OUR BODIES, OUR RIGHTS!

ADDRESSING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND GENDER-BASED VIOLENCE FOR WOMEN AND YOUNG PEOPLE WITH DISABILITIES

An In-Person Workshop Curriculum for Organizations of Persons with Disabilities

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INTRODUCTION

This in-person workshop curriculum for organizations of persons with disabilities — **Our Bodies, Our Rights! Addressing Sexual and Reproductive Health and Rights and Gender-Based Violence for Women and Young Persons with Disabilities** – was designed for facilitators with disabilities to provide information and experiential learning for women and young persons with disabilities to deepen their expertise on sexual and reproductive health and rights (SRHR), and the right to be free from gender-based violence (GBV). The goal of the workshop is to provide participants with the SRHR and GBV knowledge foundation needed to enable them to advocate for their rights to access available, accessible, acceptable, and good-quality sexual and reproductive health" and delete SHR. Please add "gender-based violence SRH.

In 2018, the United Nations Population Fund (UNFPA) and Women Enabled International (WEI) launched "Women and Young People with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights Services." This document was created for service providers and other stakeholders to learn how to improve access to sexual and reproductive health (SRH) and gender-based violence (GBV) services for women and young people with disabilities.

Based on feedback from Organizations of Persons with Disabilities (OPDs) and UNFPA Country Offices, UNFPA and WEI identified a need to support OPDs in further deepening their members' understanding of SRHR and GBV and their systemic engagement with SRHR and GBV service providers.

In 2021, UNFPA and WEI, in partnership with UNFPA's China Country Office, the Shanghai Youren Foundation, and One Plus One Disability Group, developed and piloted a virtual Train-the-Trainer (ToT) curriculum and workshop in China. Rehabilitation International supported this work. In 2022, UNFPA's Botswana Country Office and the Young People with Disabilities Network piloted the virtual training package and an in-person workshop curriculum in Botswana.

Based on learning and feedback from OPDs and workshop participants in these two countries, WEI and UNFPA refined and finalized these two curricula in 2023 to be shared and utilized widely.

UNFPA and WEI would like to acknowledge that these curricula were prepared by WEI. Anastasia Holoboff, Senior Legal Advisor, was the primary author. WEI consultants Alexandra Teixeira, He Jinglin, and Lizzie Kiama helped to write and pilot the curricula. Jane Buchanan, also a consultant, assisted with

finalization, copy editing, and production of the curricula. Sofía Minieri, Legal Advisor, provided expert input at various stages.

This publication was coordinated by UNFPA's Gender and Human Rights Branch/Technical Division, under the leadership of Leyla Sharafi, Senior Gender Advisor, and support of Nathaly Guzman, Technical Specialist on Gender and Disability, and Virpi Mesiaislehto, consultant on disability inclusion. Expert inputs were also provided by staff from UNFPA's Gender and Human Rights Branch/Technical Division, and the Sexual and Reproductive Health Branch/Technical Division. This publication was produced by UNFPA with the financial support of the Spanish Agency for International Development Cooperation (AECID).

Following or in tandem with this workshop, participants are encouraged to review the Guidelines.

This curriculum is specifically designed to be delivered in-person. If facilitators wish to conduct this curriculum virtually rather than in-person, they can refer to the Virtual Facilitation Guide available at: https://womenenabled.org/reports/our-bodies-our-rights-virtual-workshop-curriculum. It is not advised to conduct a hybrid workshop with in-person and online participants at the same time.

WORKSHOP AGENDA

This workshop is designed to be delivered sequentially, with each session building upon the other. Each session is 180 minutes (except for Session 4, which is 225 minutes). This timing is not inclusive of breaks which should be added in regularly. The pacing of the sessions is best determined by the facilitator, depending on the needs and schedule of the group.

Sessions can be broken up as determined best for the group and workshop needs. For example, Day 1: Session 1 and Session 2 (Activity 2A); Day 2: Session 2 (Activity 2B and 2C) and Session 3. It is not advised to shorten the duration of the workshop. It is not advised to change the order of the sessions, although the SRHR and GBV sections can be swapped. There are two optional activities listed in the agenda. These activities are valuable for reinforcing the substantive information learned in the SRHR and the GBV sessions. However, if the group is particularly experienced or has limited time, these activities can be skipped.

Below are some suggestions for how the workshop is best delivered:

1. **Four-Day Workshop:**

- Day 1: Session 1
- Day 2: Session 2 and Session 3
- Day 3: Session 4 and Session 5
- Day 4: Session 6

2. **Six-Day Workshop:** In this case, review session times should be extended to allow for more time to review the information discussed in previous sessions.

- Day 1: Session 1
- Day 2: Session 2
- Day 3: Session 3
- Day 4: Session 4
- Day 5: Session 5
- Day 6: Session 6

3. **One-Week Workshop:** In this case, review session times should be extended to allow for more time to review the information discussed in previous sessions.

- Week 1: Session 1
- Week 2: Session 2
- Week 3: Session 3
- Week 4: Session 4
- Week 5: Session 5
- Week 6: Session 6

Alternatively, it would be suitable to limit the workshop to only one of the subject areas (SRHR or GBV) and limit the duration accordingly. For instance, for a workshop focused on SRHR, the agenda could be:

- Day 1: Session 1 and Session 2
- Day 2: Session 2 and Session 3
- Day 3: Session 3 and Session 6

The following is an overview of the workshop agenda:

Session 1: Overview, Introduction and The Rights-Based Model of Disability	
30 min	Activity 1A: Welcome, Introductions, and Group Agreements
60 min	Activity 1B: Networking to Get Working
90 min	Activity 1C: The Rights-Based Model of Disability

Session 2: What are Sexual and Reproductive Health and Rights (SRHR)?	
15 min	Question and Answer (Q&A)/Reflections from Prior Session(s)
30 min	Activity 2A: What are Sexual and Reproductive Health and Rights (SRHR)?
75 min	Activity 2B: SRHR Key Concepts Quiz *(Optional)*
60 min	Activity 2C: Informed Consent Fishbowl

Session 3: Accessing Sexual and Reproductive Health Services	
15 min	Q&A/Reflections from Prior Session(s)
90 min	Activity 3A: Sexual and Reproductive Health Services
75 min	Activity 3B: Ensuring Services are Available, Accessible, Acceptable, and Good Quality

Session 4: Gender-Based Violence (GBV): What is it?	
15 min	Q&A/Reflections from Prior Session(s)
75 min	Activity 4A: Challenging Myths
90 min	Activity 4B: Power Station *(Optional)*
45 min	Activity 4C: What is Gender-Based Violence (GBV)?

Session 5: Gender-Based Violence and Disability: Deepening our Understanding and Access to Services	
15 min	Q&A/Reflections from Prior Session(s)
45 min	Activity 5A: Gender-Based Violence (GBV) and Disability
60 min	Activity 5B: The Survivor's Journey – Barriers to Accessing Services
60 min	Activity 5C: Improving Access to Gender-Based Violence (GBV) Services

Session 6: Q&A with Service Provider and Closing	
90 min	Activity 6A: Q&A with Medical Provider and Disability Activist
30 min	Activity 6B: Workshop Review – Pass the Ball
60 min	Activity 6C: Evaluation, Reflection, and Closing

WORKSHOP OVERVIEW

PURPOSE

This workshop is designed to be a foundational training for organizations of persons with disabilities (OPDs) to support members to understand and become champions of accessible and inclusive sexual and reproductive health and rights (SRHR) and gender-based violence (GBV) services. It is designed to introduce people with disabilities to key SRHR and GBV topics, language, and concepts but does not go into detail on any one topic. This curriculum is not a Comprehensive Sexuality Education (CSE) curriculum nor a comprehensive gender-based violence curriculum.

It is intended to be delivered by two people, at least one of whom should be a person with lived experience of disability. At least one of the facilitators should have experience facilitating workshops on SRHR and GBV or be a prior workshop participant who have had the opportunity to practice workshop facilitation through a Train-the-Trainer Model. More information about facilitators can be found below, under "Using this Document" and "Workshop Facilitators."

Below, in "Workshop Facilitators," and "Additional Resources," there are a number of helpful resources which can be used to develop facilitation and training skills for those who would like to deliver this training and require more skills in those areas.

This document and accompanying PowerPoint slides detail the curriculum for the virtual workshop. This document is designed to explain to facilitators how to effectively deliver the **Our Bodies, Our Rights! Addressing Sexual and Reproductive Health and Rights and Gender-Based Violence for Women and Young Persons with Disabilities** in person workshop for organizations of persons with disabilities.

PARTICIPANTS

This workshop is designed for 10 participants (plus participants' support persons, should they request a support person to be present them). To ensure the effectiveness of the workshop, we do not recommend proceeding without a minimum of four participants or over 16 participants (plus support persons/personal assistants, who are people who offer necessary support to

an individual, as directed by the individual, to ensure their participation on an equal basis with others).

Workshop participants should be made up of persons with disabilities who meet the following criteria:

Future trainers

As a Train-the-Trainer workshop, this curriculum is designed to be taken by participants who have an interest in becoming workshop trainers themselves in the future. Participants who wish to become future trainers should either have experience facilitating workshops on SRHR and GBV for people with disabilities, or be interested in committing to becoming facilitators by conducting future trainings with the support of an experienced facilitator. However, this workshop is also appropriate for people who are only interested in learning the material and not in becoming trainers.

Participants with basic human rights knowledge

This workshop is designed for people with disabilities who have a basic understanding of their human rights. Unfortunately, many people with disabilities have been denied the chance to understand their basic human rights fully or to see themselves as rights holders. This workshop is not appropriate for them. Ideally, participants should also have a basic understanding of their sexual and reproductive health and rights, and gender-based violence towards women and others but have not necessarily had any formal training on these subjects.

People with disabilities

This curriculum has been designed for participants with all types of disabilities. However, **facilitators should think carefully and consult with OPD members to determine the accessibility needs of participants** and assess if members with similar disabilities/access needs would prefer to participate in a workshop with their peers or in a wider diversified disability group. For example, adaptations to the curriculum materials will be needed to ensure accessibility for deaf-blind participants.

This curriculum has not yet been made accessible for people with intellectual disabilities; to tailor the curriculum to this community we recommend partnering with OPD members with intellectual disabilities to identify how to make the available curriculum accessible through supplementary support

and materials or to adapt the current curriculum to create a localized curriculum for OPD members with intellectual disabilities.[1]

If a participant requests that someone attend as their support person, that person should be welcomed and included in all future communication as requested by the participant. However, participants should be recognized as the primary participant in the workshop. Support people should not speak on the participant's behalf or participate unless requested by the participant for accessibility purposes. This should be emphasized in all communication about the workshop.

Do consider diversity in selecting participants with disabilities, recognizing the intersectional impact of discrimination and marginalization. It is important to ensure that participants from marginalized disability communities are often excluded from capacity-building spaces and SRHR and GBV conversations. They may especially benefit from this workshop.

Women, young people, and gender-diverse people

Because the principal content of this workshop is focused on women and young people[2] with disabilities and addresses topics that can be taboo or sensitive to discuss, it is strongly recommended that only women, young people, and gender-diverse people with disabilities participate in this workshop.[3] This is so that they can feel freer and safer to share their experiences, thoughts, and feelings about relationships, sexuality, and reproductive health care.

When selecting participants to invite, consider the make-up of the group and the most effective mix of backgrounds and identities to foster a safe and comfortable atmosphere for sharing and learning about sensitive topics. For example, ensure separated break-out discussions and tailoring of activities to enable particular cohorts or groups to have the opportunity to engage more directly with people with shared identities.

1 For further guidance on adapting the curriculum for people with intellectual disabilities, please refer to: Inclusion International and Down Syndrome International, *Listen, Include, Respect: International Guidelines to Inclusive Participation*, https://www.listenincluderespect.com/.

2 "Young people" refers to women, men, and those with other gender identities between the ages of 18 and 24.

3 It should be communicated clearly that this training is not for spouses, family members, adult men, or people without disabilities unless explicitly requested and discussed with participant with the disability and for accessibility purposes. Since in many communities, adult men with disabilities have also been excluded from SRHR, facilitators should use their judgment if there are older men who would be appropriate to join the group and how to organize activities and groups accordingly. For example, a 30-year-old male OPD member who is a strong advocate of SRHR and women's rights; who would greatly benefit from this information; would be sensitive to material being discussed; and whom other members of the group would feel comfortable around, could be considered.

Possible configurations could be:

- Young women
- Young women and young men
- Gender-diverse people
- Mixed-age women
- Women over 30 (or whatever age is no longer considered a youth in your community)

USING THIS DOCUMENT

While the workshop is for people with disabilities, this document is for facilitators with disabilities who will be teaching the workshop to their peers with disabilities. It is expected that there will be at least two lead facilitators.

Alternating facilitators helps to keep participant and facilitator energy at the levels required for learning and mutual trust to flourish. It also allows for facilitators to back each other up, partner together to read the group dynamics, and offer a wider range of skills and knowledge. Moreover, it enables effective management of access needs in an in-person setting and allows for support during break-out discussions, which is especially needed given the sensitivity of the curriculum subject matter.

This document contains guidance on how facilitators should go about implementing this **in-person** workshop curriculum and instructions for each session's content and activities. Accompanying this document is a PowerPoint slide deck. Facilitators should read these documents in full before organizing a workshop.

WORKSHOP FACILITATORS

This curriculum was designed ideally for facilitators who meet the following criteria:

- Have experience with facilitation, with an understanding of group dynamics, and adult learning principles.
- Have experience delivering trainings in-person.
- Are knowledgeable about and/or have direct lived experience as a person with a disability and the rights of people with disabilities. **Ideally, all facilitators should have disabilities. However, if this is not possible, at**

least one facilitator MUST be a person with a disability. This curriculum should NOT be delivered by a facilitator who does not have a meaningful understanding of the lived reality of people with disabilities.

- Are knowledgeable about SRHR, including the experiences of persons with disabilities and realizing their SRHR. (This experience can be gained from taking this course previously).

- Are knowledgeable about GBV, including the experiences of persons with disabilities and GBV. (This experience can be gained from taking this course previously).

- For workshops for women with disabilities, at least one of the facilitators should be someone who identifies as a woman.

- For workshops for young people with disabilities, at least one of the facilitators should be someone who identifies as a young person. If the workshop is divided by gender, it is strongly recommended that the facilitator be a person of the same gender.

The above criteria are recommended but not required for all facilitators. Given that many facilitators may not meet all the listed criteria, facilitators should try to work with a partner who has the experience they are lacking, so that together they have the experience required. Additionally, for facilitators who are missing areas of experience, they can seek to improve their understanding of that topic through advanced reading and preparation. For example, one facilitator may be an inexperienced facilitator who previously took this workshop and is a respected member of the OPD community. In this situation, the two facilitators should set aside time in advance of the workshop to work closely together to prepare, to practice facilitation skills, and to seek out additional learning opportunities and resources.

Globally, many people with disabilities have been denied the opportunity to develop facilitation skills. Therefore, we recommend OPDs and other stakeholders – for instance, the organization supporting the workshop – invest in one or more of the following training programs to support OPD members to develop the skills to facilitate this curriculum, or, develop their own training session(s):

- Training on facilitation and/or Training-of-Trainers. See:

  - International Disability Alliance (IDA), Bridge CRPD-SDGs Training Initiative Training of Trainers

- Mobility International USA (MIUSA), Loud, Proud and Passionate! An Innovative Rights-Based Facilitator's Guide for Leadership Training of Women with Disabilities
- Ipas, Effective Training in Reproductive Health: Course Design and Delivery. Reference Manual
- Training for Change, Training Tools
- Council of Europe, Compass: Manual for Human Rights Education for Young People

- Studying key resources on sexual and reproductive health and rights and gender-based violence and clarifying any questions they have about the content with a subject matter expert. See:
  - UNFPA and WEI, Women and Young Persons with Disabilities Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights for Women and Young Persons with Disabilities
  - UNFPA, Young Persons with Disabilities: Global Study on Ending Gender-Based Violence and Realizing Sexual and Reproductive Health and Rights
  - World Health Organization (WHO) and UNFPA, Promoting Sexual and Reproductive Health for Persons with Disabilities
  - UNFPA, UN Women, WHO, United Nations Development Programme (UNDP) and United Nations Office on Drugs and Crime (UNODC), Essential Services Package for Women and Girls Subject to Violence
  - WEI, Fact Sheet: Sexual and Reproductive Health and Rights of Women and Girls with Disabilities
  - WEI, Fact Sheet: The Right of Women and Girls with Disabilities to be Free from Gender-Based Violence
  - The Inclusive Generation Equality Collective, Feminist Accessibility Protocol
  - Contact Women Enabled International or your local UNFPA Regional or Country Office for further resources in accessible formats.

APPROACH

This workshop curriculum is designed to make the concepts of sexual and reproductive health and rights (SRHR) and gender-based violence (GBV) tangible and accessible to women and young persons with disabilities to build participants' confidence to conduct advocacy in these areas.

This curriculum aims to create a supportive process for achieving the workshop goal by intentionally:

- Breaking down the concept of "rights" and making it relatable to participants' lives.
- Explaining and reinforcing the rights-based model of disability throughout the workshop.
- Strengthening participants' understanding of sexual and reproductive health and rights (SRHR).
- Strengthening participants' understanding of gender-based violence (GBV).
- Creating opportunities for participants to connect to one another and build enough trust as a group that they can surface vulnerable issues and questions.
- Creating enough safety throughout the workshop that participants feel free to ask questions that help them make meaning of the content in the context of their lives.

PREPARING FOR THE WORKSHOP

Facilitators should take the following steps to prepare to give this workshop to participants:

1. Review this document at least once in its entirety. Then, identify areas where you need further clarity. This could include:
    - The content of SRHR, GBV, or any of the concepts presented in this curriculum.
    - The methodology or activities for delivering the content.

- Any technology being used in a session (PowerPoint; video, microphones).
- Availability and funds for transportation, facilities, and accessibility mechanisms necessary for the workshop.
- Availability of accessible support services, or appropriate alternatives, to refer participants who have experienced violence, harm, or adverse sexual and reproductive health outcomes.

2. Make a plan for clarifying anything you don't understand by consulting with subject matter experts or experienced in-person facilitators in your organization or community, or by reaching out to Women Enabled International or your local UNFPA Regional or Country Office.

3. Prepare for each session by reviewing each activity and, where necessary, adapting questions, statements, examples, or case studies to be more reflective of the realities of your participants. This could include researching local statistics, surveying local organizations, or asking participants themselves for examples. It could also include changing the names of case study characters or locations to better evoke the local context. **Feel free to replace curriculum case studies with local examples**.

TIMING AND BREAKS

Breaks are essential to ensuring sustained engagement and learning, as well as the overall accessibility of the workshop. It is suggested to include breaks in the agenda every 90 minutes. Keep to time in the agenda, as participants may have planned their bathroom, rest, or medication breaks around the pre-circulated schedule. Inform participants that they may leave when necessary to address their needs. Allocate additional time for coffee and lunch breaks. For example, consider 30-minute breaks instead of 15 minutes, or 75-minute lunches instead of 60 minutes. Avoid very early start times and late ending times when possible.

Depending on the needs, group size, and make-up of the participants, facilitators should adjust, shorten, and extend the breaks and the agenda accordingly, with engagement from participants. For example, if you have a group without accessibility needs that require breaks, then you may wish to agree collectively to shorten breaks. However, if you have a group with mixed accessibility needs and multiple interpreters, you may need to build in more breaks to accommodate the needs of participants and interpreters. It is advised to include a question about break and lunch break lengths in the

pre-workshop survey (see below). It is acceptable to extend the workshop duration to accommodate extended or additional breaks.

WORKSHOP ROLES

We recommend that each workshop has designated point people playing the following roles. Having enough facilitators and support people is critical to both creating an effective learning environment and ensuring accessibility and safety.

Two lead facilitators

We strongly recommend having two lead facilitators to deliver the workshop. The co-facilitator team can be made up of two highly experienced facilitators or one experienced facilitator and one developing facilitator. The two facilitators should both be responsible for — and where appropriate divide up — the following responsibilities in ways that work for each unique co-facilitation team:

- Both facilitators should be engaged and prepared to facilitate all sessions.
- Ensure the workshop space is appropriately set up, ensure the availability of markers, erasers and other relevant materials needed for the workshop.
- Prepare and adapt activities to best suit the anticipated workshop audience.
- Prepare and adapt the session guide for each activity and review it with the production manager in advance.
- Set the tone for the workshop by being warm and open with participants and respecting participants' time.
- Identify ways to adapt the workshop from session to session in response to participant needs and feedback.
- Connect themes across the workshop sessions.
- Be prepared to step in if something unexpected arises with your co-facilitator, participants, or otherwise.

Production manager

The production manager is responsible for all the logistics in advance of and during the workshop. We strongly recommend that this person have experience in disability rights and accommodating accessibility needs. The production manager should:

- Coordinate participants' travel and accommodation needs.
- Coordinate participants' access needs.
- Coordinate the venue and ensure accessibility.
- Organize any food or beverage offered to participants during the workshop and coordinate dietary restrictions.
- Organize and test audio and visual equipment.
- Support facilitators with the preparation of the physical environment and workshop materials to ensure the workshop is accessible and user-friendly for participants.
- Manage access-related components such as sign language interpretation, language interpretation, assistive device needs, etc.
- Print and arrange physical workshop material and ensure accessibility.
- Support audio-visual needs as required, for example, by playing a video used in an activity.
- Support participants with any issues during the workshop.

Support facilitators

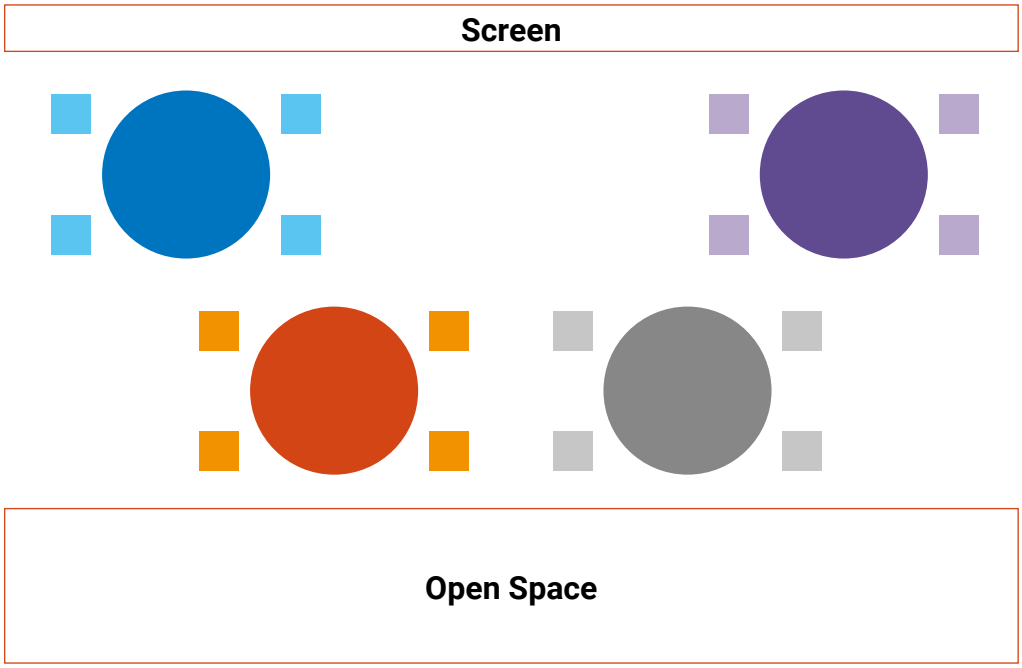
Preferably, there should be additional support facilitators who can play a support role in breakout groups. These should be OPD members or members of the organization hosting the workshop (providing the latter will not negatively affect the group dynamics). The number of support facilitators needed depends on the size of the group. Ideally, there should be enough support facilitators so that every breakout group has a facilitator with them. Their role is not to facilitate content or discussions but rather to serve as a notetaker, support any challenges in the breakout groups and generally support accessibility. They can also serve as back-up and support the production manager as needed.

On standby: social worker, psychologist, or other trained GBV counselor

If possible, workshop organizers should budget for and arrange to have a trained GBV counselor, social worker, or psychologist on standby to provide support for any participant who has experienced GBV. Ideally, this person should be trained or experienced in providing support for persons with disabilities and have access to confidential interpretation services. At a minimum, workshop organizers should provide participants with a list of available and accessible resources to provide support to participants who may need it. See Appendix 1: *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* Document Example.

ROOM ARRANGEMENT

- For in-person facilitation, the preferred room set up is round tables seating three to five participants per table. Alternatively, a horse-shoe configuration is also effective. Tables should have adequate space between them, accommodating any participant/facilitator accessibility needs. Ideally, there would also be a large open space for activities, allowing participants to move about freely. See the image below for a visual of the round tables set-up.



ENSURINGANACCESSIBLEENVIRONMENT

Meaningful accessibility is key to the success of this workshop. To ensure accessibility for both the individual participants and the workshop environment, the following steps are required:

1. **Ensure all text is accessible (for example, invitation text, PowerPoint text, activity instructions, questions, handouts)**

   - Use clear language. Do not use jargon, avoid acronyms or spell them out, and use plain, simplified language.

   - Send out all workshop information, documents, and presentations in accessible formats. If sending out something that may not be accessible to everyone (for example, a PDF document), offer alternative accessible formats (for example, Word).

   - Send out all workshop information, documents, and presentations in advance and as early as possible. Identify the best way to deliver this information. For example, for some groups, WhatsApp may be better than email. Some participants may need longer to read documents or to plan their attendance. Some participants' disabilities may limit their ability to read a document received during a workshop. Other participants may need to arrange assistance to support their attendance or review the materials.

   - If any facilitators or participants with visual impairments read Braille, consider working with these participants in advance to identify any activities that will take place away from the computer or which they are facilitating and produce these instructions in Braille or another accessible format.

   - Formatting: Use size 12- to 18-point typeface, use sans-serif fonts, and ensure adequate spacing between lines. For greater readability, use bold rather than italics or uppercase text, use left-justified text rather than fully justified text, and use high contrast colors, such as black on white.

2. **Accommodate access needs (provide reasonable accommodations)**

   - Prioritize, budget, and plan for participants' reasonable accommodations or access needs.[4] Access needs may include funds

4 Reasonable accommodations are individual accessibility needs. Reasonable accommodations are requested, while accessibility measures are put in place automatically to ensure general access and communicate that a space is inclusive. For more information, see Committee on the Rights of Persons with Disabilities, General Comment No. 2 (2014) Article 9: Accessibility, paras. 25-26, U.N. Doc. CRPD/C/GC/3, https://bit.ly/2YGof90.

to hire a support person or an interpreter; accessible travel; sign language interpretation; CART captioning; additional breaks; note taking; assistive devices; Braille materials; soft copies of documents; large print.

  - Be transparent about the workshop budget and its limitations. If you are unable to provide reasonable accommodations, discuss it with the participant and be creative in how to address the access need within your constraints. Do not rescind the invitation or request the person attend without their required reasonable accommodations.

- Ask participants if they have any access needs well in advance of the workshop and throughout the workshop.

  - Solicit access needs as part of the initial invitation and ensure participants know how to make such requests. Include contact information for participants to request further information on accessibility and to request reasonable accommodations. For example, "For questions about accessibility and to request reasonable accommodations, please contact..."

  - At the start of each new workshop day, give participants an opportunity to share any changes in their access needs. For example, "Before we get started for the day, I want to take a moment to ask if anyone has any access needs they would like to share to make today more accessible to them." Participants should be able to make such requests privately with the facilitators, if they prefer.

  - Remind participants who use screen readers to bring their computers, chargers, and any other accessibility devices with them to the workshop. If possible, have devices available to loan participants during the workshop. Ensure that there are plug points available for participants to plug in their computers or accessibility devices during the workshop.

3. Offer language translation, as needed

Budget for and provide verbal language and/or sign language and/or captioning language translation as required.

4. Provide economic support, when possible

Offer participants stipends to cover costs related to their time, transport costs, childcare needs, and/or access needs such as a support person.

5. Ensure all facilitators, organizers, interpreters, and participants engage respectfully

- All participants, regardless of their disability, should be treated as entirely capable of autonomous decision-making and making valuable contributions to the workshop.
- Communicate directly with the participant, and not their support person or interpreter.
- Work with both sign and verbal language interpreters in advance to ensure they are using respectful language and have respectful attitudes.
- Do not make assumptions about a participant's capabilities or intellectual capacity.

6. Adapt your facilitation to create an accessible environment

Conduct an accessibility audit of the venue in advance. Consider and prepare to implement the following recommended practices to ensure accessibility as needed.[5]

- Physical Access: Ensure that both the venue and overnight accommodations offered are physically accessible to all participants to ensure that everyone can move around the space in a dignified way. Do not assume that just because a facility is advertised as accessible that it is accessible. If offering overnight accommodation, ensure that all participants can stay in the same location regardless of their physical access needs. Review all activities to ensure that there are no access barriers and that adaptations are made as necessary to ensure the full participation of all participants. The space should have the following:
  - Room to accommodate personal assistants, interpreters, captioners, mobility and assistive devices in multiple locations.
  - Accessible speaking area and podiums that can be raised and lowered for speakers using wheelchairs, little persons, and those unable to stand for long periods.
  - Ramps at every door. These ramps should not be too steep.

5 Adapted from *Loud, Proud and Passionate!: An Innovative Rights-based Facilitator's Guide for Leadership Training of Women with Disabilities*, Mobility International USA (MIUSA) (2016), https://www.miusa.org/resource/books-and-journals/lppfaciliatorsguide. See also Women Enabled International (WEI), Access: Good Practices International Meeting Checklist (2020), https://www.miusa.org/resource/books-and-journals/lppfaciliatorsguide/.

- Doorways wide enough for participants in wheelchairs to comfortably pass through.
- Reconfigurable furniture, with plenty of room around tables for participants using wheelchairs to move freely, choose their preferred seating location, and sufficient space for a translator booth and interpreters.
- Accessible restrooms on the same floor as the meeting space.
- Service animal relief areas.
- Accessible emergency evacuation route.
- Have a projector and screen that is easily viewable by all participants.

- Visual Access:
  - Ask participants with visual impairments to bring their laptops or supply enough laptops with screen reader programs as needed to enable breakout groups (consult with any participants with visual impairments in advance).
  - Read and describe everything that takes place on the screen. Instead of referring to a photo, a chart, or an object on the slides as “this” or “that,” name it and describe the content. For example, the left photo is an empty chair, and the right photo is a bucket of red apples.
  - Only use videos with audio descriptions. If it is not possible to obtain a video with an audio description, and the use of the video is necessary, visually impaired participants can be provided with a screen-reader accessible text of the video description in advance, or with a personal assistant service for audio description.
  - When participants react visually, describe what is happening (for example, how many people are raising their hands, multiple group members shaking their heads to mean “no”).
  - Encourage and remind participants to say their names when speaking, which can help all participants know each other by remembering their names and/or voices.

- Auditory Access:
  - Ensure that quality sign language interpreters are available, if needed. Hire at least two interpreters to ensure that interpreters are getting regular breaks throughout a session.
  - Make sure presenters are well-lit and lips visible to participants. Ask presenters to wear bright colors with minimal patterns.
  - Share materials, including any videos that do not have captioning or embedded sign interpretation, with sign and other language interpreters in advance.
  - Wait until sign language interpreters or captioners are ready before speaking and check in with sign language interpreters and participants to ensure that the pace of your communication meets their needs.
  - Organize breakout groups in advance and coordinate with sign-interpreters to ensure that breakout groups that require interpretation are not delayed, or without interpretation.
  - Have multiple microphones available and a high-quality sound system, such as at least two portable microphones for a group of eight people.
- Verbal Access:
  - Ensure that all presenters speak slowly and leave time to repeat themselves as needed.
  - If a person's speech is hard to understand, do not hesitate to politely let a participant know that you don't understand what they are saying and allow them the opportunity to repeat themselves or communicate in writing if they prefer. Give more time to allow the participant to express themselves. Do not try to finish the participant's sentences.
- Learning Access:
  - Provide the content of your presentation ahead of time so that the participants can review before the workshop.
  - Regularly offer to repeat things if needed and offer participants a way to request a concept be repeated or explained in a different way.

- Sensory Access:
  - Be a scent-free environment, as much as possible. Ask participants and venue maintenance to use scent-free products to accommodate those with chemical sensitivities and for participants to refrain from using perfumes.
  - Have a well-lit environment with even lighting throughout. Adjust the brightness and the fluorescence of the lighting as needed for any participants with sensory disabilities.

ENSURING A SAFE AND SUPPORTIVE ENVIRONMENT

As this workshop pertains to sensitive topics, it is essential to create an environment where all participants feel safe and comfortable sharing. To do so, ensure the following steps are taken:

1. Conversations about SRHR and GBV may bring up traumatic memories or lead to a participant identifying an experience as a violation for the first time. A safe environment requires ensuring participants have access to disability-inclusive counseling in such instances. If possible, budget for and arrange to have a trained counselor, social worker, or psychologist on standby, as noted above. Prepare in advance a list of local counseling resources, as well as resources to report gender-based or sexual violence or other rights violations, to refer participants to as needed. See Appendix 1 for an example of such a list.

2. Consider the accessibility of each resource, if available. Recognizing that many services are inaccessible, consider identifying any OPD or related programs that can support a person accessing services. Distribute this list in advance and remind participants each day of the availability of this resource, particularly in a session that has brought up difficult subjects.

3. Establish a group agreement of confidentiality/privacy that assures participants that what they say will remain confidential (see Session 1). Participants may want to consider agreeing to keep the names of fellow participants private. Remind participants of their group agreement at the start of each new workshop day.

4. Remind participants regularly that they do not have to share any personal information that they do not wish to disclose with the group.

5. Ensure that images and videos used throughout the workshop feature a diverse group of people in terms of race, age, gender, disability, etc.

PREPARING PARTICIPANTS PRIOR TO THE WORKSHOP

To create an effective learning environment, we recommend taking the following steps to prepare participants for the experience:

1. **Prioritize accessibility**

   - Ensure that participants know that their disability-related needs will be accommodated and that they feel empowered to ask for what they need to fully participate in the workshop is essential to the success of the workshop.

   - It is critical that people with diverse disabilities are engaged from the planning stage and that disability access needs are prioritized and included in the budget.

2. **Clearly communicate the criteria for participation in this workshop**

   - A basic understanding of their rights.

   - Commitment to participate in all workshop sessions.

   - Commitment, to the fullest extent possible, to refrain from doing other work or activities during workshop sessions in ways that would divert their attention away from the workshop.

3. **Identify and recruit a service provider(s) for Session 6**

   The last session in this curriculum features a Q&A session with a local service provider or providers. This culminating activity is an opportunity for participants to apply and deepen their awareness of SRHR and/or GBV. It's also an opportunity for participants to have a positive experience with a service provider and to engage in a dialogue about accessible services to benefit both the provider(s) and the participants. To serve this purpose, the service provider(s) selected should be existing champions of disability inclusion or better yet, a provider with a disability.

   If this type of service provider isn't readily available, it could also work to find someone with an openness to learning and who is interested in

becoming a disability inclusion champion. In this case, the Q&A can be more of a mutual learning session where the provider brings SRHR and/or GBV knowledge and expertise, and the participants bring expertise on the lived experience of people with disabilities to share with the provider. If this is the profile of the participating provider, be sure to share information on disability rights and accessible services with the provider in advance.

4. **Send out invitations to the workshop and reminders in advance**

   - Send out invitations to confirm the participant list at least two to three weeks in advance of the workshop, if possible.

   - Send out corresponding calendar invitations and reminders in the most effective way for the group, such as via email, messaging (such as WhatsApp; Text, Facebook Messenger), social media, or in other accessible ways.

   - In invitations and reminders closer to the time of the workshop, encourage participants to arrive 5 to 10 minutes before the workshop so that they have time to resolve any technical issues and enable everyone to start on time.

   - Remind participants that we have made every effort to make this workshop as substantive as possible in a relatively short amount of time, so every minute will count!

5. **Provide funding, as needed, for transport and accommodation needs to maximize participation and attendance.** Be clear about who is the responsible party for the budget and associated questions. Share adequate information with participants.

   Budget for the following for participants and their support people:

   - Transport to and from the workshop.

   - Accommodation. Even if a workshop is in a participant's hometown, they may require accommodation at the venue to be able to participate fully, for example due to inaccessible transport).

   - Support persons for participants with disabilities. They will require their own plane tickets, meals, possibly a separate hotel room, etc.

   - Budget for and plan for reasonable accommodations. For example, printed materials in large font; accessible hotel rooms; accessible transportation.

- Budget and plan for interpretation. If a participant requires sign language interpretation, two interpreters must be provided in the type of sign language the participant uses. It is never acceptable to only hire one sign language interpreter for meetings lasting longer than one hour.

- If budget allows, consider offering an honorarium for workshop attendance.

6. Send out a pre-workshop survey two to three weeks prior to the workshop

An example pre-workshop survey form can be found in Appendix 4. The purpose of the pre-workshop survey is to provide facilitators with a baseline sense of the participant's access needs, knowledge, attitudes, hopes, and hesitations about the workshop, so that they can be accommodated, considered, and recognized in the workshop.

The survey should also serve as a baseline assessment for comparison against the post-workshop survey to demonstrate whether the workshop has achieved its intended goals. This workshop survey should be administered in-person using physical copies or a survey application such as Google forms or other locally used applications of this type. Participants should also have the option to submit their answers via email, in a Word document or by phone to someone who will not be a facilitator or production manager in the workshop.

For those who did not respond in advance to the pre-workshop survey, the survey can be administered the day of the workshop.

7. Conduct a practice session in advance of the in-person workshop

Conduct a practice session with all facilitators, the production manager, and any additional support people. Conduct a run-through of the following:

- Using the projector
- Screening videos
- Using the microphones
- Activities with substantial materials/physical needs.

- Accessibility of all spaces to be used in the workshop, including the bathrooms, break areas, and lunchroom.

8. **Consider creating a WhatsApp Group (or equivalent) for the workshop team so you can have an alternate means of communication during the workshop**

   This can be used to troubleshoot or to send messages to participants if something needs to change course or people need a reminder to return from a break.

9. **Plan for participants to complete a post-workshop survey and evaluation form either in the last session or immediately following the workshop**

   An example post-workshop survey and evaluation form can be found in Appendix 5. Follow-up after the workshop provides valuable closure and learning opportunities for both participants and the workshop facilitators and hosts. The post-workshop survey can be compared with the pre-workshop survey responses to evaluate learning objectives and the evaluation provides feedback to the workshop hosts and facilitators that can be used for continuous improvement.

   Prior to the workshop, schedule with participants who will need to fill out the survey and evaluation by proxy/interview so that you don't lose momentum after the workshop trying to schedule with people.

APPENDIX RESOURCES

The following materials, available in the Appendices, may serve as resources for you and the participants as needed.

1. Sexual and Reproductive Health and Gender-Based Violence Referrals and Support Document Example
2. Glossary: List of Key Terms and Definitions
3. List of Key Resources
4. Pre-Workshop Survey Example
5. Post-Workshop Survey and Evaluation Example
6. Certificate of Completion Example

SESSION 1

OVERVIEW, INTRODUCTION & A RIGHTS-BASED MODEL OF DISABILITY

Session Purpose

The opening session is an opportunity to set a welcoming tone, provide participants with an overview of the workshop and build opportunities for connection and trust amongst participants so that they can participate meaningfully and safely in the activities to come. Along with a review of the purpose and agenda for this workshop, this session also provides an overview of the rights-based model of disability which serves as a key foundation for the workshop.

Session Objectives

By the end of this session, participants will have:

- An understanding of the purpose of the workshop.
- A familiarity with one another and the environment.
- A shared understanding of the social and rights-based models of disability.

Session Outline

Session 1: Overview, Introduction & A Rights Based Model of Disability	
30 min	Activity 1A: Welcome, Introductions, & Group Agreements
60 min	Activity 1B: Networking to Get Working
90 min	Activity 1C: Rights-Based Model of Disability

ACTIVITY 1A: WELCOMING REMARKS, FACILITATOR INTRODUCTIONS, WORKSHOP OVERVIEW & GROUP AGREEMENTS

Duration

30 minutes

Supporting Materials

- PowerPoint slides 1 to 7
- Flipchart paper, flipchart stand, and markers

Advance Preparation

- Review and adapt the PowerPoint slides for this session as needed. You should also feel empowered not to use a PowerPoint if that is more accessible to you.
- Prepare a flipchart with a few suggested group agreements or practice editing the PowerPoint slides.

Instructions

1. You may choose to have some calmly energizing local music playing as participants enter the space. **Slide 1**.

2. Facilitators greet participants, if possible, by name, as they enter the room. Have name badges and/or table notecards available with participants' names on them so that facilitators can easily identify participants. For facilitators with visual impairments, they can be guided by assistants to actively greet each participant for introductions.

3. Facilitators introduce themselves and ask if anyone has any access needs. You should ask this at the start of each day. **Slide 2.**

   Sample script on access needs: "To ensure that this workshop is fully accessible to everyone, we are going to start each day by checking in on any new access needs anyone has to participate as best they can in the workshop. This may be related to your disability, or it may not. For example, you may be having challenges with your eyesight today and

require extra-large font, or for text to be read out loud to you today, or you may have a childcare issue and need to answer your phone if it rings."

4. Invite the host organization representative or facilitator to formally welcome participants and provide a few opening remarks about why they are hosting this workshop. Facilitators should explicitly state that comments should last no longer than two minutes. Keep comments limited to avoid losing the momentum of the workshop.

5. Facilitators share the purpose of the workshop using either the description below or their own words. **Slide 3.**

Purpose of the Workshop

The purpose of this workshop is to explore topics related to our bodies, relationships, sex, pregnancy, and violence. Many of the topics we will discuss can be considered sensitive or taboo, and this will be a space to explore them safely and without judgment. As we know, many people with disabilities are denied their basic rights when it comes to their sexual and reproductive health, and freedom from violence. Through this workshop, we seek to help you gain the knowledge you need to feel confident in understanding your rights under international law and advocating for your rights and your communities' rights in your country.

We want to support you in building your confidence to engage in advocacy to improve sexual and reproductive healthcare — like maternal health or family planning services — and gender-based violence services — like rape crisis centers or the police. These services are critical to realizing our rights as people with disabilities, and we hope that through this workshop you will gain the knowledge and confidence you need to be able to advocate for making these services more accessible to people with disabilities.

6. Review the agenda for the workshop and the day and explain the referral list. Ask if participants have any clarifying questions about the purpose or the agenda. **Slides 4 and 5.**

7. Invite participants to introduce themselves by answering the following questions. **Slide 6.**

   - What is your name?
   - Describe your appearance today.

- What organization of persons with disabilities/networks/communities are you a part of?

- What is your favorite food and why?

8. Transition now to developing group agreements. Explain that for this workshop to be successful, we will need to create a safe and supportive learning environment. Prepare a flipchart in advance with a few of what you consider to be the most important group agreements and see if the participants agree with them. Leave space at the bottom for participants to contribute additional agreements. Present one to three of these pre-determined suggestions to begin. **Slide 7.**

    - **Keep what we learn about each other confidential.** Explain that participants are free to share the general information that they learn in this workshop with others, but that they should keep any personal information and stories shared confidential.

    - **Challenge yourself to participate and share**. Explain that the success of the workshop depends on the participants' participation and sharing. Each participant is enriched by hearing about and learning from other participants' opinions and experiences. Expect that all participants are committed to creating a safe and inclusive environment and equal participation.

    - **Listen attentively and respond non-judgmentally.** It is critical for all participants to pay attention to what others say and express during the workshop without being judgmental. It is also equally important to respect each other's opinions and respond with decency even when you disagree strongly.

    - **Ask for help if you need it.** Explain to participants that if one person is having trouble understanding a new concept, others in the group may be too. Asking questions can help ensure that everyone fully understands the information that is being covered in the workshop.

9. Ask participants: **What other agreements do you recommend for making this a safe and supportive learning environment?**

10. Add participant contributions to the flipchart list. After you have a satisfactory list, confirm whether everyone consents to these agreements. **The confidentiality agreement is required for all participants to follow.** Ask if there are any other agreements anyone feels they cannot agree to. If there are, refine or delete the agreement. Thank participants for working together to create a safe and supportive learning environment.

ACTIVITY 1B: NETWORKING TO GET WORKING

Duration

60 minutes

Supporting Materials

- PowerPoint slides 9 to 15

Advance Preparation

- Ensure there is a large open space without obstructions so participants can move around and form pairs.
- Adapt the networking questions if necessary.
- Consider whether it is better to adapt the activity to keep participants in the same pair for all three networking rounds instead of switching pairs for three rounds as the activity is designed. An adapted approach of providing all three questions up-front for one large group conversation is preferable if:
    - You know or sense that most participants will feel more comfortable deepening their rapport with just one other person rather than talking with three different people at this early stage of the workshop.
    - If the diversity of disabilities in the room means that participants would be more comfortable with less moving around.
- Based on your knowledge of the participants, consider pre-assigning each round of pairs to ensure accessible sharing and impactful networking between participants.

Instructions

1. Explain that we are going to start to get to know each other and explore the themes of the workshop through a short networking activity. Provide the following instructions: **Slides 10 to 11**.

- We are going to divide into pairs. In your pair, you will have just 5 minutes to answer the question we've provided.
- After the time is up, we will call your attention back to the front of the room and we will ask you to find a new person to pair up with. We will give you a second question to discuss with your new partner.
- We'll do the same thing again for the third question, and you will find another new person to pair up with to respond to the question.
- The questions will be on the screen for your reference during the activity and facilitators will be circulating to read them aloud to you.

2. If there is an uneven number of participants, explain that there will be one group with three people in it.

3. Ask if participants have any clarifying questions and answer them before beginning.

4. Share the first question in the following ways:

- Show the PowerPoint slide
- Read it out loud

5. Have participants divide into pairs for a five minute round. Announce when there is one minute remaining.

6. Repeat steps four and five for the next two rounds.

7. Repeat steps four and five for the next two rounds.

Networking questions

Round 1: What messages do people with disabilities get about dating and marriage? **Slide 12.**

Round 2: What messages do people with disabilities get about having children? **Slide 13.**

Round 3: What messages do people with disabilities get about sex and sexuality? **Slide 14.**

8. After the three rounds have been completed, ask people to return to their seats if they have moved. Use the following question to prompt a short discussion: **Would anyone like to share what messages they discussed?**

9. Link some of the messages that participants shared to the following **key messages: Slide 15.**

   - As people with disabilities, we often receive negative messages and are excluded from conversations about relationships, having children, and sexuality.

   - Everyone, including people with disabilities, has a right to decide for themselves whether to get married and have children; to access sexual health services and information about sexuality; and everyone has a right to be free from violence.

   - In this workshop, we will explore these topics together, learn from each other, and correct some of the inaccurate information you may have heard and offer information you may not have received.

   - Facilitators may wish to consider doing a "Values clarification for action and transformation" (VCAT) exercise also at this point to encourage participants to explore their assumptions about abortion and improve participants' knowledge about safe abortion care (where legal). VCAT can also be used across other areas, on sensitive or stigmatized topics, to improve individual's awareness of their own biases and prejudices and how these limit access to SRHR. There is specific programming relevant to people with disabilities.[6]

6 Ipas, "Abortion values clarification for action and transformation (VCAT), https://www.ipas.org/our-work/abortion-values-clarification-for-action-and-transformation-vcat/.

ACTIVITY 1C: UNDERSTANDING THE RIGHTS-BASED MODEL OF DISABILITY

Duration

90 minutes

Supporting Materials

- PowerPoint slides 16 to 26
- If accessible, paper and pens (enough for all participants who will use).

Advance Preparation

- If you decide to use the video on **Slide 17**, "People with Disability Australia, The Social Model of Disability," review it in advance.
- Consider whether to create pre-assigned small groups to ensure maximum accessibility for participating in the activity. If you decide to pre-assign the small groups, also consider whether to sort groups by gender and/or age.
- Research if the country where you are doing the workshop has ratified the Convention on the Rights of Persons with Disabilities (CRPD).

Instructions

1. Transition from Activity 1B into this activity by sharing that you are now going to explore a model, or way of thinking about disability, that may be familiar to some and new to others.[7] **Slide 16.**

2. If you are using the video on **Slide 17:**

   - Play the video: https://www.youtube.com/watch?v=s6wavnGIR3w
   - Lead a full group discussion of the video:

     - **What are your reactions to this video?**
     - **What models of disability do you see reflected in your community?**

7 Adapted from Ipas, "Disability Inclusion in Reproductive Health Programs," 2021, https://www.ipas.org/wp-content/uploads/2021/06/VCATDSE21-Disability-inclusion-in-reproductive-health-programs.pdf.

3. If you are not using the video, lead a full discussion using the following questions:

   - **Has anyone ever heard of the medical model or the charity model of disability? If yes, can you explain your understanding of the model to the group? It doesn't have to be a perfect answer. We are learning together.**

   - **Has anyone ever heard of the social model or the rights-based model of disability? If yes, can you explain?**

   - **Which model makes the most sense to you?**

4 Presentation of the Two Models: Present the medical and charity models of disability and then contrast them with the social and rights-based models of disability. Explain that the medial/charity models and the social/rights-based models are each combined here for the purposes of simplification and because they often occur at the same time, but they are slightly different.

   - Medical and charity models of disability: **Slides 18 and 19.**

     - **Focus:** The individual and their impairment.

     - **Attitude:** People with disabilities need support and care as an act of charity. Disability is a medical problem that should be treated as other medical problems and eradicated when possible.

     - **Goal:** Cure or improve the individual and help them fit into society.

   - Social and rights-based models of disability: **Slides 20 and 21.**

     - **Focus:** Society and the built and social environments

     - **Attitude:** Social practices and built environments are disabling. People are disabled by society's denial of their rights, access, and opportunities.

     - **Goal:** Identifying and removing attitudinal, environmental, and institutional barriers to inclusion.

5. Explain, as needed:

   - The medical and charity models of disability are old and often harmful ways of thinking about disability. However, they are still the main way of thinking of disability in most communities. The medical/charity

model orientation sees the person with the disability as the "problem," and thus the focus is on adapting the individual to fit the existing environment and social norms. For example, if a person is born with a hearing impairment, the focus on that individual and the money spent by the government goes mostly towards "fixing" the impairment through hearing aids and devices, and research on preventing hearing impairments. The goal is, therefore, to cure or improve the individual and help them fit into society by "normalizing" their bodies and minds as much as possible.

- A rights orientation rightfully focuses on how a person is disabled by the environment they interact with rather than on the individual themselves. This means the focus shifts to addressing how social practices, including stigmatizing attitudes and policies, and the built environments are disabling, and how people are disabled by society's denial of their rights, access, and opportunities rather than on the person with a disability needing to change. For example, a person born with a hearing impairment is offered information about hearing aids and devices, but not pressured to use one, and is also offered the opportunity to learn sign language and engage with the hearing-impaired community. Relatedly, the government invests in strong accessibility mechanisms and requirements, such as captioning, sign language, and visual aids. The goal is, therefore, to identify and remove attitudinal, environmental, and institutional barriers to inclusion with a focus on how it is everyone's responsibility to remove access barriers.

6. Explain that the Convention on the Rights of Persons with Disabilities (CRPD) reflects the rights-based model of disability. **Slides 22 to 23**.

- The CRPD is a United Nations international agreement between countries where the parties agree to respect and ensure the rights in the document. This means if your country has ratified it, they have an obligation to translate the rights in the CRPD into your local laws and policies.

- The CRPD is the first international treaty on the rights of persons with disabilities. It was adopted in 2006.

- It includes articles protecting many intersecting rights, including: Article 6: Women and Girls with Disabilities; Article 16: Freedom from Exploitation, Violence, and Abuse (which includes gender-based violence); and Article 25: Health (which includes the right to sexual and reproductive health).

7. Ask participants if they have any clarifying questions about the models and take some time to answer or discuss their questions.

8. Explain that we will now practice applying the model. Let's consider how different models are reflected in the following example. **Slides 24 to 25.**

Fatima is a 24-year-old woman from a big city. Fatima has a visual impairment. She has decided that she wants to stop using condoms with her long-term boyfriend. She does not need to use condoms for [sexually transmitted infection [STI] and HIV prevention, as she is in a monogamous relationship, and she and her boyfriend have both been tested for STIs. She wants to learn about other forms of birth control. She visits the local women's health center as she heard they can help with getting contraceptives.

When she arrives, Fatima cannot figure out which floor the office is on because there are no auditory, digital, or braille directions. She has to ask the male security guard where to go. When she arrives at the office, the receptionist tells her that there is a disability services office down the road. Although Fatima explains that she knows she is in the right place, the receptionist refuses to allow her to see a nurse. After she explains her reason for being there, the nurse asks her if she should be having sex, and if she had ever considered sterilization. Fatima felt so defeated by the experience that she left.

9. After the example has been read, ask the group:

- **What are your reactions to this example?**
- **What different models can you see reflected in this example?**
- Additional prompt questions, as required:
  - What model can we see reflected in the physical barriers she experienced? How would a rights-based approach change this physical space?
  - What model can we see reflected in the attitudinal barriers she experienced? How would a rights-based approach change her access to the health center?

10. Close this activity and this session with the **key messages** below. As always, try to link the key messages to the contributions participants made throughout this session. **Slide 26.**

- This workshop is based on the rights-based model of disability.

- As we discuss the topics of this workshop, we will approach these discussions with the rights model in mind.
- What are the barriers, how are they created by the medical/charity model, and how can we think about dismantling them using the social/rights-based model?
- We will encourage each other to focus on how society and services can be more accessible, not on how individuals can better fit into inaccessible situations and environments.

SESSION 2

WHAT ARE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)?

Session Purpose

The purpose of this session is to deepen participants' understanding of sexual and reproductive health and rights.

Session Objectives

By the end of this session, participants will have:

- A shared understanding of sexual and reproductive health and rights
- An increased comfort level discussing and recognizing that people with disabilities have sex and are entitled to the same SRHR as people without disabilities
- A strengthened understanding of what informed consent looks like in practice

Session Outline

Session 2: What are Sexual and Reproductive Health and Rights (SRHR)?	
15 min	Q&A/Reflections from Prior Session(s)
30 min	Activity 2A: What are Sexual and Reproductive Health and Rights?
75 min	Activity 2B: SRHR Key Concepts Quiz *(Optional)*
60 min	Activity 2C: Informed Consent Fishbowl

Open the Session: Ask participants if they have any questions or reflections from the last session that they would like to share. Try to limit this dialogue to 10 minutes. If there are pressing topics that require clarification, let participants know that you will make a plan for revisiting that topic or share further information via email. (15 minutes)

ACTIVITY 2A: WHAT ARE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)?

Duration

30 minutes

Supporting Materials

- PowerPoint slides 28 to 39
- Women Enabled International, Sexual and Reproductive Health and Rights Factsheet
- UNFPA and WEI, Women and Young Persons with Disabilities: Guidelines, pages 91 to 98
- UNFPA and WHO, Promoting Sexual and Reproductive Health for Persons with Disabilities
- *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example

Advance Preparation

- Anticipate some of the questions participants may have after being presented with this content and think about how you will answer those questions.
- Consult with a trusted colleague who has expertise in sexual and reproductive health and rights about any questions you, yourself, may have. Ask this person if they would be willing to help you answer any questions you may not be able to answer during the workshop. This way, you can let

participants know that, if you don't have the answer to their questions, you will follow up and get more information to share in later sessions.

- Either the co-facilitator or the production manager should be prepared to document participants' questions during the Q&A portion of the presentation.

- Update the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document to include local resources and organizations.

Instructions

1. Introduce Session 2 and explain that we are now going to begin activities that are focused on developing our understanding of sexual and reproductive health and rights (also known as SRHR for short). **Slide 28.**

2. Share with participants that the focus of this session is to build a collective understanding of sexual and reproductive health and rights. Acknowledge again that talking about sexuality can feel uncomfortable or taboo. Emphasize that sexuality is a key part of the human experience and that it is important to be able to talk about it.

3. Remind participants that they received via email the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. Clarify that this list contains local sexual and reproductive health and rights service providers, including counselors, should any of the topics in this and the following sessions raise any sexual and reproductive health and rights issues or concerns for any of the participants or leads them to want to seek services.

4. Explain that you will start with a short presentation on the rights that people with disabilities have related to their bodies, sex, relationships, and pregnancy. Start by first asking the group, and then use the conversation to lead into the presentation: **What do you think about when you think about sexual and reproductive health and rights? Slide 29.**

What are Sexual and Reproductive Health and Rights (SRHR)?

Introduce the definition of sexual and reproductive health and rights as defined in international law and by the World Health Organization. **Slide 29.**

In short, sexual and reproductive health and rights refers to people's rights to:

- Complete physical, mental, and social wellbeing in all matters relating to their reproductive system
- A satisfying and safe sex life
- The freedom to decide if, when, with whom, and how often to reproduce (to have children)

Provide these definitions, which are more detailed. **Slides 30 to 32.**

- **Reproductive health** is a state of complete physical, mental, and social well-being and not merely the absence of illness, in all matters relating to the reproductive system and to its functions and processes.
- **Reproductive rights** are the rights of all people to decide freely and responsibly on the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.
- **Sexual health** is a state of complete physical, mental, and social well-being in relation to sexuality, not merely the absence of illness. It requires a positive and respectful approach to sexuality and sexual relationships, as well as pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.
- **Sexual rights** are the rights of all people to attain the highest attainable standard of sexual health free of coercion, violence, and discrimination of any kind; to pursue a satisfying, safe, and pleasurable sexual life; to have control over and decide freely and consensually, on matters related to their sexuality, reproduction, bodily integrity, choice, and gender identity; and to accessible services, education, and information necessary to do so.
- **Bodily autonomy** means being able to determine one's life and future, and having the information, services, and means to do so free from discrimination, coercion, and violence. It is the power to make basic decisions about one's own body and health, such as whether to have sex, use contraception, or seek health care.

- **Self-determination** means having the freedom and support to make choices about one's own life and requires the knowledge and skills to advocate for oneself.

- **Informed consent** is the process of communication between a service provider and a service recipient. The service provider gives accurate, comprehensive, clear information about the services available, benefits risks, and alternatives to the service recipient in a manner and form that they understand, and with support as requested and directed by the service recipient, without threats, intimidation, or inducements. The service recipient themselves, then voluntarily consents to services or declines them, based on this information.

Sexual and Reproductive Health: Key Interventions

Explain that realization of SRHR includes a lot of different types of health care information, goods, and services that are related to our bodies, sex, relationships, and being pregnant. These include the following key interventions. These are also discussed in more detail in Session 3. **Slide 33 to 35.**

- Comprehensive sexuality education and information: understanding anatomy, sexual orientation, healthy relationships, and more!

- Information, counseling, and services for a range of modern contraceptives.

- Prenatal, childbirth and postnatal care, including emergency obstetric and newborn care.

- Safe abortion services (where legal) and treatment of the complications of unsafe abortion.

- Information, prevention, testing, and treatment of HIV infection and other sexually transmitted infections [STIs].

- Prevention of, detection of, immediate services for, and referrals for cases of sexual and gender-based violence.

- Prevention, detection and management of reproductive cancers, especially cervical cancer.

- Information, counselling, and services for subfertility and infertility.

- Information, counselling, and services for sexual health and well-being, including routine health services such as pelvic exams, pap smears, mammograms, and cancer screenings.

- Adolescent and youth-tailored services.

Explain that women and young people with disabilities encounter many violations of their SRHR. **Slide 36.**

- Harmful stereotypes and assumptions about persons with disabilities.

- Inaccessible information about SRHR.

- Lack of access to sexual and reproductive health services due to a variety of factors, such as physical or communication barriers.

- Compounded harms due to, for example, lack of diagnosis or screening.

- Heightened rates of medical procedures without informed consent, such as forced sterilization, forced abortion, and forced contraception.

- Disrespectful and abusive treatment.

Data and evidence on sexual and reproductive health and disabilities data. **Slides 38 and 39.**

- Studies have shown that young people with disabilities are as sexually active and have the same concerns about sexuality, relationships, and identity as their peers without disabilities. (UNFPA Global Study)

- In one study of 426 young people with disabilities in Ethiopia, over 50% believed that sexual and reproductive health services were unavailable to people with disabilities. (UNFPA Global Study)

- A study in Uganda found that 77% of surveyed young women with disabilities between 15 and 25 years old had never used any form of contraception. (UNFPA ESA Situational Analysis)

- In one study in India, only 22% of women with physical disabilities reported having had regular gynecologic visits.

6. After you are finished with the presentation, take at least 10 minutes to answer any questions participants may have about what you've presented. If there isn't time to answer all of the questions or you don't know some of the answers, let them know that your co-facilitator or the

production manager is documenting all of the questions and offer to make time to answer them in a later session. Alternatively, share your email for participants to ask their questions privately.

7. Emphasize the following **key messages** throughout your presentation and question session: **Slide 39.**

   - The right to sexual and reproductive health means that people have the right to: complete physical, mental, and social well-being in all matters relating to their reproductive system; a satisfying and safe sex life; and the freedom to decide if, when, with whom and how often to reproduce (to have children).

   - People with disabilities have the same rights to sexual and reproductive health as everyone else. This includes the right to make our own choices about our bodies, intimate relationships, how we express our sexuality, and whether to have children.

   - Sexual and reproductive health and rights includes the right to access information, services, and goods necessary to exercise this right.

ACTIVITY 2B: SEXUAL AND REPRODUCTIVE HEALTH RIGHTS KEY CONCEPTS QUIZ

Duration

75 minutes

Supporting Materials

- PowerPoint slides 40 to 57
- WEI, Sexual and Reproductive Health and Rights Factsheet
- UNFPA and WEI, Women and Young Persons with Disabilities: Guidelines
- UNFPA, Young Persons with Disabilities: Global Study on Ending Gender-Based Violence and Realizing Sexual and Reproductive Health and Rights

Advance Preparation

- Review the quiz questions and answers, below. Edit as needed for the workshop participants to make sure the questions are relevant to the local context and participants' experience with SRHR topics.

Instructions

1. Explain to participants that we will now answer some questions together to practice our understanding of what we just talked about and learn some key terms and ideas that are important to understanding sexual and reproductive health and rights. Emphasize that this is not a test, and it is understandable if they do not feel they know all of the answers. Explain that it is another learning activity, and we are all learning together. **Slide 40.**

2. Describe to the participants that the first question is on the screen and that you will be reading each question and then asking for a volunteer to share their answer. Share that there are six questions, and that participants are encouraged to ask questions afterward if they need further explanation. **Slides 41 to 53.**

3. Ask the first question and offer to read it again for anyone who requires it. Ask for volunteers to answer by either raising their hand or nodding

their head (or other accessible ways as required by the group). After one answer (even if it is the wrong answer), go to the answer. Read the answer out loud and ask if there are any questions (limit discussion to 10 minutes).

4. Repeat Step 3 for each question.

Quiz:

Question 1: Sexual and reproductive health and rights includes which of the following?

a) Complete physical, mental, and social well-being in all matters related to the reproductive system.

b) A satisfying and safe sex life.

c) Freedom to decide if, when, with whom, and how often to reproduce.

d) All of the above.

Answer: D. All of the Above. The World Health Organization defines sexual and reproductive health to include all of these facets:

- The complete physical, mental, and social well-being (not merely the absence of disease, dysfunction, or infirmity).
- A safe and satisfying sex life (including the ability to develop healthy relationships).
- The freedom to decide if, when, with whom, and how often to reproduce (including the information and means to do so).

To ensure this last point, a person must be free to make self-determined decisions through:

- Respect for legal capacity around reproductive decision-making, including decisions to retain fertility and/or become a parent (and necessary safeguards against forced sterilization, forced abortion, and forced contraception).

- Information related to sexual and reproductive health, including information on a range of contraceptive methods, must be available in accessible and alternative forms and formats.

Question 2: Sexual and reproductive rights are explicitly recognized in which of the following international treaties from the United Nations?

a) Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

b) Convention on the Rights of Persons with Disabilities (CRPD)

c) International Covenant on Civil and Political Rights (ICCPR)

d) Convention on the Rights of the Child (CRC)

Answer: B. The Convention on the Rights of Persons with Disabilities (CRPD). The CRPD is the only international treaty that expressly mentions sexual and reproductive health. Article 25 requires that governments "Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes."

Question 3: *True* or *False*: Women with disabilities have the same right as women without disabilities to become parents.

Answer: A. *True*. Women with disabilities have the same right as women without disabilities to decide if they want to become parents and to have access to the information and means to determine the number and spacing of their children. Despite this right, stereotypes that women with disabilities should not become parents can contribute to substandard care, including discrimination, abusive treatment, and heightened rates of medically unnecessary cesarean sections, for women with disabilities who try to access maternal and newborn health services. Such negative treatment can deter them from seeking prenatal health care. Materials about maternal and newborn health are not regularly available in accessible formats.

Question 4: *True* or *False*: A parent can give permission for a medical procedure for their 45-year-old child with a disability without consulting their child.

Answer: B. *False*. Every patient has the right to informed consent before receiving medical services, although informed consent is not consistently guaranteed, especially for people with disabilities. Informed consent is the process of communication between a service provider and a service recipient. The service provider gives to the service recipient accurate, comprehensive, clear information about the services available, benefits, risks, and alternatives in a manner and form that they understand, and with support as requested and directed by the service recipient, without threats, intimidation, or inducements. The service recipient themselves voluntarily consents to services or declines them, based on this information.

**Be sure that this answer is fully accurate in your country's context. If the country you are presenting in has a formal guardianship system, there could be circumstances under which a parent can legally give permission if they are the person's legal guardian. However, these circumstances are usually very limited and still require the person with the disability to be consulted.*

Question 5: *True* or *False*: Teaching young people with disabilities sexuality education promotes sexual activity among young people.

Answer: B. *False*. Comprehensive sexuality education (known as CSE) actually contributes to delayed onset of sex, increased use of contraceptives, fewer sexual partners, and a reduction in adolescent pregnancy and STIs and HIV. Women and young people with disabilities have the same rights as women and young people without disabilities to access CSE. Yet harmful stereotypes about disability and sexuality can prevent women and young people with disabilities from accessing this important information. These include:

- Stereotypes that women with disabilities, particularly women with intellectual disabilities, will become hypersexual if they are provided information about sexuality and sex.

- Stereotypes that women with disabilities are asexual and do not need such information.

Question 6: Bodily autonomy means:

a) Being able to utilize all of your limbs without the use of assistive devices.

b) The medical term for a human body.

c) Your body is for you, and your body is your own to have the power to make choices about in a dignified way.

d) An individual body.

Answer: C. Bodily autonomy means being able to determine one's life and future, and having the information, services, and means to do so free from discrimination, coercion, and violence. It is the power to make basic decisions about one's own body and health, such as whether to have sex, use contraception, or seek health care. The power to make decisions about sexuality and reproduction is fundamental to women's and people with disabilities' empowerment overall. When societies do not equip persons with disabilities with the means to control whether, when, and with whom to have sex and whether, when, with whom, and how often to become pregnant, they are denying large numbers of people of their right to bodily autonomy.

5. End this activity with the **key messages** for the session and thank participants for their engagement. **Slides 54 to 57.**

- The topics we discussed in this game represent the range of subjects covered under sexual and reproductive health and rights.
- In many communities around the world, the topic of sexuality is thought to be a private subject and talking about it in the open like this can be hard. This is especially true for people with disabilities and other groups of people such as young people or gender-nonconforming people.
- Sexuality and sexual health are key parts of being human and there is nothing to be ashamed about. When we have access to accurate, unbiased, and evidence-based information about sexuality and sexual health, we can feel empowered, make healthy decisions, and enjoy healthy intimate relationships.
- In this activity we have learned about some key concepts that may be new to you, they are:
  - **Reproductive health** is a state of complete physical, mental, and social well-being and not just the absence of illness, in all

matters relating to the reproductive system and to its functions and processes.

- **Reproductive rights** are the right of all people to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

- **Sexual health** is a state of complete physical, mental and social well-being in relation to sexuality, not just the absence of illness. It requires a positive and respectful approach to sexuality and sexual relationships, as well as pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.

- **Sexual rights** are the rights of all people to attain the highest attainable standard of sexual health free of coercion, violence, and discrimination of any kind; to pursue a satisfying, safe, and pleasurable sexual life; to have control over and decide freely and consensually, on matters related to their sexuality, reproduction, bodily integrity, choice, and gender identity; and to accessible services, education, and information, necessary to do so.

- **Self-determination** means having the freedom and support to make choices about one's own life and requires the knowledge and skills to advocate for oneself.

- **Informed consent** is the process of communication between a service provider and a service recipient. The service provider gives accurate, comprehensive, clear information about the services available, benefits, risks, and alternatives to the service recipient in a manner and form that they understand, and with support as requested and directed by the service recipient, without threats, intimidation, or inducements. The service recipient themselves voluntarily consents to services or declines them, based on this information.

- **Bodily autonomy** means being able to determine one's life and future, and having the information, services, and means to do so free from discrimination, coercion, and violence. It is the power to make basic decisions about one's own body and health, such as whether to have sex, use contraception or seek health care.

ACTIVITY 2C: INFORMED CONSENT FISHBOWL

Duration

60 minutes

Supporting Materials

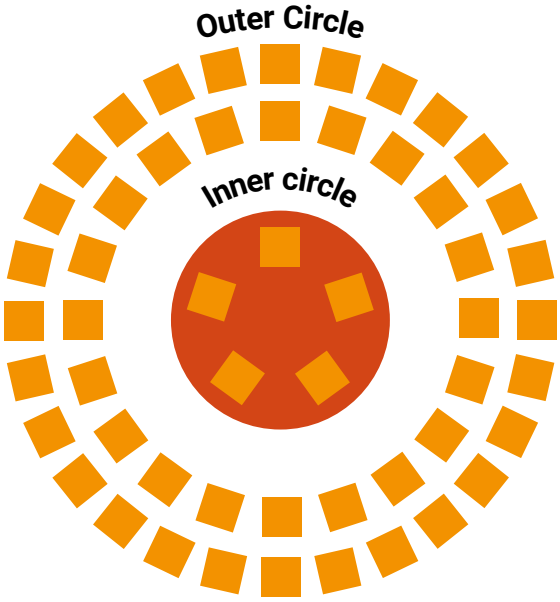
- PowerPoint slides 58 and 59
- UNFPA and WHO, Promoting Sexual and Reproductive Health for Persons with Disabilities
- *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example

Advance Preparation

- Decide who you want to participate in the fishbowl, it could be a mix of facilitators and participants or only participants.[8] The instructions below are written for a facilitator and participant team.
- The following roles are required for both scenes:
  - Narrator
  - Patient (Select a female to play the patient.)
  - Husband or Personal Assistant or Interpreter
  - Doctor
- Determine if you think it would be more effective to share the script with the actors in the fishbowl in advance or to have their answers be improvised.

8 Fishbowl is a strategy for organizing discussions. Participants are separated into an inner and outer circle. In the inner circle, or fishbowl, students have a discussion or conduct an activity. Participants in the outer circle listen to and observe the discussion or activity, consider what is being said and done, and prepare to respond.

- Set-up the physical space: a big circle of chairs surrounding a wide-open space (a “fishbowl”).



Instructions

1. Explain to the group that we will now be doing an exercise to help us better understand the process of informed consent which is a key SRHR concept to understand. Describe that you and the participants will be acting out two scenes for the rest of the group to observe and reflect upon. Explain that the first scene will be a bad example of getting informed consent and the second scene will be a good example.

2. Ask the group: **Does anyone know what sterilization is?** Provide the correct definition and inform participants that they will hear this procedure referred to in the following scenes.

   Sterilization: A sterilization surgery is a medical procedure done to prevent future pregnancies permanently. For women this procedure is technically referred to as tubal ligation. It requires surgery and prevents the woman from ever becoming pregnant again. Some women chose to have this surgery to prevent future pregnancy. It is usually irreversible.

   For men, sterilization is known as a vasectomy, which cuts and seals the tubes that supply sperm to semen.

3. Ask the actors to set up and describe for the other participants what is happening in the scene. For example, Mary is playing our patient and she is sitting in a seat facing Paul, who is playing the doctor. Next to Mary is Ibrahim who is playing her husband.

4. **Scene One:** Inform participants that they should feel free to improvise and go off script.

   - *For the narrator, throughout the scenes, you should narrate significant visual changes or cues. For example, if the person playing the patient looks worried, you should say: Our patient looks worried. She turns to her interpreter and shakes her head. Actors, you should pause while the narrator describes the scene for the audience.*

   - Narrator: *(Describe the visual scene – Example: The patient enters the room. She is very pregnant and leaning on her husband for support. The patient and her husband sit in the chairs facing the doctor).*

   - Doctor (speaking to the person's assistant/husband/interpreter): Hello, and how is Mrs. Smith feeling today?

   - Patient: I am feeling strong and am excited to meet my baby!

   - Doctor: Ok, that is good to hear. So, as we are nearing the end of your pregnancy we need to discuss your future fertility. Having another baby would be dangerous and unsafe for both you and the baby. I would strongly advise against it and would recommend sterilization to reduce the risk in the future. It would be a simple procedure we could do while we are conducting the cesarean section.

   - Patient: What are the risks?

   - Doctor: (speaking to the person's assistant) Oh there is nothing to worry about; it is a very simple procedure and would not require any further healing than the cesarean will require. I think this is the best thing for her. Okay?

   - Patient's Husband: Well, if you think it's for the best, then I think it should be ok….

   - Doctor: Ok great, just sign this form please. (hands patient the form without reading or asking for clarification).

   - Patient signs and returns (looks worried).

5. Explain that we will now see a different scene of a doctor seeking informed consent.

6. **Scene Two:**

   - Narrator: *(Describe the visual scene)*
   - Doctor: Hello, Ms. Smith. How are you feeling today?
   - Patient: Doing well, I'm feeling strong and really excited to meet my baby!
   - Doctor: That is great to hear. Today we will be listening to the baby's heartbeat to make sure everything is okay, and I will be talking you through the cesarean section process, as we discussed earlier. However, before we get to that, I wanted to ask you what your plans are for future children? Do you want to have more kids after this?
   - Patient: I'm not sure. I always wanted to have two or three children, but I'd like to see how I find managing one child first!
   - Doctor: Great, if you do not want to have a child right away, we should discuss family planning methods you can use to prevent getting pregnant.
   - Patient: Yes, I would like to do that.
   - Doctor: Excellent; I will go through the various options with you at our next appointment and bring examples to show you. The reason I have brought it up with you today is that there is a permanent method called sterilization, or tubal ligation, that we could do when we are doing your cesarean section. This procedure would mean you would never be able to have children again. I am hearing from you that you want to keep your options open to have more children in the future so I will not share any more information about this option. Is that right?
   - Patient: Yes, I do not want to have that procedure.
   - Doctor: Understood; we will not conduct the sterilization surgery. Do you have any other questions about family planning after the baby is born?

7. Open the floor for reflection and conversation, use the following prompts as needed:

   - What did you think while watching these scenes?
   - Which scene was most like your experience with doctor visits?
   - What differences do you see in the two scenes?

- Did the second scene help you better understand what informed consent can look like in practice?

- What are some good practices you can take from this activity on how doctors should seek informed consent from patients with disabilities?

8. Close by summarizing the following **key messages. Slide 59.**

- **Informed consent** is the process of communication between a service provider and a service recipient. recipient. The service provider gives the service recipient accurate, comprehensive, clear information about the services available, benefits risks, and alternatives in a manner and form that they understand, and with support as requested and directed by the service recipient, without threats, intimidation, or inducements.

- The service recipient must receive counseling about the services available, benefits, risks, and potential alternatives in a language and form that is understandable to the service recipient.

- The service recipient themselves voluntarily consents to services or declines them, based on this information.

- People with disabilities are often denied these rights or have these rights violated.

- People with disabilities have the right to informed consent for any medical procedure or medication and to receive respectful and dignified treatment from care providers.

SESSION 3

ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Session Purpose

The purpose of this session is to deepen participants' understanding of how key concepts relating to sexual and reproductive health and rights apply to accessing relevant sexual and reproductive health services.

Session Objectives

By the end of this session, participants will have:

- An introduction to the Available, Accessible, Acceptable, and Quality Framework (AAAQ or "triple A Q" framework)
- An understanding of the twin-track approach and how it applies to services
- An opportunity to assess some of the barriers to SRHR for women and young people with disabilities

Session Outline

Session 3: Accessing Sexual and Reproductive Health Services	
15 min	Q&A/Reflections from Prior Session(s)
90 min	Activity 3A: Sexual and Reproductive Health Services
75 min	Activity 3B: Ensuring Services are Available, Accessible, Acceptable, and Good Quality

Open the Session: Ask participants if they have any questions or reflections from the last session that they would like to share. Try to limit this dialogue to 10 minutes. If there are pressing topics that require clarification, let participants know that you will make a plan for revisiting that topic or share further information via email. (15 minutes)

ACTIVITY 3A: SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Duration

90 minutes

Supporting Materials

- PowerPoint slides 61 to 69
- Paper and makers/ white board/ chalk board.
- Paper and pens for individual brainstorming.

Advance Preparation

- Anticipate some of the questions participants may have after being Familiarize yourself with the sexual and reproductive health key service areas and be prepared to explain each of the service areas with examples.
- Ensure you have a good understanding of the twin-track approach to disability inclusion.
- Review the sexual and reproductive health referral document so that you know the available services in the area.
- Share the case study with any interpreters present in advance.
- Remind participants who use devices to write, to bring their computers or tablets for this activity.
- Email a copy of Elsa's story to everyone the night before and print one copy of Elsa's story to bring with you. Provide printed copies (including in large font) as appropriate based on participants' access needs.
- Prepare the paper or white board or chalk board with two columns: Mainstream and Disability-Specific.

Instructions

1. Explain that we are now going to focus on applying what we learned to real-life situations when we need to access sexual or reproductive health services. **Slide 61.**

    - Start by asking the group: **What sexual or reproductive health services can you name?** Write their answers down and read aloud as you write.

    - If people are struggling, explore with the group why the answer is challenging. Is it because people are still uncomfortable talking about this topic? Is it because they have never heard of these services? Is it because they've never thought of these services as sexual and reproductive health services?

    - After 10 to 15 minutes of discussion, share the slide with the SRHR Key Service Areas. Review each area briefly and ask if there are any questions about what each of these services includes. Share local examples of service providers if available. **Slides 62 and 63.**

    Sexual and Reproductive Health Key Service Areas

    - Comprehensive sexuality education and information: understanding anatomy, sexual orientation, healthy relationships, and more!

    - Information, counseling, and services for a range of modern contraceptives.

    - Prenatal, childbirth and postnatal care, including emergency obstetric and newborn care.

    - Safe abortion services (where legal) and treatment of the complications of unsafe abortion.

    - Information, prevention, testing, and treatment of HIV infection and other STIs.

    - Prevention of, detection of, immediate services for, and referrals for cases of sexual and gender-based violence.

    - Prevention, detection and management of reproductive cancers, especially cervical cancer.

    - Information, counselling, and services for subfertility and infertility.

- Information, counselling, and services for sexual health and well-being, including routine health services such as pelvic exams, pap smears, mammograms, and cancer screenings.

- Adolescent and youth-tailored services.

2. Share with the group that we are now going to do an activity to help us think about how a person's disability impacts their access to services. Ask for a volunteer to read the following story aloud: **Slide 64.**

Elsa is a 35-year-old Deaf woman. She lives in a rural community and is married. She knows sign language, but sign language interpreters are not common in her community. She has never visited a health clinic and has never received sexual or reproductive health services. She recently found out she is pregnant and is excited to have the baby. The Ministry of Health has designed a Community Reproductive Healthcare Outreach Program for Elsa's area, but they did not consider people with disabilities. The Ministry comes to you as the representative of an organization of persons with disabilities and asks: How can we make our outreach program more accessible to Deaf women like Elsa?

3. Spend the next 10 minutes brainstorming by themselves or with their neighbor **how can a Community Reproductive Healthcare Outreach Program be made accessible to Deaf women?** Offer paper and pencils to those who would like them. **Slide 65.**

4. After 10 minutes, ask for volunteers to share their ideas. Explain that as people share their answers you are going to write them down in either the Mainstream column or the Disability-Specific column. Clarify that things that can be classified as mainstream will be parts of the program that everyone benefits from and that disability-specific actions are ones that are required by a person because of their disability. Emphasize that both are equally important and necessary to make a service accessible.

5. Explain that as people share their answers, your co-facilitator will be transcribing them. Write their answers down on the paper you prepared with the two columns: one that says "Mainstream" and one that says "Disability-Specific." Read aloud as the answers are transcribed and categorized.

6. Conclude the activity by explaining that you are now going to share an approach with them that may be helpful for thinking about accessible services, especially in advocacy moving forward. Provide an explanation of the **twin-track approach** using the following explanation. Open the floor for questions. **Slide 66.**

- The twin-track approach means:
  - Systematic mainstreaming of the interests of people with disabilities across all plans, strategies, and policies, and
  - Taking targeted and monitored action specifically for people with disabilities.
- Explain that using our example of a reproductive health outreach service, mainstreaming would mean:
  - The program is available to all community members, including people with all types of disabilities.
  - It includes requirements that all program staff receive training on disability inclusion and combatting bias.
  - All program staff are trained in adapting outreach services for different disabilities.
  - All program staff know which clinics for referrals are disability inclusive.
  - It is staffed by people with and without disabilities.
- Using the example again, explain that parts of the program should b developed and funded for people with disabilities, such as:
  - An additional outreach program developed specifically for people with disabilities and staffed by people with disabilities. These staff people accompany the mainstream program on outreach visits and conduct separate visits as needed.
  - Disaggregated data collection on who receives services, including disaggregation by disability.
  - A monitoring program designed to ensure disability inclusion.
  - Sign language interpreters
  - Braille materials.
  - Large-print materials.
  - Electronic materials readable by screen readers

  - Easy-read or simplified materials.

  - All program staff have access to a referral list for disability-specific services not directly to reproductive health, such as community-based rehabilitation.

- Offering services through only one approach will not provide women and young persons with disabilities with the range of services, involvement, and inclusion necessary to realize their rights.

- Service providers do not necessarily need to be responsible for offering both types of services but should understand the key referral points and be able to make effective referrals.

7. Ask if there are any questions or reflections. Allow space for discussion and reflection on current community services. Consider using the following prompt for discussion: **Do you see any of the ideas we just discussed for making the outreach program more accessible reflected in the services currently available in your community.**

8. Explain that in the next part of the training, we will explore in more detail the exact nature of services, which must be available, accessible (including affordable), acceptable, and of good quality.

9. Conclude with the following **key messages** for the session. Adapt to reflect the conversation that has taken place throughout the activity. **Slides 67 to 69.**

- Fundamental sexual and reproductive health services to which people with disabilities should have access include:

  - Comprehensive sexuality education and information: understanding anatomy, sexual orientation, healthy relationships, and more!

  - Information, counseling, and services for a range of modern contraceptives.

  - Prenatal, childbirth and postnatal care, including emergency obstetric and newborn care.

  - Safe abortion services (where legal) and treatment of the complications of unsafe abortion.

  - Information, prevention, testing, and treatment of HIV infection and other STIs.

- Prevention of, detection of, immediate services for, and referrals for cases of sexual and gender-based violence.
- Prevention, detection and management of reproductive cancers, especially cervical cancer.
- Information, counselling, and services for subfertility and infertility.
- Information, counselling, and services for sexual health and well-being, including routine health services such as pelvic exams, pap smears, mammograms, and cancer screenings.
- Adolescent and youth-tailored services.

- All people with disabilities have the right to access services that are available to the rest of the community. People with disabilities also have the right to have disability-related requirements met. This is sometimes referred to as a twin-track approach.

ACTIVITY 3B: ENSURING SERVICES ARE AVAILABLE, ACCESSIBLE, ACCEPTABLE, AND OF GOOD QUALITY

Duration

75 minutes

Supporting Materials

- PowerPoint slides 70 to 79
- *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example
- Paper and pens

Advance Preparation

- Review the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document so that you know the available services in the area, particularly the contraceptive services available locally.
- Ensure you have a good understanding of the AAAQ or "triple A Q" framework and examples of each category.

Instructions

1. Explain that in this final SRHR activity, we are going to learn a final concept and apply all that we have learned to an example from our own community.
2. Ask participants to take a few minutes of silent reflection to **think of a time you or a friend wanted to access contraceptive (or family planning) services in your community. Did you or your friend face any barriers? If not, what made these services accessible? Slide 71.**
3. After the five minutes are up, ask if anyone wishes to share any immediate reflections that came to mind. Limit the discussion to 15 minutes.

4. Explain that you will now share a concept that can help us understand our rights to comprehensive sexual and reproductive health services. Explain the **AAAQ Framework** using the following explanation. **Slide 72.**

- United Nations human rights bodies have identified four essential and related standards which are necessary to have good healthcare that uphold your right to health, including sexual and reproductive health. Health care education, information, goods, and services must be available, accessible (including affordable), acceptable and of good quality. This is known as the AAAQ framework.

- **Available** means that information, goods, and services are available in sufficient quantity across a country. This includes having enough trained service providers and appropriate healthcare facilities. Examples of increasing availability include: **Slide 73.**

  - Services that are based in communities, not concentrated in larger towns or cities.

  - Mobile, accessible outreach services by trained staff, including people with and without disabilities, are periodically conducted to reach women and young persons who live in isolated areas or residential institutions or who otherwise may not be able to reach services. Services are adapted to meet people's specific requirements.

  - A wide variety of modern contraceptive methods are available and in sufficient supply in healthcare facilities and other community spaces, both in urban and rural and/or remote areas.

- **Accessible** means the information, goods, and services are accessible to all people, including people with disabilities. The requirement of accessibility includes physical accessibility, economic accessibility, and information accessibility. For example, services are accessible when: **Slide 74.**

  - Free or subsidized transportation is available to women and young persons with disabilities and their personal assistants or support persons so they can reach services.

  - Where resources allow, goods and services are subsidized so they are free or at a low-cost for all low-income women and young persons, regardless of age, marital status, or disability.

  - Information about services and communication with service providers is available in a wide variety of accessible formats,

including Braille; large print; audio; digital formats, compatible with screen readers; Sign language with an interpreter of a preferred gender; captioning; simplified formats (for example, plain language, easy read); pictorial guides; and local language interpretation, among others.

- There are no barriers to entering healthcare facilities or accessing different floors of the facilities, such as uneven pathways, narrow entrances, or stairs. Doors are wide enough and light enough to push. Counters are low enough to accommodate someone in a wheelchair. There is sufficient room in examination or labor and delivery rooms for a wheelchair to turn around. Facilities' furniture and equipment (such as hospital beds and exam tables) and procedures are physically accessible. For instance, alternative birthing positions and supports are offered to women with physical disabilities.

- **Acceptable** means that health information, goods, and services conform to ethical standards, are culturally respectful, sensitive to the gender and disability requirements of the individual, and respectful of a person's privacy and confidentiality. For example, services are acceptable when. **Slide 75.**

  - Providers and staff are trained on the rights of persons with disabilities, including to respect the will and preferences of women and young persons with disabilities, to respect their reasonable accommodation requirements and to empower them to direct their treatment and ask for assistance when necessary.

  - Service providers speak directly to the person with a disability and not to the person's accompanying family member or caregiver.

  - During a physical exam, a person with a physical disability directs the transfer to the examination bed and their body's positioning.

  - Intercultural approaches to the provision of sexual and reproductive health services are promoted and used.

- **Quality** means that health information, goods, and services are scientifically and medically appropriate and delivered by trained personnel. For example, services are of good quality when. **Slide 76.**

  - Service providers and support staff are trained to understand the informed consent process for adults with different types of disabilities, including those with high support requirements. Feedback mechanisms are in place to collect feedback on the

quality of sexual and reproductive health services from the end users themselves to inform future programming.

> **Slide 77 Example:** As part of the Australian Government's Transformative Agenda for Women, Adolescents, and Youth in the Pacific, in 2022, the Fiji Ministry of Health and Medical Services, the Fiji Disabled People's Federation (FDPF), Medical Services Pacific, the Pacific Disability Forum, UNFPA, and Women Enabled International partnered to design and implement a Community-Based Sexual and Reproductive Health Officers program.
>
> Under the program, OPDs hire women and young people with disabilities, who are hired as SRH outreach officers. They also train service train providers on disability rights and disability inclusion. The outreach officers and service providers travel to different communities across Fiji, including remote areas, to conduct two-day educational sessions for women and young people with and without disabilities. They cover SRHR and explain which SRH and GBV services are available as well as how to access these services, from an intersectional and disability-inclusive approach.

5. Emphasize that you are sharing this concept in case it is helpful for understanding the type of services people with disabilities have a right to receive. But explain that if this feels too complicated that it is not essential to understand to advocate for you and your communities' rights. Ask if there are any questions.

    - Share that you are going to now divide the group into groups of two for a brainstorming activity. Once participants are in their groups, ask each participant to use the service provider they reflected on earlier to answer the following question: **Using the AAAQ framework to guide you, how can you improve the contraceptive service in your community that you reflected on earlier?** Explain that each group will have 15 minutes to brainstorm. Offer participants paper and pens if they would like to use them. **Slide 78.**

6. After 15 minutes, invite everyone back to the group. Ask three people to share their brainstorming on how to improve the service they selected. Limit discussion to 15 minutes.

7. Summarize the activity with the following **key messages: Slide 79.**

   - Sexual and reproductive health services should be **available** where you can reach them; they should be **accessible** to you no matter where you live, your disability, or how much money you have; they should be provided in an **acceptable** way, which means they are respectful and confidential; and they should be of good **quality**.

   - This is sometimes referred to as the AAAQ or "triple A Q" framework.

8. Conclude by asking if there are any questions about anything that you've covered in the past sessions on sexual and reproductive health and rights (SRHR) and explain that the next section of the workshop will be about gender-based violence (GBV).

SESSION 4

GENDER-BASED VIOLENCE (GBV) – WHAT IS IT?

Session Purpose

The purpose of this session is to deepen participants' understanding of gender norms and link gender norms to the types of violence that people with disabilities, particularly women and young people with disabilities, encounter. This session builds up to an understanding of gender-based violence and provides participants with key terms for understanding such violence.

Throughout this session, it is essential that you regularly remind participants about, and have easily available, the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example.

Session Objectives

By the end of this session, participants will have:

- A shared understanding of gender norms and how violence against those who do not conform to gender expectations is itself a gender norm.
- An introduction to the power dynamics that contribute to gender-based violence.
- An understanding of key terms related to violence including terms for those involved in violence and terms to describe the types of violence someone may face.
- An understanding of what is meant by the term gender-based violence (GBV).

Session Outline

Session 4: Gender-Based Violence (GBV): What is it?	
15 min	Q&A/Reflections from Prior Session(s)
75 min	Activity 4A: Challenging Myths
90 min	Activity 4B: Power Station *(Optional)*
45 min	Activity 4C: What is Gender-Based Violence (GBV)?

Open the Session: Ask participants if they have any questions or reflections from the last session that they would like to share. Try to limit this dialogue to 10 minutes. If there are pressing topics that require clarification, let participants know that you will make a plan for revisiting that topic or share further information via email. (15 minutes)

ACTIVITY 4A: CHALLENGING MYTHS

Duration

75 minutes

Supporting Materials

- PowerPoint slides 81 to 83
- UNFPA, How Changing Social Norms is Crucial in Achieving Gender Equality
- *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example
- List of gendered myths
- Paper or cards for myths
- Paper and pens

Advance Preparation

- Adapt the list of gender myths to reflect those that are most common in the local context where participants are from, as well as those that most commonly relate to GBV, particularly at the intersection with disability.[9]

- Write your final lists out on small sheets of paper to hand out and leave some blank. Examples can include the following, but these should be adapted to the relevant norms in your community:

  - Men who cry are weak
  - Women should only be sexually attracted to men
  - Women are not good at sports
  - Men can't wear pink
  - In a family, men should make all the important decisions
  - Women should do all of the housework
  - Men and boys are smarter than girls

Instructions

1. Share that for the next two sessions we will be focusing on the topic of gender-based violence (GBV). Explain that to understand GBV, we're first going to explore the concept of gender. **Slide 81.**

2. Remind participants about the group agreements, particularly the confidentiality agreement, and the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. Remind participants that they do not have to share anything they are not comfortable sharing, and they can take a break at any time.

3. Ask if anyone can explain the difference between sex and gender. If no one volunteers, assure them that this can be confusing and present the following definitions using the additional notes found in the PowerPoint slides. **Slide 82.**

   - **Biological sex** is the physical body a person is born with (internal and/or external anatomical sexual characteristics). Some people are born with male characteristics, some with female characteristics, and some are born with mixed male and female characteristics (referred to as 'intersex').

9 Adapted from UNESCO Bangkok, "Challenging Myths in Connect with Respect: Preventing Gender-Based Violence in Schools," 2022, page 46.

- **Gender** refers to the characteristics of women, men, girls, and boys that are socially constructed. This includes norms, behaviors and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time.

- Gender and sex are related to but different from gender identity. Gender identity refers to a person's deeply felt, internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth.[10]

- Ask if there are any questions and allow time for discussion.

- Include in this discussion a conversation about sexual orientation and gender minorities and how these communities experience discrimination based on gender norms relating to the biological sex they were assigned at birth.

4. Explain how in most communities, there are expectations around gender, which often lead to myths about how people should act based on their biological sex and about what they can and cannot do. For example, how a woman should act around men. These myths are often not based on the reality of how people live their lives. Explain how it is important to identify these myths and recognize and challenge the ways these myths can be hurtful or harmful, which we are going to start doing in this next activity.

5. Tell participants that we are going to divide into small groups to discuss common myths. Explain that you have already prepared a list of common myths and read the list out loud. Ask participants if they have any myths to add and include the new myths on the blank cards.

6. Divide participants into small groups and assign each group two or three myths, giving them the strip of paper with the myth on it for reference. If there is a small group with participants with visual impairments or other disabilities, offer to email or text the myth to the group participants or assign a facilitator to stay with the group. Ensure that all participants have time to read the myth and ask any clarifying questions. Ask the group to discuss the following questions for the next 10 minutes:

- Is this myth commonly believed in our community?
- What are some things that prove that this is a myth (not true)?
- What is the result or impact when people believe this myth?

10 On gender and gender identity, see World Health Organization (WHO), "Gender and Health," https://www.who.int/health-topics/gender#tab=tab_1.

7. Once the 10 minutes are up, ask groups to spend the next 10 minutes coming up with ways that they can challenge each of the myths. Provide them with paper and pens to write up their responses or ask one person to type on their computer.

8. After the allotted time is up, ask each group to share one of the myths they discussed and the ideas they came up with for challenging this myth with the larger group.

9. Allow for 5 to 10 minutes of group discussion relating to the topics that came up.

10. Close this activity with the following **key messages. Slide 83.**

    - Sex is biological, and gender is created by society and can vary across cultures or change over time
    - Gender identity refers to a person's deeply felt, internal and individual experience of gender
    - Gender norms lead to myths about what is and is not possible for people.
    - These myths can fuel harm and violence
    - We can work together to challenge these myths

ACTIVITY 4B: POWER STATION

Duration

90 minutes

Supporting Materials

- PowerPoint slide 85
- Friends of UNFPA, What is Gender-Based Violence (GBV)?
- UNFPA and WEI, Women and Young Persons with Disabilities: Guidelines, pages 49-51
- *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example
- A long piece of string or rope at least 300 cm/10 feet long
- Tape
- Large sheets of paper in two different colors (for example, red and green).
- Pens or markers
- A bell, flag, lights, large sign, group text message, buzzer, or other props to indicate an "emergency"

Advance Preparation

- Determine how you will create the "power station" in your space in the most accessible way for participants in the group.[11] Stretch the string to represent the power cable across the room, either at shoulder height or lying on the floor.
- Select how you will use the props to indicate the "emergency" in an accessible way. Consider asking participants the day before this activity if they are comfortable with the props you selected. For example, if you have participants with sensory sensitivities or PTSD, choose low-impact props

11 Adapted from Council of Europe, "Compass- Manual for Human Rights Education for Young People," pp. 253-255, https://www.coe.int/en/web/compass.

such as a flag and a gentle buzzer. Or if you have participants with hearing and visual impairments, ensure you have both a visual and auditory option.

Instructions

1. Explain to participants that we are now going to discuss another key element of gender-based violence which is power and the abuse of power through violence. Remind participants about the referral document and that they can take a break at any time.

2. Share with participants that we will be doing this through an active activity where we will be pretending to work at a power station. Describe how normal power stations generate electricity from gas, the sun or other materials but this power station generates energy from the community. However, sometimes there are dangerous surges of violence that can result in an explosion at the power station. Explain that as the facilitator, you are the manager of the station, and the participants are the technicians.

3. Break participants into groups of three to five people and hand out one color paper and pens. Ask participants to brainstorm together examples of violence they see around them and in their communities, paying particular attention to the experiences of people with disabilities and gender-related examples. Encourage them to think about what they experience or hear about in their community and from peers (such as bullying from peers; physical violence from spouses; breaking assistive devices). Tell the group they will have 10 minutes to brainstorm and agree upon the examples of violence that are most common (two to four issues) and to write these topics down on the paper in big letters (one issue per page).

4. Collect the sheets and give participants a five-minute break. During the break remove any duplicate sheets and attach the remaining pieces of paper to the power cable. If you can, tape them along the string so they do not slide. Consider if you need to split the group into two with two power cables in two different spaces if it is accessible and your space allows.

5. Invite participants back to join you in front of the power cable. Describe how in front of them is the power station's power cable and the types of violence that are posing a risk to the power station's safety. Remind everyone that in this activity you are the station manager, and they are technicians whose job it is to fix any issues with the power cable.

6. Hand out the second color paper and pens and tape and answer any questions.

7. Use your flag or buzzer and indicate that the alarm just went off with a notification from the Health and Safety Executive that the plant has a dangerous issue with one area of the power cable. Explain that the next time they see the flag or hear the buzzer, you will point to the part of the power cable and read the type of violence impacting that section where there is a problem. The job of the technicians is to shut down the power source (the violence) to be able to stop the emergency. Tell participants that they must come up with a proposed solution to stop that form of violence in their community to avoid the emergency. Emphasize that the teams must quickly brainstorm a solution, write it down on the different colored paper and then race to stick it over top of that form of violence to patch up the power cable before the whole power station explodes! Explain that this is an urgent situation, and they will only have two minutes to brainstorm and create their patch.

8. After one round, step forward and read the solutions and briefly discuss the suggestion with the group.

9. Repeat until all the violence papers are removed or you reach the time allotted (45 to 60 minutes). If available, tape the violence forms next to the solutions on the wall for participants to review later.

10. Invite participants to sit or return to their chairs. Conduct a debriefing session using the some or all following question prompts as needed:

    - How did people feel about this activity?
    - What are the causes of the types of violence we listed?
    - How was power used in the types of violence we identified?
    - How was power used in the solutions we identified?
    - How was disability a factor in any of the violence or solutions we identified?
    - How was gender a factor in any of the violence or solutions we identified?
    - Do any of our proposed solutions seem realistic?

11. Close this activity with the following **key messages. Slide 85.**

- Power can be used for good purposes or bad. We can use the kind of power we have to make positive changes in our communities.
- Gender-based power relations within society put many women, girls, and people who don't fit into community gender norms at risk of violence.
- Disability-related power imbalances can place people with disabilities at risk of violence.
- Gender equality requires the empowerment of women and people from marginalized genders, with a focus on identifying and redressing power imbalances and giving every person autonomy to manage their own lives.

ACTIVITY 4C: WHAT IS GENDER-BASED VIOLENCE (GBV)?

Duration

45 minutes

Supporting Materials

- PowerPoint slides 86 to 91
- Friends of UNFPA, What is Gender-Based Violence (GBV)?
- UNFPA and WEI, Women and Young Persons with Disabilities: Guidelines, pages 49-55
- SafeLives, Spotlight Report # HiddenVictim. Disabled Survivors Too: Disabled People and Domestic Abuse
- UNFPA Asia and Pacific Regional Office, Measuring Prevalence of Violence against Women: Key Terminology
- *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example.

Advance Preparation

- Anticipate some of the questions participants may have after being presented with this content and think about how you will answer those questions.
- Consult with a trusted colleague who has expertise in GBV to get support with answering any questions you yourself may have. Ask this person if they would be willing to help you answer any questions you may not be able to answer during the workshop. This way, you can let participants know that if you don't have the answer to their question that you will follow-up and get more information to share with them via email, on the phone or in later sessions.
- Familiarize yourself with and ensure that the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document is accurate and that all facilitators are prepared to share it with participants and assist them with accessing the services listed, if needed.

- Share the case study the day before this activity with participants and interpreters.

Instructions

1. Explain to participants that we are now going to get into understanding the specifics of how we can define gender-based violence. Remind participants of the referral sheet. Go through the following points, stopping to answer questions and provide examples as needed. **Slides 87 and 88.**

    - Gender-based violence (GBV) is an umbrella term for any acts of or threats of violence that are perpetrated against people on the basis of their gender or their perceived gender. It disproportionately impacts women, girls, and gender non-conforming people (Refer back to Activity 4A and the gender role myths that were discussed).

    - People with disabilities must be able to live their lives free from gender-based violence. (Emphasize how, despite often being excluded from dialogues around GBV, people with disabilities are entitled to the same right as people without disabilities to live free from gender-based violence, and that women, girls, and gender non-conforming people with disabilities are disproportionately impacted by GBV).

    - GBV takes several forms — physical, emotional, psychological, sexual, and economic. Offer examples of each category.

    - These acts can occur in public or in private. Violence committed by intimate partners is a form of GBV, but perpetrators can also be strangers, caretakers, family members, support staff. Emphasize that this means that the government has an obligation to prevent and address violence from intimate partners, family members, caretakers, and support staff even when it happens in private, online, at a hospital, etc.

    - GBV is also sometimes also used to describe violence against men or people who do not identify as one gender. Explain how, since gender-based violence is violence based on socially ascribed (i.e. gender) differences between males and females, any violence that is motivated by this is considered GBV. For example, a young male is physically attacked because his peers think he acts too feminine, or a non-binary person is sexually assaulted by a man who insists they should be sexually attracted to men because they present as female.

2. Open the floor for questions. If multiple people have questions, take three to four questions, answer them, and address any overarching areas of confusion.

3. Next, share that we are going to discuss a case study to practice what we just learned. Ask for a volunteer or read the following case study aloud. **Slide 89.**

   This is a real example adapted from Stay Safe East in the United Kingdom, an organization run by people with disabilities to support people with disabilities who experience violence:

   Maria is a disabled woman. Her partner refuses to allow her to see the specialist nurse for her condition or to have handrails installed in their home. He stops Maria from using a walking stick, and when Maria tries to walk without it, he mocks her walking and tells her to stand up straight, knowing she will fall and hurt herself. Her partner has pushed and shoved Maria but never hit her. The falls Maria has had over many years were put down as 'accidents' due to her impairment. Maria's partner controls her money, and Maria cannot leave the house without her partner's help, as accessibility in their community is poor.[12]

4. Group Discussion (20 minutes): Ask participants to share their thoughts on the case study and use the following prompts to guide the conversation:

   - **Does Maria's experience meet our definition of gender-based violence? If so, how?** (consider returning to the definition slide)
   - **How does Maria's gender affect the violence she experienced?**
   - **How does Maria's disability affect the violence she experienced?**
   - **If Maria sought help** from the police, how do you think they might respond?

5. Close the discussion by asking if there are any further clarifying questions and reminding participants about the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document.

12 SafeLives, "Spotlight Report # HiddenVictims. Disabled Survivors Too: Disabled people and domestic abuse," 2017, https://safelives.org.uk/sites/default/files/resources/Disabled_Survivors_Too_Report.pdf.

6. Summarize the main points of the discussion, emphasizing the following **key messages. Slides 90 and 91.**

- Gender-based violence is violence that targets people on the basis of their gender. It is rooted in gender inequality, the abuse of power, and harmful gender norms.
- It can affect anyone, including people with disabilities.
- We can work to stop gender-based violence by learning to identify it in all its forms. This includes recognizing that GBV happens to people with disabilities. Naming it as a wrong action can be the first step in efforts to prevent or respond appropriately to the problem.
- GBV can take several forms such as physical, psychological, emotional, sexual, and economic forms. It can take place in private, in public, online, or at work.
- Perpetrators can be intimate partners but also strangers, caretakers, family members, support staff, and health workers.
- The term GBV is also used to describe any form of gendered violence, including violence against men or gender minorities when the violence is driven by gender roles and stereotypes.

SESSION 5

GENDER-BASED VIOLENCE (GBV) AND DISABILITY: DEEPENING OUR UNDERSTANDING AND ACCESS TO SERVICES

Session Purpose

The purpose of this session is to gain a deeper understanding of the gender-based violence (GBV) experiences of all people with disabilities, especially women and young people with disabilities, and the barriers they face to accessing services.

Throughout this session, it is essential that you regularly remind participants about and have easily available the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example.

Session Objectives

By the end of this session, participants will have:

- A deepened awareness of the intersection of gender-based violence and disability.
- A shared understanding of the barriers to accessing services that people with disabilities who experience gender-based violence face.
- Greater awareness of local resources for support with gender-based violence and areas of advocacy.

Session Outline

Session 5: Gender-Based Violence (GBV) and Disability: Deepening our Understanding and Access to Services	
15 min	Q&A/Reflections from Prior Session(s)
45 min	Activity 5A: Gender-Based Violence (GBV) and Disability
60 min	Activity 5B: The Survivor's Journey – Barriers to Accessing Services (Optional)
60 min	Activity 5C: Improving Access to Gender-Based Violence (GBV) Services

Open the Session: Ask participants if they have any questions or reflections from the last session that they would like to share. Try to limit this dialogue to 10 minutes. If there are pressing topics that require clarification, let participants know that you will make a plan for revisiting that topic or share further information via email. (15 minutes)

ACTIVITY 5A: GENDER-BASED VIOLENCE (GBV) AND DISABILITY

Duration

45 minutes

Supporting Materials

- PowerPoint slides 93 to 106
- WEI, Gender-Based Violence Factsheet
- UN Special Rapporteur on Violence Against Women Rashida Manjoo, *Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences: Women with Disabilities*
- UNFPA, Young Persons with Disabilities: Global Study on Ending Gender-based Violence and Realizing Sexual and Reproductive Health and Rights, pages 25-37

- *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example

Advance Preparation

- Brainstorm sample examples of general and disability-specific forms of violence that people with disabilities experience to insert into the table in case participants are having trouble with examples.

- Prepare the three flip board pages using the tables on PowerPoint slides 98, 100, and 102 as examples or practice annotating directly onto the slides.

Instructions

1. Introduce participants to the new session on Gender-Based Violence and Disability: Deepening our Understanding and Access to Services.[13] Explain that in this session, we will be focusing on strengthening our understanding of how a person's disability relates to their experience of gender-based violence (GBV) and the gender-based violence services to which every person is entitled. **Slide 93.**

2. Begin by asking the group: **How do you think a person's disability impacts their experience of gender-based violence?** Utilize the following prompts as needed to facilitate a conversation on disability and GBV. **Slides 94 and 95.**

    - People with disabilities have similar experiences of GBV as people without disabilities. Sometimes a person's disability may not be an influential factor in a person's experience. Provide examples.

    - People with disabilities also experience unique forms of GBV due to their disabilities. Provide examples.

    - Sometimes other characteristics, such as race, indigeneity, sexual orientation or gender identity, age, immigration or refugee status, can make it even more likely for people with disabilities to experience GBV.

    - People with disabilities seldom receive information about GBV, which can make it harder to identify such violence and recognize it as a rights violation.

13 This activity is partially adapted from Asian-Pacific Resource & Research Centre for Women (ARROW), Sreshtha Das, "Reclaiming SRHR of Women and Girls with Disabilities, Module 8: Abuse and Violence," 2021, https://arrow.org.my/publication/reclaiming-srhr-of-women-and-girls-with-disabilities/

- These factors, combined with inaccessible services and other barriers, can make it hard for people with disabilities to get help or stop the violence.

- Because of harmful stereotypes, people with disabilities are often excluded from GBV-related advocacy discussions.

3. Review the Gender-Based Violence Data and Evidence slide and connect the intersections of disability and gender. **Slide 96.**

- People with disabilities are **three times more likely** to experience physical violence, sexual violence, and emotional violence than people without disabilities.

- Women with disabilities are estimated to be up to **10 times** more likely to experience sexual violence.

- Boys and men with disabilities are **twice** as likely as boys and men without disabilities to be sexually abused in their lifetime.

4. Group Discussion (30 minutes): Explain that using what we learned in the last session, we are going to discuss some of the specific ways that people with disabilities experience violence to help us better understand the experiences of our communities, particularly people who may have different disabilities from our own. Emphasize that we are doing this because often violence against people with disabilities is ignored, or not recognized as gender-based violence and therefore is not part of the efforts to end GBV.

Explain that by the end of this exercise, we want to have a full picture of the needs of our communities so we can fully assess if they are being met by GBV providers in the community. Remind participants that they can excuse themselves from this activity or take a break anytime. Read each question aloud and share on the screen if helpful. Write the answers in the prepared flipchart page as the group answers each question, verbally narrating what you are writing and where. Remind participants to consider other disabilities that may not be represented in the group. Use PowerPoint slides as needed. **Slides 97 to 102.**

- **What are examples of violence that women/young people with disabilities experience? (For example, physical, verbal, emotional/ psychological, economic, or sexual).**

- **In what areas of our lives does this violence occur? (For example, family, community, health systems, institutions, hospitals).**

- **What are some of the factors that increase the risk of GBV for people with disabilities? (For example, disempowerment, exclusion from school, and inaccessible police services).**

5. Conclude by asking for any final reflections or questions. Remind participants again of the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document.

6. Summarize the main points of the discussion, emphasizing where possible the following **key messages. Slides 103 to 106:**

- People with disabilities face an increased risk of all forms of GBV.
- People with disabilities face the same forms of GBV as people without disabilities, as well as unique forms of GBV due to their disabilities.
- GBV against people with disabilities can take place in private and in public, including in facilities that are responsible for taking care of people with disabilities' needs.
- People with disabilities who also have additional marginalized characteristics, for example, race, indigeneity, sexual orientation or gender identity, age, immigration or refugee status, can face an increased risk of GBV.
- People with disabilities seldom receive information about GBV.
- Because of harmful stereotypes, people with disabilities are often excluded from GBV-related advocacy discussions.
- These factors—combined with inaccessible services and other barriers — can make it hard for people with disabilities to get help or stop the violence.

ACTIVITY 5B: THE SURVIVOR'S JOURNEY – BARRIERS TO ACCESSING SERVICES

Duration

60 minutes

Supporting Materials

- PowerPoint slide 107 and 108
- Survivor's Journey Hypothetical Script
- If accessible to your group, role assignments written on individual pieces of paper.
- Ball of yarn or string.
- UNFPA and WEI, Women and Young Persons with Disabilities: Guidelines, pages 49-90
- *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. See Appendix 1 for an example.

Advance Preparation

- Carefully review the survivor's journey hypothetical script and your role as narrator.
- Brainstorm how to make the activity as accessible as possible and how to facilitate the discussion at key points.
- Ensure you have enough space for the exercise to take place.
- Share the hypothetical script in advance with participants and ask them to review at least a day before the session to have time to reflect. Include the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document in the communication.
- Schedule a break directly after this activity, as participants often require a break after the emotional work required by this activity.

Instructions

1. Explain that this next group exercise is a role play enacting a survivor's journey and the constraints and barriers she faces when trying to access different services. The key objective of the exercise is to highlight the multiple needs of survivors, the complications and obstacles that inhibit access to timely services, and the value of coordinated approaches to service provision. If time allows, the exercise should be followed by 15 minutes of reflection and Q&A to allow participants to share their experience in their sector and in their setting.

2. Prepare participants that this session involves personal reflection and remind participants about the group agreements, particularly the confidentiality agreement, and the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document. Remind participants that they do not have to share anything they are not comfortable sharing and that they can take a break at any time.

3. Prior to reading the story:

   - Ask for six volunteers and make sure they are adequately spaced in a circle in the front of the room.
   - Randomly give members of the circle each one of the pieces of paper with a different role and ask them to hold it up so everyone can see it. Read it out loud for each participant.
   - Identify the volunteers who have received the **mother** and **survivor** cards and ask them to stand in the middle of the circle. Give the **mother** the ball of string.
   - Read the following story and ask the participants who have volunteered as the mother and survivor to walk over to each person mentioned in the story and give them a piece of the string to hold onto while keeping the ball of yarn.
   - As co-facilitator, you will play the narrator.

4. Script:

   Narrator: This is a story of Sara, an 18-year-old girl with a physical disability, who lives in a small, tightly knit community. She is, like most teenagers, full of life and enthusiasm. She just started going to college and loves the new-found freedom. She commutes to college every day from home. One day, she comes home from college and locks herself in

her room crying. Her family members try to speak to her, but she would not open her door. Finally, after her mother insists all night, Sara speaks to her mom and tells her that the neighbor had sexually assaulted her on her way back from college.

The mother does not know what to do – so she takes her daughter to the **Community Health Volunteer** for advice. *(The mother and daughter should walk/roll over to the person holding the Community Health Volunteer card and to give her the end of the string to hold onto while the mother keeps hold of the rest of the ball)*.

The mother tells the Community Health Volunteer what her daughter told her. The Community Health Volunteer is skeptical but tells the mother and daughter that they should see the **Nurse**.

The mother and daughter walk over to the **Nurse** and explain the story. The Nurse listens to the story, examines the daughter and advises the mother to take her daughter to the Doctor as this is a case of sexual assault and only a trained medical officer can handle such cases especially involving people with disabilities. *(The mother and daughter should walk over to the person holding the Nurse card and give her the string to hold onto while the Community Health Volunteer still holds her string and the mother keeps hold of the rest of the ball)*.

The mother and daughter go to the **Doctor** and tell him the story. The Doctor tells the mother that since this is a criminal case, the mother must first go to the **Police** first to report the case before he can examine her. *(The mother and daughter should walk over to the person holding the Doctor card and give her the string to hold onto while both the Community Health Volunteer and nurse still hold their strings and the mother keeps hold of the rest of the ball)*.

The mother and daughter walk over to the **Police Officer**. The Police Officer tells the mother that her daughter should be grateful that someone wanted to have sex with her given that she is disabled and why would she want to file a case against him. However, the mother insists and the Police Officer interviews the daughter and says he will investigate but explains that first he needs a medical certificate from the Doctor. *(The mother and daughter should walk over to the person holding the Police Officer card and give her the string to hold onto while the Community Health Volunteer, nurse, and doctor still hold their strings and the mother keeps hold of the rest of the ball)*.

The mother and daughter go back to the **Doctor** but the doctor's office does not have an accessible examination bed so they have to travel to an accessible medical office four hours away. When they arrive, the mother

explains the story and the Doctor examines the daughter and gives the mother a medical certificate. *(The mother and daughter should walk back over to the person holding the Doctor card and give her another section of the string to hold onto while the other volunteers continue to hold their strings and the mother keeps hold of the rest of the ball)*.

By this time, it is too late for the mother and daughter to go back to the Police Officer and give him the form, so they go home.

A few days pass during which the neighbor has come over and threatened the mother because he's heard that she has been talking to the Police. The mother is afraid, so she and her daughter go to the **Police** and file the case with the medical certificate from the Doctor. Another few days have passed but they have not heard back from the Police. So, the mother and daughter go back to the **Police** to follow up on the status of the case. The Police Officer says he hasn't been able to investigate because he has lost the file. So, they refile the case. *The mother and daughter should walk back over to the person holding the Police card and give her another section of the string to hold onto while the other volunteers continue to hold their strings and the mother keeps hold of the rest of the ball)*.

5. Guiding questions for discussion.

   - **Ask the survivor to express how he or she felt in going to all these people for help?**
   - **What can the group see? What happened here? *[Describe what can be seen visually and allow opportunity to feel tangled yarn]***
   - **How many times did the survivor and mother have to tell the story, how many examinations were undertaken, how much time, energy, and resources did the survivor and her mother have to use?**
   - **How does the survivor and the group feel that her disability impacted the survivor's experience?**

6. Offer a break if people need it.

7. Ask people to return to their seats. Lead a group discussion using the following questions:

   - Remind participants about the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document.

- Ask participants to imagine if this survivor arrived at their office or got in touch with them. She is upset about what she experienced and wants your help to advocate for change. Think about the services and advocacy tools we have discussed.

- **How can we advocate for the survivor to get help faster and to reduce the number of points she has to go to? (for example, referral mechanism, data sharing, case management, integrated services)**

- **How can we address the disability-related discrimination she experienced?**

- **Have you seen any good practices to address the problem we saw today?**

8. Thank participants for engaging in the group discussion. Close by reminding participants again of the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document.

9. Summarize the main points of the discussion, emphasizing where possible the following **key messages. Slide 108.**

- People with disabilities face heightened barriers to seeking out GBV services.

- Learning from the experiences of people with disabilities who have sought services is essential to improving access to services.

- GBV services should be available to everyone, including people with all different types of disabilities.

- When required, disability-specific services are important and should be available in addition to mainstream services (recall the twin-track approach).

ACTIVITY 5C: IMPROVING ACCESS TO GENDER-BASED VIOLENCE (GBV) SERVICES

Duration

60 minutes

Supporting Materials

- PowerPoint slides 109 to 114
- Flipchart and markers

Advance Preparation

- Read UNFPA and WEI, Women and Young Persons with Disabilities: Guidelines, pages 49-91
- See also: UNFPA, Essential Services Package for Women and Girls Subjected to Violence.
- Prepare a flipchart with two columns: one titled "barrier" and the other titled "solutions." Alternatively, practice using the PowerPoint slide. See PowerPoint slide 88 for template.

Instructions

1. Explain that we are now going to discuss what gender-based violence (GBV) services are essential to protecting, respecting, and fulfilling the rights of people with disabilities to be free from violence. Ask for people to raise their hands and share: **Name a type of gender-based violence service and share in a sentence or two what that service does.**

2. After a brief discussion, go through the essential gender-based violence services using the PowerPoint slide and remind participants about the AAAQ or "triple A Q" framework and the twin-track approach, if useful. Share each service area and connect to earlier examples shared by the group. After each service area, **ask participants if they can name a local service provider that offers this service and inquire if that service is accessible. Slides 110 and 111.**

- Gender-based violence prevention services, including, for example, programs to support, educate, and provide respite care for families and caregivers.
- Health services to provide medical services and documentation of violence for medico-legal evidence.
- Justice mechanisms, such as accessible investigative procedures and judicial proceedings.
- Policing, such as accessible police stations and victim-centered approaches.
- Social services, such as help lines, safe accommodations, legal rights information, help recovering or replacing identity documents.

3. Explain to the participants that we are now going to work through dismantling common barriers to services and identifying solutions. **Ask participants to reflect on Sara's journey in the last activity and share barriers they noticed and potential solutions**. Explain that you or your co-facilitator will be writing their answers on the flip chart which features two columns titled Barrier and Solutions. Emphasize that you will read everything that is written down aloud. Share the following example to get started.

- *Barrier:* The community health worker is skeptical that Sara experienced violence.
- *Solution:* Training for community health workers about GBV and people with disabilities and connecting survivors with services. **If time allows, ask participants to brainstorm other common barriers GBV survivors experience and potential solutions. Slide 112.**

4. Use the following barriers and solutions to help guide the conversation.

- Service providers are not prepared for victims/survivors or witnesses with disabilities. *Solution:* Training and support for providers such as disability-inclusion training taught by community members with disabilities.
- Service locations are physically inaccessible. *Solution:* Accessibility audit by local OPD to identify barriers and solutions.
- Information is often inaccessible and unavailable in alternative formats, such as Braille, plain language, easy read, or text-to-speech.

Solution: Funding for accessible information materials developed in consultation with OPDs.

- Women with disabilities may fear losing custody of their children if they report violence, particularly as courts may enforce the discriminatory stereotype that a non-disabled partner must be a more competent parent. *Solution:* Survivor-support programs trained to support parents with disabilities and work with the justice system.

- Healthcare providers may not seek informed consent or know how to provide respectful care to a person with a disability. *Solution:* Disability-inclusive informed consent protocols for healthcare providers and relevant training.

- Impunity for violence against women with disabilities can embolden perpetrators who know that there are few services and judicial mechanisms available and accessible to people with disabilities. *Solution:* Accessible complaint and judicial mechanisms. Disaggregated data by gender and disability on GBV prosecutions and services.

5. Summarize the main points of the discussion, emphasizing where possible the following **key messages. Slides 113 and 114.**

- People with disabilities have all the same rights as persons without disabilities to be free from violence, and to access GBV services needed to realize this right.

- People with disabilities are often denied access to GBV services because of legal and policy barriers; programmatic barriers; and access barriers (physical, social, economic, and attitudinal).

- People with disabilities have a right to be free from violence. Fulfilling this right includes access to comprehensive GBV services that address both their general and disability-specific needs.

- You are the experts on how best to dismantle current barriers to services in the community.

6. Offer a Preview of the Final Session.

- Explain that in Session 6 we will be meeting with a service provider.

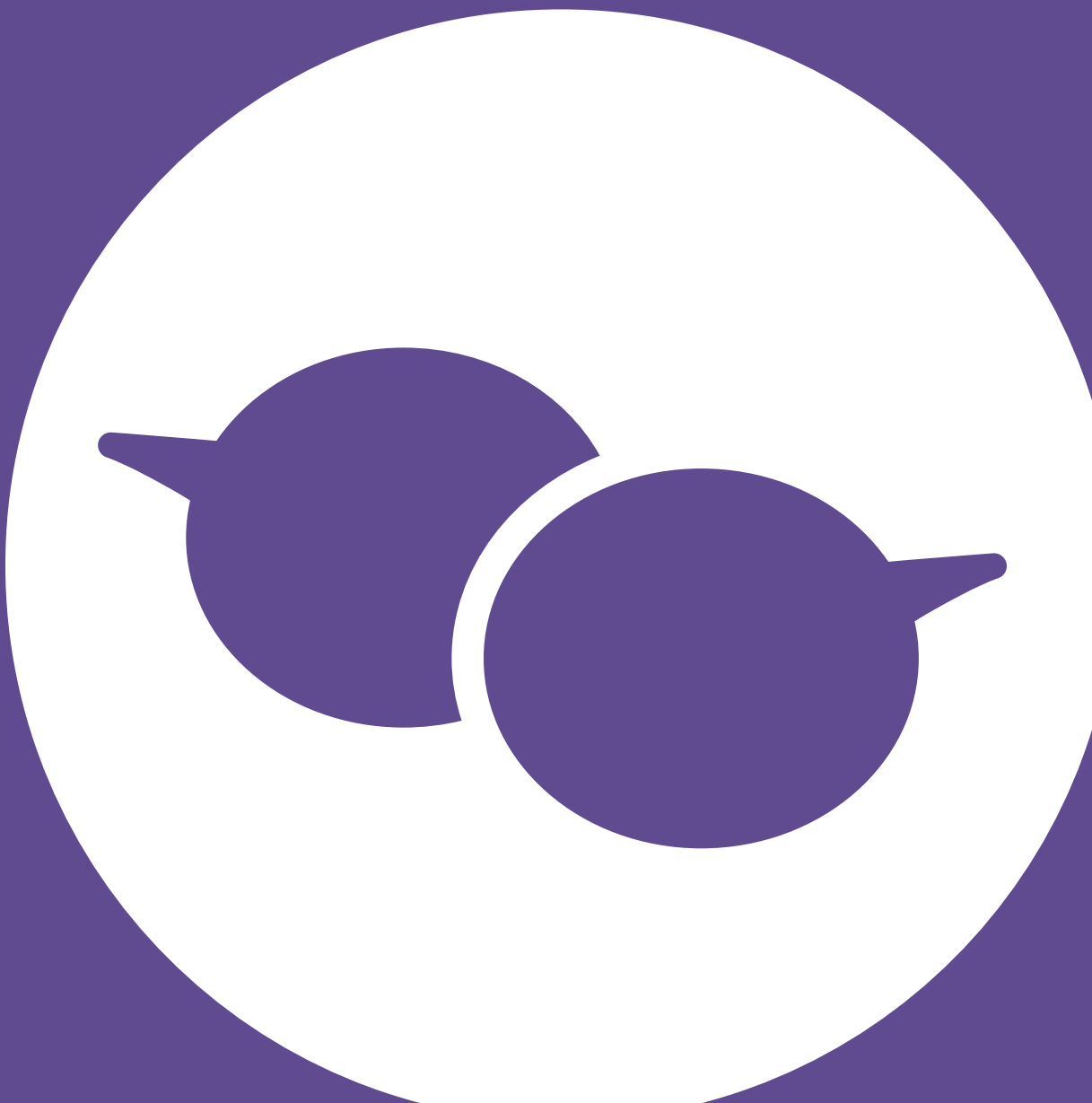
- Conduct a high-level review of the workshop to date.

- Give participants two to three minutes to reflect on questions that they might want to ask the service provider.

- For homework, ask each participant to reflect on what they've learned in the workshop and prepare one to two questions for the closing session.

Close by reminding participants again of the *Sexual and Reproductive Health and Gender-Based Violence Referrals and Support* document.

SESSION 6



Q&A WITH SERVICE PROVIDER AND CLOSING

Session Purpose

The purpose of this session is to provide participants with an opportunity to apply and deepen new knowledge and skills gained in the workshop by engaging with a local service provider. It is an opportunity for participants to ask questions and deepen their awareness of sexual and reproductive health and rights and/or gender-based violence and apply their learnings from the workshop to assess the accessibility of the service and consider solutions. It's also an opportunity for participants to have a positive experience with a service provider and to engage in a dialogue about accessible services to the benefit of both the provider and the participants.

Session Objectives

By the end of this session, participants will have:

- An opportunity to have any lingering questions about SRHR and/or GBV answered or know where to seek further information.
- Experienced a positive interaction with a service provider(s).
- Had the opportunity to engage in dialogue with a service provider about inclusive services and areas of improvement.
- A chance to review the key messages from the workshop.
- Provided feedback on the workshop curriculum.

Session Outline

Session 6: Q&A with Service Provider and Closing	
90 min	Activity 6A: Q&A with Medical Provider and Disability Activist
30 min	Activity 6B: Workshop Review – Pass the Ball
60 min	Activity 6C: Evaluation, Reflection, and Closing

ACTIVITY 6A: Q&A WITH SERVICE PROVIDER

Duration

90 minutes or a half-day visit to the provider's office.

Advance Preparation

- As far in advance as possible, identify one local sexual and reproductive health or gender-based violence service provider who has experience providing services to people with disabilities and/or is open to improving the disability-inclusiveness of their service. Invite them to attend workshop session to engage in a dialogue with participants about what they do and how they make their services accessible (or to host a site visit for participants).
- If arranging a site visit, ensure accessible transport is booked, and accessibility needs are discussed in advance with the provider.
- Prepare some questions in advance for speakers as backup questions. For example:
  - Does your organization track how many people with disabilities use your service?
  - How are your services accessible to people with disabilities?
  - How do you manage stigma and stereotypes that may impact delivery of services to people with disabilities?
  - What are the biggest challenges you face in providing services to people with disabilities?

- How can local organizations of people with disabilities support you in making your services more disability inclusive?

Instructions

1. Let participants know that for this next session, they will be meeting with a local sexual and reproductive health or gender-based violence service provider for a Q&A session. Prior to their joining, the group will review the topics and concepts discussed to date, so that they can refresh their memories and reflect on any additional questions they might have for the provider.

2. Conduct a high-level brief overview of the workshop to date (10 to 15 minutes)

    - Ask participants to share any thoughts after reviewing each day/block of activities.

    - Remind participants about Elsa and Sara's experiences – recalling the barriers and solutions.

    - Offer a quick refresher on the AAAQ framework and twin-track approach as needed.

3. Give participants five minutes to write out any additional questions they have which they can place in the question box/bag.

4. If time allows, engage participants in a short conversation on effective and respectful advocacy techniques to help them prepare should the conversation lead to identifying areas of inaccessibility in the provider's current service provision areas.

5. Once the time is up, introduce the provider and begin the Q&A session (45 minutes). Have some pre-prepared questions in case there is additional time left, or if the group has a limited number of questions.

6. Close the activity by thanking the provider for their time and for all that they do to support women and girls and people with disabilities.

ACTIVITY 6B: WORKSHOP REVIEW

Duration

30 minutes

Supporting Materials

- Onion ball made up of 6 to 10 sheets of paper with one review question per sheet of paper.
- Phone or speaker to play music.

Advance Preparation

- Prepare 6 to 10 review questions and write one question per piece of paper.
- Once you have chosen and sequenced the questions, crumple each question into a ball, keeping in mind that the first question you crumple will actually be the last question answered. Crumple the next around the first one and the next around that, until you have a large ball of questions wrapped around each other. This is the onion that will now be peeled open.
- Prepare music to play while the ball is being passed.

Instructions

1. Ask participants to stand in a large circle facing each other. Explain that you're going to play some music (using your phone, computer, or some other device), and while the music is playing, they should pass the ball around the circle one by one until the music stops.

2. Play 10 to 15 seconds of music. When the music stops, ask the person holding the onion ball to peel off the first question from the outside of the ball and read it aloud (or else you or your co-facilitator will come over and read it aloud for them). Let them know that they can ask the group for help answering the question if they want to. The group should try to help them answer the question. Once the question has been answered, start the music again.

3. Continue tossing the ball with the music playing and pausing the music for the next question. When the music is paused the person holding

the ball peels off the next question and answers it on their own or with support from the group.

4. Repeat these steps for the desired number of rounds/questions.

5. Lead a round of applause for successful completion of the review!

Sample Questions

Select approximately six to eight of the questions below, depending on how much time you want to allocate to review.

1. What is one new insight you gained from this workshop?

2. *True or False?* The social model of disability focuses on the barriers created by the environment (rather than by bodily impairment), including in physical, information, and communication contexts; the attitudes and prejudices of society; policies and practices of governments; and the often-exclusionary structures of health, welfare, education, and other systems.

   Answer: True.

3. When people say "CRPD" they are referring to …

   A. A type of contraceptive
   B. The Convention on the Rights of Persons with Disabilities
   C. The Committee of Racial Prejudice Discrimination
   D. Gender-based violence counseling formats

   Answer: B.

4. Sexual and reproductive health includes which of the following?

   A. Complete physical, mental, and social well-being in all matters related to the reproductive system
   B. Satisfying and safe sex life
   C. Freedom to decide if, when, with whom, and how often to reproduce
   D. All of the above

   Answer: D. All of the above.

5. *True or False:* Women with disabilities have the same rights as women without disabilities to become parents.

Answer: True.

6. Gender-based violence is rooted in which of the following:

A. Gender inequality
B. The abuse of power
C. Harmful gender norms
D. All of the above

Answer: D. All of the Above.

7. Gender-based violence includes which of the following? (Select all that apply)

A. Physical violence by a husband against his wife
B. Forced abortion
C. Robbery
D. Sexual abuse by a caregiver

Answer: A, B, and D.

8. What are some of the barriers to ending the cycle of violence for women with disabilities?

A. Fear of institutionalization
B. Emotional, financial, caregiving or physical dependence on the abuser
C. Inaccessible shelters
D. Not being recognized as a victim or survivor

Answer: All of the above and more.

ACTIVITY 6C: EVALUATION, REFLECTION, AND CLOSING

Duration

45 minutes

Supporting Materials

- PowerPoint slides 115 and 116
- Handouts or email of post-workshop survey and evaluation (one per participant)
- Paper, pens and envelopes
- Flipchart paper, flipchart stand and markers

Advance Preparation

- Create the post-workshop survey and evaluation. See Appendix 5 for an example.
- The day before this session, email participants the post-workshop survey and evaluation as a Word document and a Google Form link.

Instructions

1. Remind participants that they received the post-workshop survey and evaluation yesterday and ask them to find the documents.
2. Let participants know they will now have 10 minutes to complete the survey and evaluation either using their devices or the physical copy you will hand out. However, if they cannot complete the documents now due to accessibility reasons, they should feel free to take a 10-minute break and complete it at a later point. Once 10 minutes have passed, ask if participants need more time.
3. Once participants have completed the survey and evaluation, let them know that we will be moving into our final closing activity. Let participants know that for this final activity they will be writing a letter

or email to themselves, and they should choose the most accessible format for them. In this letter, they can write about anything that they felt was meaningful to them from the workshop or they can use the prompts listed on PowerPoint slide. Read the prompts out loud. Encourage them to write about one thing that they plan to use from this workshop in the future. **Slide 115.**

- **One thing I have appreciated about this workshop has been….**
- **One question I still really want answered is…**
- **This workshop has helped me to…**
- **As a result of this workshop, I will….**

4. Share that often after a workshop ends, the next day we feel very energized, and we talk about the workshop with our colleagues and friends. After one week, we may still reflect on some of the things we shared and learned, and after a few weeks, the workshop may feel like a distant memory. Let them know that once they have written their letters, to put them in the envelope, seal it, and write "open in one month" on the envelope (or to email or text it to themselves with the subject line "Open in One Month." The purpose of this letter is that when the workshop learnings and energy start to fade, they can open the letter or email in one month and remind themselves of what they were most energized about, or things they wanted to continue to reflect on.

5. After everyone has finished their letters or emails, **ask if there are any thoughts or comments anyone would like to share from their letter or about the workshop in general.**

6. Share appreciation for co-facilitators and participants. **Slide 116.**

- Facilitators share appreciation for participants and for co-facilitators, production managers, interpreters, and others.

- Participants: Is there anyone who would like to share an appreciation out loud?

7. Before ending, ask participants to think of one positive word to describe how they have felt about the workshop. At your prompt, ask everyone to say that one word out loud at the same time so that the final workshop moment is filled with positivity!

APPENDICES

APPENDIX 1: EXAMPLE OF A SEXUAL AND REPRODUCTIVE HEALTH REFERRALS AND GENDER-BASED VIOLENCE REFERRALS AND SUPPORT DOCUMENT

Sexual and Reproductive Health and Gender-Based Violence Resources

Our Bodies, Our Rights! Virtual Workshop on Addressing Sexual and Reproductive Health and Rights and Gender-Based Violence Pilot: 3-7; 10-14 October 2022

GENDER-BASED VIOLENCE SERVICES

Need help? Access all organizations offering GBV services in Botswana- download the AME app on Google play https://www.bgbvc.org.bw/index.php/ame-app

Botswana Gender Based Violence Prevention and Support Centre (BGBVPSC)
Physical Address: Plot 6062/3 Extension 19 Broadhurst, Gaborone
Postal Address: Private Bag X046, Gaborone Botswana
Telephone: +267 3907659
Mobile: +267 74 265 081
Fax number: +267 3908691
Website: https://www.bgbvc.org.bw/

Send HELP to 16510/ 74265081/73659641

Women Against Rape Trust (WAR)
Physical Address: Plot 517, Moeti Road
Postal Address: Box 779, Maun, Botswana
Telephone: + 267 68 60 865
Fax: + 267 68 63 058
Website: www.womenagainstrape.org.bw

Tollfree number: 6860243
73437147/ 73437187

Stepping Stones International (SSI)
Private Bag 00421, Gaborone, Botswana
Telephone: +267 573 9858
Fax: +267 573 9898
info@steppingstonesintl.org
Website: https://www.steppingstonesintl.org/

Botswana Substance Abuse Support Network (BOSASNet)
Physical Address: Plot 5346, Okavango Road, Gaborone
Phone: +267 3959119/3913490
Email address: info.bosasnet@gmail.com/ admin@bosasnet.com
Website: http://bosasnet.com/

Men and Boys for Gender Equality
Address Plot 6213, Morubisi Road, Extension 19 Tshimotharo., Gaborone
Telephone: 267395776/ 74711845
Website: www.menandboys.org.bw

Emang Basadi
Address. Plot 551, South Ring Rd, Dilalelo Ext 4, Gaborone, Botswana;
Telephone: +267 3909335 +267 3911421
Fax. +267 3909335.

Childline Botswana
Tollfree number: 11611
Contact number: 72300901

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Botswana Family Welfare Association (BOFWA)
Gaborone clinic
Private Bag 00100, Gaborone.
Phase 4, Plot No. 23769
Next to Sedibeng Lodge
bofwa@bofwa.org.bw
Telephone: 3165129

Kanye clinic
P.O. BOX M1050, Kanye
Kgwatlheng, Next to Ntebogang CJSS
Telephone: 540 3086

Maun clinic
Private Bag 341, Maun
Riverside ward
Telephone: 6864718

Mochudi clinic
P.O. BOX 2067, Mochudi
Plot 2067, Raserura ward
Telephone: 572 9990

Kasane Clinic
Private Bag K7, Kasane
Plot 382, Botshabelo ward
Behind the new bus rank
Telephone: 6352253
Website: http://bofwa.org.bw/

SRHR AIDS Trust
Plot 605, Extension 4, Gaborone
Telephone: 3700675/7
Website: https://www.srhrafricatrust.org/

TEBELOPELE
Unit 4 Plot 39, Gaborone International Commerce Park
Gaborone
Telephone: 267 395 8014/15 & 267 395 8022
Website: https://www.tebelopele.org.bw/

Men for Health & Gender Justice
Head of Office
Plot 37257 Bogogobo Crescent, Block 8, Gaborone
P.O.BOX 382 AAD, Gaborone
Telephone: 3901767
Email: info@menforhealth.org

Palapye Male Health Centre
Telephone: 4920148

Maun Male Health Centre
Telephone: 6862081
Website: https://www.menforhealth.org/

SENTEBALE
Physical: Sentebale Botswana
Ground Floor, Moroja Mews 1St Floor
CBD Gaborone
Postal: Private Bag 13, Poso House
Gaborone
Email: admin1@sentebale.co.bw
Telephone: +267 318 4777
Website: https://sentebale.org/

BOTSWANA-BAYLOR
1836 Hospital Way
Gaborone, Botswana
info@baylorbotswana.org.bw
Telephone: +267 319 0083
Telephone: +267 319 0079
Website: https://www.botswanabaylor.org/
Opening Hours: Monday-Friday - 7:30 - 16:30, Saturday and Sunday – Closed

APPENDIX 2: GLOSSARY: LIST OF KEY TERMS AND DEFINITIONS

Our Bodies, Our Rights!

Workshop on Addressing Sexual and Reproductive Health and Rights and Gender-Based Violence

GLOSSARY

Adolescents are boys and girls between the ages of 10 and 19 years old. The period is defined by the physical, cognitive, behavioral, and psychosocial changes taking place during the period and illustrated by increased sense of self, confidence, and independence.[14]

Comprehensive sexuality education (CSE) refers to sexuality education that is rights-based and assists people with obtaining accurate and age-appropriate information about all aspects of sexual and reproductive health and rights; healthy exploration of sexuality; empowerment; and positive thinking about sexuality and sexual and reproductive health and rights. CSE also supports the development of positive life skills and relationships.[15]

Economic violence involves denying a person access to and control over basic financial resources.[16] Since many people with disabilities are not given responsibility over their finances, people with disabilities can be at risk of this form of violence.

Justice system refers to both formal and informal justice systems. Formal justice systems involve the State and its agents administering justice through the enforcement and application of laws. Mechanisms include law enforcement, criminal justice systems, and courts and judges.[17] Informal justice systems refer to the range of mechanisms varying in formality involved in access to justice and rule of law, but that exist outside of the

14 UNFPA and Save the Children USA, "Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings," 2009, http://www.unfpa.org/publications/adolescent-sexual-and-reproductive-health-toolkit-humanitarian-settings.

15 UNFPA, "UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender," 2014, http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_OperationalGuidance_WEB3.pdf.

16 U.N. Secretary-General, "In-depth Study on All Forms of Violence Against Women: Report of the Secretary General," U.N. Doc.A/61/122/Add.1 (July 6, 2006), paras.111-113, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N06/419/74/PDF/N0641974.pdf?OpenElement.

17 United Nations United Population Fund (UNFPA), UN Women, World Health Organization (WHO), United Nations Development Programme (UNDP), and United Nations Office on Drugs and Crime (UNODC), "Essential Services for Women and Girls Subject to Violence (Module 1)," 2015, http://www.unfpa.org/publications/essential-services-package-women-and-girls-subject-violence.

traditional State justice structure. Informal justice systems may or may not be connected or recognized by the State. Mechanisms include systems involved in the "resolution of disputes and the regulation of conduct by adjudication or the assistance of a neutral third party that [] is not a part of the judiciary as established by law and/or whose substantive, procedural or structural foundation is not primarily based on statutory law".[18]

Gender-based violence (GBV) refers to acts of or threats of violence that are perpetrated against people on the basis of their gender or their perceived gender, biological sex, as well as social and gender norms. GBV can refer to acts that "results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[19]

Gender-based violence can take a variety of forms — physical, emotional, psychological, sexual, economic — and can include violence perpetrated by intimate partners, family members, caregivers, medical or other service providers, law enforcement, military personnel, educators, employers, and strangers.20 This violence can be against women and girls, who are and have historically been victimized by harmful gender roles. It can also be experienced by people of gender minorities, such as transgender, nonbinary, and gender nonconforming persons and men, if the violence is motivated by "socially ascribed (i.e. gender) differences between males and females".[21]

Healthcare service providers offer healthcare services in a systemic way. Examples include doctors, midwives, nurses, community health workers, and other individuals trained to provide health services.[22]

Health system is defined by the World Health Organization as "all the activities whose primary purpose is to promote, restore and/or maintain health" and "the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve".[23]

18 UNDP, UNICEF, and UN Women, "Informal Justice Systems: Charting a Course for Human Rights-Based Engagement," 2012, http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2013/1/informal-justice-systems-charting-a-course-for-human-rights-based-engagement.pdf?la=en&vs=5500.

19 WHO, "Health Topics: Violence against Women," https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

20 Declaration on the Elimination of Violence Against Women, G.A. Res. 48/104, U.N. Doc. A/RES/48/104 (Dec. 20, 1993), art. 2.

21 Inter-Agency Standing Committee (IASC), "Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, https://interagencystandingcommittee.org/system/files/2015-iasc-gender-based-violence-guidelines_lo-res.pdf.

22 WHO, "Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines, 2013, http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf.

23 WHO, "Health System Strengthening: Glossary," 2011, www.who.int/healthsystems/Glossary_January2011.pdf.

Informed consent is the process of communication between a service provider and a service recipient. The service provider gives accurate, comprehensive, clear information about the services available, benefits risks, and alternatives to the service recipient in a manner and form that they understand, and with support as requested and directed by the service recipient, without threats, intimidation, or inducements. The service recipient themselves voluntarily consents to services or declines them, based on this information.

Legal capacity refers to the right of people with disabilities to recognition everywhere as people before the law. Under international human rights law, people with disabilities have a right to legal capacity, which is distinct and independent from mental capacity, on an equal basis with individuals without disabilities. Supported decision-making mechanisms may be necessary to empower people with disabilities to exercise their right to legal capacity.[24]

Person with a disability is the person-first language used by the Convention on the Rights of Persons with Disabilities to refer to a "person who has some type of physical, intellectual, mental, cognitive, or sensory impairment that in interaction with various barriers may hinder his or her full participation in society on an equal basis with others".[25]

Psychological violence refers to behavior that is controlling, isolating, humiliating, or embarrassing and which causes the person upon who it is perpetrated psychological distress.[26]

Reasonable accommodation is defined by the CRPD as "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to people with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms".[27]

Reproductive health refers to a person's complete physical, mental, and social well-being, not only the absence of disease or illness, in all matters relating to the reproductive system and to its functions and processes. Reproductive health includes the ability to enjoy a satisfying and safe sex life and the freedom and legal capacity to decide if, when, with whom, and how often to do so. For women and young people with disabilities, this means the right to be free from forced sterilization, contraceptives, and abortion (where legal); access to accessible information about reproductive health and safe,

24 Committee on the Rights of Persons with Disabilities (CRPD Committee), "General Comment No. 1, Article 12: Equal Recognition Before the Law," U.N. Doc. CRPD/C/GC/1 (May 2014), para. 39.

25 CRPD, art. 1.

26 U.N. Secretary-General, "In-depth Study on All Forms of Violence Against Women," para.113.

27 CRPD, art. 2.

effective, affordable, and acceptable methods of family planning; and the right to access quality accessible maternal and newborn health services.

Reproductive rights are human rights recognized in national laws, international laws, and international human rights documents that uphold the rights of all people to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. Women and young people with disabilities, as with all rights-holders, must be free to make these decisions free of discrimination, coercion, or violence.[28]

Sexual health is defined as "a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence".[29]

Sexual rights are the rights of all people to attain the highest attainable standard of sexual health free of coercion, violence, and discrimination of any kind; to pursue a satisfying, safe, and pleasurable sexual life; to have control over and decide freely and consensually, on matters related to their sexuality, reproduction, bodily integrity, choice, and gender identity; and to accessible services, education, and information, necessary to do so.

Sexual violence refers to abusive sexual contact, making a person engage in a sexual act without consent, and attempted or completed sex acts with a person who is unable to consent to sexual contact. It can take many forms, including any unintended or non-consensual sexual act, sexual harassment, and violent acts. A person may be unable to consent due to their disability (however, having a disability does not mean a person is automatically unable to consent to voluntary sexual conduct). Other reasons a person may be unable to consent include that the person is asleep, unconscious, ill, under pressure, or under the influence of drugs or alcohol.[30]

Supported decision-making refers to regimes that replace substitute decision-making models, such as guardianship. Supported decision-making "comprises various support options which give primacy to a person's will and preferences, and respect human rights norms. It should provide protection for all rights, including those related to autonomy (right to legal capacity, right to equal recognition before the law, right to choose where to live, etc.), and rights related to freedom from abuse and ill-treatment (right to life, right to physical

28 CRPD, art. 23(1).

29 WHO, "Sexual and Reproductive Health: Defining Sexual Health," 2017, http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/.

30 UNFPA, et al., "Essential Services for Women and Girls Subject to Violence (Module 1)."

integrity, etc.)".[31] Substituted decision-making models perpetuate power imbalances, which can make women and young people with disabilities especially vulnerable to gender-based violence and other forms of abuse and ill-treatment.[32]

Survivor-centered services are those that "prioritize the rights, needs, dignity and choices of the survivor—including the survivor's choice as to whether or not to access legal and judicial services".[33]

Twin-track approach has been defined by the Committee on the Rights of Persons with Disabilities as: "systematically mainstreaming the interests and rights of women and girls with disabilities across all national action plans, strategies and policies concerning women, childhood and disability, as well as in sectoral plans concerning, for example, gender equality, health, violence, education, political participation, employment, access to justice and social protection" and "targeted and monitored action aimed specifically at women with disabilities".[34]

Victim/survivor is a person who has experienced or is currently experiencing gender-based violence. There has been debate about the use of the terms victim and survivor. The UN Secretary-General's "In-Depth Study on Violence Against Women" explains that for some, "the term 'victim' should be avoided because it implies passivity, weakness and inherent vulnerability and fails to recognize the reality of women's resilience and agency. For others, the term 'survivor' is problematic because it denies the sense of victimization experienced by women who have been the target of violent crime".[35]

Violence against women is defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life".[36] This definition includes the many forms violence against women with disabilities can take, including intimate partner violence, caregiver violence, medical violence (e.g. forced sterilizations and other procedures, forced medication or overmedication), sexual violence, psychological violence, economic violence, institutional violence, and violence during emergencies.

31 CRPD Committee, General Comment No. 1.

32 Office of the United Nations High Commissioner for Human Rights (OHCHR), "Thematic Study on the Issue of Violence Against Women and Girls and Disability," U.N. Doc. A/HRC/20/, 2012, para. 16, http://www2.ohchr.org/english/issues/women/docs/A.HRC.20.5.pdf.

33 IASC, "Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery."

34 CRPD Committee, General Comment No. 3 Article 6: Women and Girls with Disabilities, U.N. Doc. CRPD/C/GC/3 (2016), para. 27.

35 U.N. Secretary-General, "In-depth Study on All Forms of Violence Against Women," para. 21.

36 Declaration on the Elimination of Violence Against Women, art. 1.

Violence, non-partner is violence committed by a caregiver (non-partner), family member, friend, acquaintance, neighbor, work colleague, or stranger. Frequently, non-partner violence is committed by a person familiar to the victim/survivor. For people with disabilities, offenders can serve in a caregiver role for the person either in the person's home or in an institutional setting.

Violence, intimate partner refers to the range of sexual, psychological, and physical acts that can be used against women and young people with disabilities by a current or former intimate partner, without that person's consent. For people with disabilities, intimate partner violence is regularly perpetrated by partners who are also caregivers for that person, which can often prevent such violence being identified.

Young people refers to girls, boys, young women, and young men from age 10 to 24 years old, encompassing the globally accepted definitions of adolescents (an age range of 10 to 19) and youth (age range of 15 to 24).[37]

Youth refers to people ages 15 to 24.[38]

37 UNFPA, "Girlhood, Not Motherhood: Preventing Adolescent Pregnancy," 2015, https://www.unfpa.org/sites/default/files/pub-pdf/Girlhood_not_motherhood_final_web.pdf.

38 UNFPA, "Girlhood, Not Motherhood: Preventing Adolescent Pregnancy."

APPENDIX 3: KEY RESOURCES

LEADERSHIP AND FACILITATION TRAINING PROGRAMS:

- International Disability Alliance (IDA), Bridge CRPD-SDGs Training Initiative Training of Trainers (free program but restricted availability)
- Mobility International USA (MIUSA), Loud, Proud and Passionate!: An Innovative Rights-based Facilitator's Guide for Leadership Training of Women with Disabilities. (fee)
- IPAS, Effective training in reproductive health: Course design and delivery. Reference manual. (free)
- Training for Change, Training Tools (free and fee-based trainings)
- Council of Europe, Compass: Manual for Human Rights Education for Young People (free)
- This Ability, Digital Dada Program (free program but restricted availability)
- LaVant Consulting, 'Digital Accessibility' Live Training Event [Recorded]

ACCESSIBILITY RESOURCES:

- WEI, Access: Good Practices International Meeting Checklist
- The Inclusive Generation Equality Collective, Feminist Accessibility Protocol
- Inclusion International and Down Syndrome International's Listen, Include, Respect: International Guidelines to Inclusive Participation
- Rooted in Rights, How to Make your Virtual Meetings and Events Accessible to the Disability Community

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND GENDER-BASED VIOLENCE RESOURCES:

- WHO & UNFPA, Promoting Sexual and Reproductive Health for Persons with Disabilities
- UNFPA, UN Women, WHO, UNDP & UNODC, Essential Services Package for Women and Girls Subject to Violence
- UNFPA & WEI, Women and Young Persons with Disabilities Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights for Women and Young Persons with Disabilities
- UNFPA, Young Persons with Disabilities: Global Study on Ending Gender-based Violence and Realizing Sexual and Reproductive Health and Rights
- WEI, Fact Sheet: Sexual and Reproductive Health and Rights of Women and Girls with Disabilities
- WEI, Fact Sheet: The Right of Women and Girls with Disabilities to be Free from Gender-Based Violence
- UNFPA, My Body is My Own: Claiming the Right to Autonomy and Self-Determination
- Asian-Pacific Resource & Research Centre for Women (ARROW), Sreshtha Das, Reclaiming SRHR of Women and Girls with Disabilities: A Training of Trainers Manual on Disability Rights, Gender, and SRHR
- SafeLives, Spotlight Report # HiddenVictims. Disabled Survivors Too: Disabled people and domestic abuse

APPENDIX 4: PRE-WORKSHOP SURVEY EXAMPLE

PRE-WORKSHOP SURVEY

Our Bodies, Our Rights! In-Person Workshop on Addressing Sexual and Reproductive Health and Rights and Gender-Based Violence

Please return to: [insert email] by October 2nd

Name (optional):
Email (optional):
Phone number (optional):

1. **How would you describe your knowledge of human rights? Check one:**
   - ☐ Very knowledgeable
   - ☐ Basic knowledge
   - ☐ Not very knowledgeable yet

2. **How would you describe your knowledge of sexual and reproductive health and rights? Check one:**
   - ☐ Very knowledgeable
   - ☐ Basic knowledge
   - ☐ Not very knowledgeable yet

3. **How would you describe your knowledge of gender-based violence? Check one:**
   - ☐ Very knowledgeable
   - ☐ Basic knowledge
   - ☐ Not very knowledgeable yet

4. **Have you ever facilitated a workshop for your peers before?**

5. **What are you most concerned about relating to this workshop?**

6. **What are you most looking forward to about this workshop?**

7. **What are your goals for this workshop?**

8. **How do you expect to use the learnings of this workshop into practice?**

9. **Is there anything you would like the organizers of this workshop to know?**

APPENDIX 5: POST-WORKSHOP SURVEY EXAMPLE

POST-WORKSHOP SURVEY

Our Bodies, Our Rights! In-Person Workshop on Addressing Sexual and Reproductive Health and Rights and Gender-Based Violence

Please return to: [insert email] by October 12th 2022

Name (optional):
Email (optional):
Phone number (optional):

1. **The goal for this workshop was to provide you with basic information about sexual and reproductive health and rights and gender-based violence to enable you to advocate for your own and your community's rights to access available, accessible, acceptable, and good quality SRHR and GBV services. Do you think this was achieved? If not, why not?**

2. **How would you describe your knowledge of sexual and reproductive health and rights and related services AFTER this workshop? Check one:**

   ☐ Very knowledgeable.
   ☐ Basic knowledge.
   ☐ Not very knowledgeable yet.

3. **How would you describe your knowledge of gender-based violence and related services AFTER this workshop? Check one:**

   ☐ Very knowledgeable.
   ☐ Basic knowledge.
   ☐ Not very knowledgeable yet.

4. **How do you see yourself using the learnings of this workshop in practice?**

5. **Has this workshop made you more comfortable with advocating for the sexual and reproductive health rights and gender-based violence-related rights of persons with disabilities? Please explain.**

6. **Would you feel comfortable facilitating this virtual workshop to your peers?**

   ☐ Yes
   ☐ No

7. **Please explain why you feel comfortable facilitating or why not?**

8. **In your opinion, what was the most successful activity and why?**

9. **In your opinion, which was the least successful activity and why?**

10. **How accessible was this workshop and the related communication for you, and how can we improve?**

11. **If you could change one thing about this workshop, what would it be?**

12. **Is there anything you would like the organizers of this workshop to know?**

APPENDIX 6: COMPLETION CERTIFICATE EXAMPLE

WOMEN ENABLED INTERNATIONAL

WE DECIDE

UNFPA

Ri

Certificate of Completion

THIS CERTIFICATE IS AWARDED TO

NAME

FOR THE SUCCESSFUL COMPLETION AND FACILITATION OF THE

OUR BODIES, OUR RIGHTS! IN-PERSON PILOT WORKSHOP ON SEXUAL & REPRODUCTIVE HEALTH AND RIGHTS AND GENDER-BASED VIOLENCE

7TH TO 11TH OF NOVEMBER 2022

MS. MARYANGEL GARCIA-RAMOS
EXECUTIVE DIRECTOR
WOMEN ENABLED INTERNATIONAL

MS. TLANGELANI SHILUBANE
HEAD OF OFFICE
UNFPA BOTSWANA

NOTES

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