement of SRH rights?	54.3	54.4	54.0	-0.4%

Source: Estimates calculated by the Inter-American Development Bank, based on Colombia's 2015 Demographic and Health Survey.

**Statistically significant at 95 percent of confidence; *statistically significant at 90 percent of confidence.

3.4 Gaps in Legal and Institutional Frameworks

Although most LAC countries have ratified the UNCRPD and the Convention on the Elimination of All Forms of Discrimination against Women, and most have norms and laws that directly or indirectly protect the rights of persons with disability, only a few have specific laws that address disability and VAW alike. For example, Costa Rica and Uruguay have incorporated specific articles in their disability or VAW laws that encourage relevant policy development (UNDP, 2012). Notwithstanding this example, the process of bringing legislation into line with both conventions is far from complete in LAC. Further efforts are needed to modify laws and implement regulations to fully implement a strong legal framwork that protects women and girls with disabilities from violence and to provide adequate services to violence survivors.

Throughout the region, there are several public institutions responsible for protecting the rights of persons with disabilities and of women. To pursue their mandate, many have developed instruments such as National Plans of Action for the Human Rights of Persons with Disabilities, and Gender Equality and the Elimination fo Violence against Women and Girls. Although these programatic frameworks represent an important opportunity for countries to advance policies to protect women and girls with disability from violence, they are nonspecific and lack actions and indicators that would faciltiate the implementation of UNCRPD recommendations.

Thus, despite the efforts made by each government on the issues of VAWG and disability, planning and implementation processes for national plans, programs, and public policies have yet to be harmonized, including the allocation of adequate funding to increse capacity to specifically address VAWG with disabilities. Furthermore, current actions by countries are highly fragmented, making it difficult to coordinate and establish linkages between the governmental bodies involved.

3.5 Gaps in Service Provision

Across the LAC region, violence response services for women and girls with disabilities are either nonexistent or minimal. These are limited due to challenges such as the following:

1. **Limited accessibility to shelters, intervention centers, helplines, and counseling.** Women with disabilities are often excluded from existing services for victims of violence because there are no specific provisions to ensure their access, such as ramps, elevators, materials in braille, sign language interpreters, or captioned phones for deaf women.

2. **Lack of qualified service providers**. Most providers of services for victims of violence are not qualified to address the specific needs of women and girls with disabilities. There are inadequate training options, support structures, and guidelines in place to help providers identify and address different needs; for example, people with intellectual disabilities may require more time to communicate their experiences and/or build a trusting relationship with providers.[13] This also holds true among health care providers; in a survey exploring the training of healthcare professionals in the United States, more than 80 percent of medical school students reported having received no clinical training relating to people with intellectual disabilities.[14]

3. **Lack of clear protocols to prevent VAWG with disabilities.** Disability service providers should acknowledge and address the fact that violence occurs within the service system (Rau Barriga et al., 2017). A study by the UN Human Rights Council (UN, 2012) states that while a few countries report that they pay special attention to the needs of women and girls with disabilities in programs and policies addressing gender-based violence, there is little information on specific actions taken to prevent such violence within the disability service system. In the case of women and girls with disabilities who are

[13] For additional recommendations, refer to Shah, Balderston, and Woodin (n.d.).
[14] For the training of health professionals, see Special Olympics “Resources” at https://resources.specialolympics.org/Topics/Research/Program_Research_Toolkit/Training_of_Health_Professionals.aspx.

institutionalized or who live in supported accommodations, the report described insufficient and inappropriate use of data on inspection reports, lack of resources for oversight of institutions and for training of assistants. In addition, reports submitted to the Human Rights Council by nongovernment and disability organizations indicate that these efforts remain inadequate and ineffective, and the lack of clear protocols and verification mechanisms represent a critical gap in the provision of services to people with disabilities.

4. **Underreporting of violence and lack of adequate response by the justice system.** Although people with disabilities are likely to face elevated levels of risk for abuse, many crimes never come to the attention of the police. A small qualitative study in the United Kingdom (Walter-Brice et al., 2012), which includes interviews with five women with learning disabilities, found that the women experienced multiple forms of abuse from their partners, much of them severe, including the use of weapons; that the abuse, harassment, and threats continued after the end of the relationship; that responses from police and social services were minimal; and that the women were left unprotected (although children were removed from their mothers).

5. **Lack of support in sexual and reproductive health care for women and girls with disabilities.** Qualitative studies (Lee et al., 2015) have shown that service providers often have limited awareness of the sexual and reproductive health needs of women with disabilities and an inadequate understanding of their rights. Service providers have very little training in relation to disabilities and limited access to the resources that would enable them to provide disability-inclusive services. Some service providers hold prejudiced attitudes toward women with disabilities seeking sexual and reproductive health services, resulting in disability-based discrimination. Service providers are also often unaware of specific factors undermining the health of women with disability, such as violence and abuse.

4. Key Issues and Promising Practices

As mentioned in Section 2.1, all countries in the LAC region have signed the UNCRPD; this convention recognizes that women and girls with disabilities are often at greater risk of violence and it calls upon all member states to implement appropriate measures to protect persons with disabilities from all forms of violence and abuse, including the development and implementation of women and child-focused legislation and policies. In the LAC region, some countries are making efforts to improve their legal frameworks as well as create and implement national plans that include actions to protect women with disabilities from gender-based violence and to provide them with appropriate sexual and reproductive health services.

4.1 Legal and Institutional Frameworks in LAC that Address Violence against Women and Girls with Disabilities

4.1.1 Uruguay

Uruguay has set an example in the region with the passage of the "Law on Violence against Women based on Gender" (Law Nº 19580, 2018[15]), which proposes specific actions for girls and adolescents, elderly women, and women with disabilities.

Among the most innovative actions for women with disabilities, the Law includes the following:

- The right for the victims of violence to have an interpreter, language adaptation, or augmentative communication, as well as other necessary support and reasonable adjustments, to guarantee their rights when they suffer from any disability.
- Generation of minimum quality standards for the detection and treatment of violence to ensure that the actions aimed to strengthen women's autonomy take into account their diversity based on age, sexual orientation, gender identity, racial and ethnic origin, disability, and beliefs.
- Development of protocols to ensure that all healthcare professionals have regular training in the prevention of violence and the attention and rehabilitation of victims of violence, taking into account the disability variable.
- Development and sharing of informative and materials about prevention, security, and preservation of evidence in situations of gender-based VAW with disabilities.
- Strengthening of the reporting and investigation mechanisms and processes of gender-based violence toward women with disabilities, mainstreaming the perspective of disability in the programs, plans, actions, and protocols of the relevant institutions.
- Designing police intervention protocols, guides, and manuals relating to VAW, factoring in the special needs of women with disabilities.
- Provision of information for women with disabilities, their families, personal assistants, and the general population with the goal of preventing, recognizing, and denouncing gender-based VAW with disabilities.
- Developing actions to guarantee respect for the rights to sexual and reproductive health of women in situations of disability, ensuring that they have access to information appropriate for their age; the necessary means to allow them to exercise their rights; and the wherewithal to teach others to respect their right to exercise their sexuality, their reproductive capacity, their gender identity, and their sexual orientation.
- Provision of appropriate assistance to women with disability in fulfulling their responsibilities as parents, and ensuring that in no case will a child or adolescent be separated from his or her mother because of the disability of the child, mother, or both.

Uruguay's National Program on Disabilities commits to preventing gender-based violence or violence based on the vulnerabilities of people with disabilities. It aims to develop and implement actions to improve autonomy, self-esteem, and responsible maternity and paternity. PRONADIS coordinates these actions with the Ministry of Health (Ministerio de Salud Pública); National Institute of Women (Instituto Nacional de las Mujeres, or INMUJERES); Secretary of Women (Secretaría de la Mujer, Intendencia de Montevideo); Secretary of the Social Management of

[15] Promulgated December 22, 2017, and published on Janury 9, 2018.

Disabilities (Secretaría de de Gestión Social para la Discapacidad) of the Municipality of Montevideo; and civil society organizations, as well as international organizations such as UN Women, WHO, and the UN Population Fund. The PRONADIS webpage offers women with disabilities tools and resources to help them learn about and exercise their sexual and reproductive health rights, as well as to detect and report gender-based violence.

4.1.2 Costa Rica

Costa Rica's Law Nº 7600, "Equality of Opportunities for Persons with Disabilities" (promulgated May 29, 1996), includes as one of its main objectives to protect those with disabilities who are victims of physical, emotional, or sexual violence; have been neglected; do not have a family; or have been abandoned by their relatives by providing them access to services that allow them to exercise their autonomy and develop a dignified life. The Law's regulatory framework in Article 19 states that the Center for Women and Family Development (Centro Nacional para el Desarrollo de la Mujer y la Familia) should formulate policies to prevent and treat cases of domestic violence against people with disabilities.

4.1.3 Mexico

Mexico's 2014−18 National Program for the Development and Inclusion of People with Disabilities (Programa Nacional para el Desarrollo y la Inclusión de las Personas con Discapacidad 2014−2018) includes a strategy (No. 6.5) promoting affirmative action to protect women with disabilities against any form of violence or abuse of their rights. The strategy includes the (i) promotion of safe houses with adapted infrastructure; (ii) development of programs and actions to prevent violence against women with disabilities, protect them, and provide them with the necessary services; (iii) support to civil society to promote respect toward people with disabilities, allowing the exercise the rights of people with disabilities; (iv) development of mechanisms to explose violence and discrimination against women, girls, and elderly women with disabilities; and (iv) communication and dissemination of information about services and organizations that provide legal and human rights advice relating to disability, discrimination, and violence.

Progress and achievements of the program include the following:[16]

- The government now provides orientation to women with disabilities through the "Módulo de Gestión Social" of its National Institute of Women (Instituto Nacional de las Mujeres), which refers them to public, private, and civil organizations to receive legal, psychological, and medical support. The institute has so far provided 33 advisory services to 12 women with a physical disability, 1 with a psychosocial disability, 12 with a visual disability, and 6 with a hearing disability.
- The National Commission to Prevent and Eradicate Violence against Women (Comisión Nacional para Prevenir y Erradicar la Violencia Contra las Mujeres, or CONAVIM) has put in place a communication campaign to promote the rights of women with disabilities. The commission also has adapted its webpage to facilitate use by people with disabilities.

[16] For further information, see CONADIS (2016).

- The National Institute of Social Development (Instituto Nacional de Desarrollo Social, or INDESOL) has carried out 1,238 preventive actions in favor of and 654 responses to women victims of violence with disabilities.
- The Gender Equality Division of the Senior Officer of the Department of Public Education (Oficialía Mayor de la Secretaría de Educación Pública, or SEP) has launched various communication campaigns on gender equality, human rights, violence eradication, and integral sexual education, using content and images of people with disabilities.
- The National Institute of Social Development has implemented four workshops of four hours each about gender violence and human rights for children in the municipalities of La Paz, Los Cabos, and Baja California Sur, benefiting 85 children (21 girls and 64 boys) with auditory disabilities.

4.1.4 Argentina

Argentina's National Plan for People with Disabilities[17] includes the following objectives:

- Promotion of awareness for the prevention of VAW with disabilities. The objective of this activity is to ensure communication materials on gender-based violence are made available to women with disabilities.
- Modification of Hotline 144 to ensure that women with auditive disabilities are able to communicate.
- Development of a guide on issues relating to sexual and reproductive health and violence.

4.2 Emerging Good Practices at a Global Level

While there are few violence prevention efforts tailored for women with disabilities at the global level, the interventions that do exist do not clearly demonstrate a decrease in the incidence of violence and/or the mitigation of risk factors. Much work has yet to be done in this area, with various aspects to consider in the development of future interventions, including the following (Van Der Heijden, 2017):

- Interventions to be based on evidence and on theory in terms of analyzing the triggers that increase the risk of VAW with disabilities.
- Interventions to focus on caretakers, not only as protectors but also as potential perpetrators.
- Social services and relevant agencies to build awareness of the various forms of violence, such as being prevented from using a wheelchair or other assistive device; being over or under-medicated; being neglected or refused help; or misuse of welfare grants by family members,
- Service providers to develop protocols or compulsory guidelines to ensure that all instances of violence or cases of suspicion are properly identified and investigated.
- Service benerficiaries to be involved in the development of intervention strategies.

- Interventions to include the building of resilience in women and girls with disabilities by socially and economically empowering them so that they are able to care for their own health (including sex education and reproductive health) and become financially independent.
- Interventions to discredit the social and cultural myths relating to disability stigma and gender stereotyping; for example, interventions should send a clear message that a woman or girl with disabilities have the right to speak up if she is attacked for having denied sex to an intimate partner.
- Strategies to ensure the ability of women with disabilities to access their environments safely.

The global flagship program of the UK Department for International Development, What Works to Prevent Violence, presents an analysis of nine interventions that aim to prevent abuse or violence against women with disabilities. Focus is placed on building the awareness and skills of women with developmental and/or intellectual disabilities. The program was delivered to women in the form of groups, and included some of the assistants and service providers. Outcomes demonstrate that none of the interventions has led to a decrease in the incidence of violence, many of which had lacked sufficiently rigorous impact evaluation. Nevertheless, it expected that the results of this first effort will lead to more promising approaches, three of which are outlined as follows:

- The “A Safety Awareness Program (ASAP) for Women with Disabilities, is a peer-led psychoeducational program in the United States that consists of eight weekly, 2.5-hour educational and interactive classes to increase the safety knowledge of women with disabilities in terms of abuse, while promoting safety behaviors (NIJ, 2017). ASAP staff educate and train professionals (e.g., disability service providers, domestic and sexual violence agency staff, criminal justice personnel) to promote awareness about and prevent sexual and domestic violence against women with disabilities. Program staff also offer technical assistance and/or consultation to individuals and organizations seeking information and guidance to reduce the risks of abuse against people who have a disability or to increase accessibility of victim service agencies or programs to survivors of abuse who have a disability.

  Findings suggest that ASAP has the potential to enhance protective factors including abuse awareness, abuse and safety knowledge, safety skills, safety self-efficacy, social support, and safety-promoting behaviors in women with disabilities. Although the intervention and control groups did not differ at pretest on any of the measures, the intervention group scored significantly better at either post test, follow-up, or both time points on every protective factor measured. The differences between women who did and did not participate in ASAP for Women were generally greater at the post test assessment, and significant differences between groups remained at the 6-month follow-up assessment on most measures (Robinson-Whelen et al., 2014).

- The U.S. program, Effective Strategy-Based Curriculum for Abuse Prevention and Empowerment (ESCAPE) for Adults with Developmental Disabilities (ESCAPE-DD),[18] evaluated by Hickson et al (2015), focused on the decision-making skills of adults with intellectual and developmental disabilities in hypothetical situations of abuse. Fifty-eight women and men with intellectual development disability were randomly assigned to an intervention group or a wait-list control group. Participants in the ESCAPE-DD intervention made significantly greater gains on measures of overall effective decision-making and "safe-now" effective decision-making relative to participants in the control group (84 percent vs 63 percent) (Hickson et al., 2015).

  Impact evaluations of ESCAPE since 2005 have used three different scales to evaluate decision-making performance before and after the training: the Social-Interpersonal Decision-Making Video Scale, the Self Social Interpersonal Decision-Making Scale, and the Nowicki-Strickland Internal–External Scale (Khemka, Hickson, and Reynolds, 2005). Participants in the treatment group respond to the various vignettes relating to interpersonal psychological, physical, and sexual abuse situations after undergoing decision-making training. Although the ESCAPE curriculum and research is innovative and rigorous, it also has limitations. One shortcoming is that although the authors present results in terms of its impact on knowledge, decision-making, and empowerment, ESCAPE so far has been evaluated with relatively small samples, which makes it challenging for measuring outcomes with statistical significance. Furthermore, the intervention did not evaluate the most pressing issue of whether or not the program reduced sexual assault victimization.

- Robinson-Whelen et al. (2010) studied the impact of the Safer and Stronger Program (SSP) on abuse awareness, safety self-efficacy, and safety-promoting behaviors among women with disabilities in the United States. The SSP is a computer-based assessment tool that offers an accessible and anonymous method for women with disabilities to self-screen for intimate partner violence by disclosing their exposure to abuse, describing the characteristics of their primary perpetrator, and reporting their use of safety-promoting behaviors. Using a total sample of 305 women, findings suggest that the SSP can significantly increase abuse awareness; the SSP increased abuse awareness among women who reported little or no past-year abuse, although not among participants who reported sexual, physical, or multiple abuse experiences within the past year, who already had high levels of awareness. No measurable effect, however, was detected on safety self-efficacy or safety-promoting behaviors among the participants.

In addition to the examples cited above, larger studies are now being implemented with experimental designs to evaluate the effectiveness of sexual abuse prevention interventions. For example, a randomized controlled trail, designed by Chodan, Häßler, and Reis (2017), will enroll 120 girls aged 8 to 12 with mild intellectual disability from special schools in Germany to

[18]The ESCAPE program has had three iterations: ESCAPE (Khemka and Hickson, 2002), ESCAPE-DD (Khemka and Hickson, 2008) and ESCAPE NOW. The structure of the curriculum includes 12 instructional lessons and six support group sessions within three broad units: Knowledge of Abuse and Self-Empowerment, Decision-Making Strategy Training, and Support Group Sessions.

participate in a structured group training program, “Emma Untouchable”. The intervention will include behavioural therapeutic exercises and psychoeducational elements. After block randomization, the effects of the prevention program will be examined in a controlled four-time follow-up design. Preventive skills will be assessed in terms of individual changes in measures of knowledge, verbal reports of anticipated behavior, role plays, and *in situ* probes. The authors claim that this study will be the first randomized controlled trial on the effectiveness of a prevention program for girls with intellectual disability, using valid outcome measures with a large sample.

5. Conclusions

This note reviews the concepts, prevalence, risks, data, legal and institutional frameworks, and evidence-based interventions to prevent VAWG with disabilities. When gender collides with disability, both exacerbate vulnerability to violence, which may occur within personal relationships, homes, institutions, and the community. Evidence shows that women and girls with disabilities face barriers to information and services. Usually, these challenges are a result of lack of information and the attitudes of society, including those of public administrators, health care and other service providers. Also, there is limited access to preventive services that address VAW, such as domestic violence and sexual abuse programs and facilities, legal services, and health care systems, particularly in terms of sexual and reproductive health.

Research on VAWG that contains disaggregated data is rare. Surveys in LAC are not generally carried out with sufficiently large sample sizes to generate statistically significant findings for this subpopulation. As a result, most existing research is qualitative, often based on interviews with individual women only. The shortage of evidence-based programs to prevent VAWG with disabilities is illustrative of a larger problem throughout the LAC region; there is a significant gap in prevention services for VAW with disabilities in practice and in research alike. Countries must continue to develop and incorporate rigorous evaluation methodologies into their program planning, and implementation. Given these challenges, the following recommendations are outlined:

Recommendation 1: Support the collection and publication of data on VAWG with disabilities at the national and subnational levels.

a. Support the gathering of data through population censuses and surveys, using the standards of the DHS Disability Module and the WHO study (WHO, 2005). This could include financing larger sample sizes in future/planned DHS, Disability, or VAW Surveys.
b. Expand and improve the quality, completeness, and interconnectivity of administrative databases, particularly with respect to reporting on VAWGs with disabilities in health and justice systems, and the classification of victims of femicides to include the disability variable.
c. Expand existing systems of standardized indicators and conduct country-level studies on the extent and cause of the issues.

Recommendation 2: Incorporate women and girls with disabilities as targeted beneficiaries in operations that directly invest in gender equality and women's empowerment, such as integrated services for women or Women's City programs.[19]

a. Strengthen the articulation, coordination, and relationship between Women's City centers and the relevant territorial actors in the provision of services to fully include women and girls with disabilities. Make reasonable adjustments to existing services and centers; in the case of new centers, use universal design principals to ensure access to all.

Recommendation 3: Address VAWG with disabilities in policy reform operations.

a. Strengthen national policy frameworks and action plans to include measures to address VAWG with disabilities through policy-based loans.
b. Expand national and subnational laws, policies, strategies, and action plans to include reasonable adjustments to existing provisions/mechanisms to protect women and girls with disabilities and expand VAW services that are accessible to them. Improve multisector coordination, coordination across levels of government, and information for decision-making.

Recommendation 4: Mainstream a focus on VAWG with disabilities into operations that aim to improve public safety and prevent VAW.

a. Address the specific needs of women and girls with disabilities within interventions that aim to increase women's and girl's safety in urban transport and urban development operations by designing infrastructure and services with universal access.

b. Support solutions to encourage and facilitate the reporting of VAWG with disabilities, while strengthening the capacity of the justice system.
c. Support innovative justice services (including one-stop shops), legal aid, and courts that offer reasonable adjustments to ensure that women and girls with disabilities can access the justice to which they are entitled. Support the development of policies and strategies within prisons to ensure reasonable adjustments for women with disabilities.

Recommendation 5: Include an explicit focus on women and girls with disabilities in operations in the areas of social protection, health care, and caring services.

a. Provide training and protocols, with appropriate verification mechanisms, for child and elder care service providers and health care professionals to enable them to detect, help prevent, and offer services with reasonable adjustments in cases of VAWG with disabilities.
c. Support the prevention of the intergenerational transmission of VAWG with disabilities through positive parenting programs.

[19] These are an innovative line of operations (ES-L1056, HO-L1117 and DR-L1080) that promotes women's empowerment and delivers key services to women under one roof, providing a safe environment and integrated, high-quality services.

d. Improve access to sexual and reproductive health education and services by women and girls with disabilities. Increasing knowledge of and access to such services, offered by providers who are sensitive to the specific needs and vulnerabilities of women and girls with disabilities, can serve as a protective factor with regard to sexual abuse.

Recommendation 6: Strengthen the region's knowledge base on VAWG with disabilities by generating rigorous evidence on the effectiveness of interventions.

a. Map existing promising practices aligned with the UNCRPD
b. Support pilot programs or interventions within existing programs with more rigorous impact evaluations.

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Annex: Intimate Partner Violence in Colombia

Table A1: Intimate Partner Violence in Colombia by Type of Impairment

	Intimate Partner Violence				
	Sexual	**Physical**	**Psychological**	**Economic**	**Any Violence**
1. Hear voice or sounds					
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.64%
Women without impairment 1 (N=24,808)	7.9%	31.8%	64.0%	30.36%	66.55%
Women with impairment 1 (N=82)	7.6%	64.1%	82.1%	39.59%	84.27%
Difference (percentual points)	-0.3	32.37**	18.11*	9.23**	17.72*
2. Talk, communicate					
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.40%
Women without impairment 2 (N=24,882)	7.6%	31.9%	64.1%	30.97%	66.65%
Women with impairment 2 (N=8)	0.0%	27.8%	53.8%	62.29%	53.80%
Difference (percentual points)	-7.62	-4.15	-10.26	31.32**	-12.85
3. See close, far, around					
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.64%
Women without impairment 3 (N=23,524)	7.4%	31.4%	63.8%	31.13%	66.36%
Women with impairment 3 (N=1,366)	11.3%	39.8%	68.0%	41.70%	70.85%
Difference (percentual points)	3.95**	8.37**	4.18*	10.57	4.49**
4. Move around, walk, climb					
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.64%
Women without impairment 4 (24,631)	7.6%	31.8%	64.0%	30.63%	66.57%
Women with impairment 4 (N=259)	13.6%	42.2%	68.8%	38.52%	72.94%
Difference (percentual points)	6.04**	10.37**	4.82	7.89**	6.37
5. Hold or use arms/hands					
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.64%
Women without impairment 5 (N=24,792)	7.6%	31.9%	64.0%	31.05%	66.62%
Women with impairment 5 (N=98)	8.1%	45.2%	70.8%	38.47%	72.07%
Difference (percentual points)	0.53	13.3*	6.73	7.42*	5.45
6. Understand, remember, take decisions					

	Intimate Partner Violence				
	Sexual	**Physical**	**Psychological**	**Economic**	**Any Violence**
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.64%
Women without impairment 6 (N= 24,863)	7.6%	31.9%	64.0%	31.11%	66.62%
Women with impairment 6 (N=27)	17.0%	58.0%	91.1%	35.65%	91.05%
Difference (percentual points)	9.36	26.12**	27.02**	4.54	24.43**
7. Dress, take a shower					
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.64%
Women without impairment 7 (N=24,870)	7.6%	31.9%	64.1%	31.12%	66.65%
Women with impairment 7 (N=20)	16.7%	27.9%	57.5%	44.45%	57.50%
Difference (percentual points)	9.08	-4.00	-6.56	13.33	-9.15
8. Relate, interact with others					
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.64%
Women without impairment 8 (N=42,888)	7.6%	31.9%	64.1%	31.13%	66.64%
Women with impairment 8 (N=2)	46.1%	53.9%	100.0%	46.12%	100.00%
Difference (percentual points)	38.51**	21.95*	35.95	14.99	33.36
9. Do daily chores with no cardio/respiratory conditions					
Women (average) (N=24,890)	7.6%	31.9%	64.1%	31.13%	66.64%
Women without impairment 9 (N=24,717)	7.6%	31.9%	64.0%	31.14%	66.61%
Women with impairment 9 (N=173)	10.3%	41.2%	71.0%	30.07%	72.40%
Difference (percentual points)	2.73	9.28*	7.01	-1.07	5.79

Source: Estimates calculated by the Inter-American Development Bank, based on Colombia's 2015 Demographic and Health Survey.

**Statistically significant at 95 percent of confidence; *statistically significant at 90 percent of confidence.

Table A2: Intimate Partner Violence in Colombia and Disability by Type of Violence

	Women	Women without Disabilities	Women with Disabilities	Difference (percentage points)
Sexual Violence	***7.6%***	***7.3%***	***11.4%***	***4.1****
Ever been physically forced into unwanted sex by husband/partner	7.6%	7.3%	11.4%	4.1**
Physical Violence	***31.9%***	***31.0%***	***42.2%***	***11.2****
Ever been pushed, shaken or had something thrown by husband/partner	28.0%	27.9%	38.7%	10.8**
Ever been slapped by husband/partner	21.4%	20.8%	28.3%	7.6**
Ever been punched with a fist or hit by something harmful by husband/partner	5.7%	5.5%	7.6%	2.1**
Ever been attacked with knife/gun or another weapon by husband/partner	2.8%	2.7%	3.7%	1.0
Ever been strangled or burnt by husband/partner	4.4%	4.3%	5.7%	1.4
Psychological Violence	***64.1%***	***63.6%***	***69.0%***	***5.4****
Husband/partner jealous if respondent talks with other men	51.3%	51.1%	53.7%	2.6
Husband/partner accuses respondent of unfaithfulness	31.0%	30.5%	36.3%	5.8**
Husband/partner does not permit respondent to meet female friends	23.9%	23.3%	30.9%	7.6**
Husband/partner tries to limit respondent's contact with family	13.3%	12.7%	20.3%	7.6**
Husband/partner insists on knowing where the respondent is	29.9%	29.2%	36.8%	7.6**
Husband/partner ignores/does not address her	27.9%	27.0%	36.8%	9.8**
Husband/partner has not requested opinion for family/social gatherings	13.6%	13.1%	20.2%	7.1**
Husband/partner has not requested opinion on important family matters	12.3%	11.8%	17.2%	5.4**
Ever been threatened with knife/gun or another weapon by husband/partner	7.0%	6.7%	9.9%	3.2**
Ever been insulted or made to feel bad by husband/partner	21.3%	20.6%	29.6%	9.0**
Husband/partner has threatened to leave her	15.5%	4.9%	22.1%	17.2**
Husband/partner has threatened to take away children	12.8%	12.6%	15.6%	3.1**
Economic Violence	***31.1%***	***30.4%***	***39.6%***	***9.2****
Husband/partner does not trust respondent with money	13.5%	13.1%	18.5%	5.5**
Husband/partner threatens to withdraw economic support	10.5%	10.1%	14.9%	4.7**

	Women	Women without Disabilities	Women with Disabilities	Difference (percentage points)
Husband/partner did not allow to study/work	14.1%	13.8%	16.6%	2.8**
Husband/partner spent the household money	16.2%	15.7%	22.0%	6.3**
Husband/partner take away money or real estate	4.4%	4.3%	6.1%	1.8**

Source: Estimates calculated by the Inter-American Development Bank, based on Colombia's 2016 Demographic and Health Survey.

**Statistically significant at 95 percent of confidence; *statistically significant at 90 percent of confidence.