Vulnerability of refugees with communication disabilities to SGBV: evidence from Rwanda

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Refugees with communication disabilities are particularly vulnerable to sexual and gender-based violence, in part because of their limited ability to report abuse.

In recent years, there has been a concerted effort by humanitarian actors to include people with disabilities in service provision and programming. However, those identified as having disabilities are more often than not people with 'visible' physical difficulties. People with less visible challenges, such as communication disabilities, often go unidentified and are unable to access the humanitarian and protection services they need.

A person with communication disabilities may have difficulties in understanding and/or in expressing themselves, using spoken or signed language. Studies suggest that up to 49% of people with disabilities who seek services in East Africa have some form of communication difficulty[1] but the challenges they face are often not identified due to the 'hidden' nature of the disability: communication disability is both invisible and often complicated by other disabilities. Services to assist people with communication disabilities in many low- and middle-income countries are either non-existent or in short supply. In addition, widespread misunderstanding of the causes and nature of communication disabilities often results in people's exclusion from, or poor access to, support within the community and through formal and informal services.

Sexual and gender-based violence (SGBV) is a significant risk for refugees in Rwanda, particularly for women and children. The

risk is considered to be significantly higher for refugees with disabilities, because of factors such as being separated from family members, isolation, poor living conditions that may impact them disproportionately, and shortfalls in community protection mechanisms. Other contributing factors include people with disabilities being stigmatised, their accounts of abuse being discredited and, in some cases, their lack of mobility hindering escape.

People with communication disabilities may be specifically targeted as they are far less able to report abuse, to describe the perpetrator effectively or to follow through with legal proceedings. In addition to the lack of support services available following abuse, evidence suggests that preventative measures, such as sexual and reproductive health education for refugees, is often not accessible to people with communication disabilities.

There is some emerging evidence that humanitarian organisations are beginning to recognise communication disabilities as a barrier to accessing services for SGBV (including prevention, support and legal redress), and as a major protection risk,[2] but there is little evidence of good practice in supporting people with communication disabilities to report SGBV and to access ongoing support. Front-line humanitarian staff in Rwanda are aware of the difficulties that people with communication disabilities face across the SGBV response systems but feel ill-equipped to respond to their needs.

Identifying the challenges

In response to concerns identified by UNHCR (the UN Refugee Agency) Rwanda, and following an in-depth literature review,[3] a project involving Manchester Metropolitan University, Communicability Global and UNHCR was set up to find out more about the scale and nature of the challenges facing refugees with communication disabilities and their carers in relation to access to SGBV medical, legal and psychosocial support services.[4] We first carried out focus group discussions in Rwanda with frontline humanitarian staff and community members (including community mobilisers, who are responsible for assisting refugees to access appropriate support services) from a refugee settlement and from an urban refugee setting. We also carried out a small number of individual and small-group interviews with carers of people with communication disabilities, to find out what challenges they and the person with the communication disability face. (At this stage, we did not talk to carers of people with communication disability about SGBV specifically, due to the sensitive and distressing nature of the topic.) Information about the experience of SGBV survivors who have a communication disability was obtained indirectly, from humanitarian staff and community mobilisers.

We then held a workshop for key stakeholders (UN agencies, national organisations, local Disabled People's Organisations and a clinical psychologist with expertise in SGBV) to explore the difficulties faced by refugees with communication disabilities in accessing appropriate services, gaining support for improvement of services, and to establish a consortium of expert organisations to take this work forward.

Findings from this preliminary investigation indicate that understanding about communication disability is very limited across the board, at community level and among service providers and strategic actors. For people with a communication disability, barriers to accessing services occur at every stage of SGBV response: prevention, disclosure, support and redress. There were anecdotal reports of perpetrators targeting people with communication disabilities and bribing them with food, or threatening them with exposure, and evidence of people with communication disabilities being targeted in their own homes when they were alone. Endemic stigmatisation and discrediting of people with communication disabilities by community members and service providers make reporting abuse almost impossible.

Critically, service providers do not have sufficient knowledge and understanding about the range and impact of communication disabilities, or skills to support people with communication disabilities. There is also a

widespread misunderstanding that using sign language is the best solution, even though most people with communication disabilities in humanitarian contexts do not use a formal sign language. It was apparent that when a SGBV survivor has a communication disability, medical practitioners did not have the skills to take a medical report and police are unable to take statements effectively. Furthermore, judicial systems may not be able to prosecute if a victim cannot bear witness to the crime. In addition, counselling and psychosocial support services are often based on talking therapies, and providers lack the skills and resources necessary to provide services using alternative methods.

Improving services

During the workshop, participants identified what they thought they and their organisations could do over the next five years or more to improve services for refugee survivors of SGBV who have a communication disability. Their commitments included training and capacity building for all service providers about understanding and identifying communication disabilities, awareness raising and sensitisation among communities, developing materials to help people with communication disabilities to disclose SGBV (for example, by using picture symbols or objects for people to show what they experienced, rather than having to use only spoken words) and to access medical and legal services, and better inclusion in education – both formal education and in sexual and reproductive health (SRH) education. SRH has been identified as crucial in the prevention of SGBV and both the literature review and reports from stakeholders highlighted the lack of inclusive SRH education services in refugee communities.

Priorities identified for the project include a) working with key stakeholders to engage with refugee survivors of SGBV with communication disabilities and their families, in order to better understand their needs and the challenges they face – and to involve them in future developments in this area; and b) working with partners to design, implement and evaluate changes in processes and services to increase the inclusion of people with communication disabilities in SRH education, and to improve their ability to access appropriate responses to SGBV.

In order for this work to be done, humanitarian actors clearly need to be able to identify people with communication disabilities. This will require training of agency staff, community leaders, disability committees and community mobilisers (and volunteers), and the establishment of systems to record and document people and needs.[5] It will also be essential to consider the ethical implications and support systems needed to engage with such a vulnerable group of people on such a sensitive and distressing topic.

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1. Hartley S (1995) 'The proportion of people with communication disabilities seeking help from community development assistants (CDAs) in Eastern Uganda', Proceedings of the 23rd World Congress of the International Association of Logopedics and Phoniatrics, Cairo.

2. Plan International (2016) *Protect Us! Inclusion of children with disabilities in child protection* https://plan-international.org/protect-us

3. Literature review online at http://bit.ly/MMU-LitReview or from Julie Marshall.

4. The project was supported by Elrha's Humanitarian Innovation Fund www.elrha.org/hif

5. See also Women's Refugee Commission (2015) *I See That It Is Possible: Building Capacity for Disability Inclusion in Gender-based Violence (GBV) Programming in Humanitarian Settings* plus *Toolkit* http://bit.ly/WRC-2015-disability-GBV