2025

CARE-INT

Preliminary analysis on ***gender-based violence*** and ***disability.*** Regulatory framework, data and good practices.

Table of contents

Introduction	4
1. Regulatory framework and reference documents international institutions	9
1.1 The global system of the United Nations	9
1.2 The European Union regional system	11
1.3 The national system	13
1.3.1 Italian legislation	13
1.3.2 Legislation in the Netherlands	14
2. Analysis of the phenomenon	**15**
2.1 Context	15
2.2 Definitions of violence	16
2.3 Violence as discrimination	16
3. Available data	**19**
3.1 Context	19
3.2 EU survey on gender-based violence against women and other forms of interpersonal violence (EU-GBV)	20
3.2.1 Women who have experienced violence from their partner, according to level of disability (activity limitation)	25
3.2.2 Women who have experienced violence by someone other than their partner, by level of disability (activity limitation)	27
3.2.3 Women who have experienced violence by a family member or relative, by level of disability (activity limitation)	30
3.2.3 Women who have experienced violence by a stranger, by level of disability (activity limitation)	32

4. Role of professionals in Italy and in the Netherlands **36**

4.1 Context 36

4.2 Comparison of the two training courses in Italy and the Netherlands on professional roles 37

4.3 Strengths and challenges to be addressed in order to improve the training offer 41

5. Good practices from United Nations agencies **44**

5.1 Strengthen the capacity of gender-based violence practitioners to work with victims of violence with disabilities 44

5.2 Capacity building: rights holders and duty bearers 45

5.3 Effective identification of needs 46

Bibliography and Web **48**

The project "**CARE-INT: Equipping future care professionals to tackle intersectional discrimination and violence against women with disabilities**" is implemented in Italy and in the Netherlands thanks to the co-financing of the European Union under the Erasmus+ program.

The **goal** is to **promote the rights and inclusion of women with disabilities** and combat intersectional violence and discrimination.

Graphic Project
Roberta Arena

Introduction

"No, it doesn't surprise me, simply because when faced with a disabled woman, men today still feel physically stronger. So when they can't dominate her psychologically, they try to compensate with physical violence. If she also has an intellectual disability, it can be even easier to trigger violent behaviour[1]*"*.

"Good morning. I am a woman with a physical disability and I was sexually abused by a physiotherapist. This therapist made me believe that through a breathing technique I would be able to ride a horse again. At first, he kissed me on the cheek and seemed affectionate towards me, and he told me that because I wasn't breathing properly, I had to do this breathing technique, otherwise I would never be able to ride a horse again, and riding was very important to me. I didn't know this therapist very well because he wasn't the physiotherapist who had been treating me for years; he was a new physiotherapist, a substitute. He tricked me into believing that if I didn't do what he said, I would never be able to ride a horse again, given my severe physical stiffness. He promised me that if I followed his technique, I would be able to walk! That day, he had me draw a picture of horses and then said, 'I need to see your back'. Then he stood me up and pulled down my underwear and trousers. He told me to 'breathe hard'. I did, because I believed what he told me because, if you tell me it's a breathing technique for physiotherapy, I'll do it. Then he turned me over onto my stomach and did it again. Then he picked me up and did it again and said, 'Next time, come like this so you can breathe better and walk again,' and he did it again while I was in his arms. I'll say one thing: sexual abuse is disgusting! I say that women should not be abused. My mother noticed after a while. She had put me on the bed and was helping me with my homework. She could feel that I was physically stiff, so she tried to help me stretch and relax my body. Physical stiffness is part of my condition (spastic tetraparesis), so she laid me down on the bed, massaged me, and I told her what had happened. For us women with physical disabilities, rehabilitation is vitally important, so I didn't know how to say it because the therapist had made me believe it was therapy. I didn't know it was sexual abuse. When I was abused, I was a minor, so that also contributed to my not recognising the sexual abuse I had suffered[2]*"*.

Women with disabilities represent **16% of the female population in the EU**, over 36 million people who often experience various types of disabilities, including physical, psychosocial, intellectual and sensory conditions that may or may not involve functional limitations. Furthermore, the diversity of women with disabilities includes those with multiple and intersecting identities in all contexts, such as ethnic, religious and racial backgrounds; refugee, migrant, asylum seeker and internally displaced status; LGBTIQ+ identity; age; and marital status.

As a result of substantially different life experiences based on these factors, women and girls with disabilities are often pushed to the extreme margins and suffer **profound discrimination**. The different forms of discrimination not only add up, but interact, amplifying their effects[3].

All of this can lead to lower economic and social status, increased risk of violence and abuse,

1 Investigation by SuperAbile Inail, 2017. Testimony of Osanna Brugnoli, now in a wheelchair after an accident deliberately caused by her partner, who could not accept the end of their relationship

2 Testimony of Emanuela taken from the Proceedings of the Conference 'Forgotten Wounds: Gender Perspectives on Social Violence' 2016

3 CRPD GC No. 13

including sexual violence, limited access to education, healthcare (including sexual and reproductive health), information, services, justice, and civic and political participation. Acts of violence against women and girls with disabilities also include other **forms of physical and psychological violence** and neglect, including:

- denial of medication and assistive devices (such as wheelchairs, braces and white canes);
- removing a ramp or mobility devices;
- refusal by home care workers to assist with daily activities (such as washing, dressing and eating);
- denial or threat of denial of food or water;
- verbal abuse and ridicule related to disability;
- removal or control of communication aids;
- intimidation;
- damaging or threatening to damage property or pets;
- psychological manipulation;
- restricting relationships with family members or friends;
- women and girls with disabilities are also particularly vulnerable to forced sterilisation and medical treatment, including the administration of drugs or electroshock therapy.

In addition to the forms of violence listed above, certain **factors that contribute to the increased risk of violence** to which women and girls with disabilities are exposed must be taken into account, including **barriers to accessing information** and services on gender-based violence, which play a significant role. For example, information on different forms of gender-based violence and where to access support and services may not be available in accessible formats (e.g. Braille, Sign Language and captions) or may not be shared in a way that is understandable to persons with intellectual disabilities (e.g. in easy-to-read or illustrated formats). Women and girls with disabilities are often excluded from women's groups, activities and meeting places where this information is commonly disseminated.

Transport has also been identified as a substantial barrier preventing women and girls with disabilities from accessing a range of services and support: they may need assistance to use public transport or money to hire a private vehicle. Furthermore, even if these women and girls reach a safe space or facility where they can receive help, **environmental barriers**, such as inaccessible stairs or toilets, can negatively affect their experience. Finally, and perhaps most importantly, negative attitudes and harmful **stereotypes** about disability held by family members, communities and even service providers represent a significant barrier.

Violence against women is defined by *the Declaration on the Elimination of Violence against Women* 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'.

The Office of *the High Commissioner for Human Rights* adopts a comprehensive definition of what constitutes violence against women and girls with disabilities in accordance with international human rights standards and as articulated by organisations for persons with disabilities: "violence perpetrated through physical force, legal coercion, economic coercion, intimidation, psychological manipulation, deception and misinformation, and in which the absence of free and informed consent is a key analytical component".

In 2020, UN Women[4] reported that **61% of European women with disabilities** (compared to 54% of women without disabilities) **had experienced harassment since the age of 15**.

Thirty-four percent had experienced physical or sexual violence from a partner, and 60% of women with intellectual disabilities reported sexual abuse. In most cases (87%), the perpetrator of the violence is someone known to the victim, often a caregiver. As highlighted in the latest EDF human rights report[5], in Italy and the Netherlands, full legal guardianship[6] of persons with disabilities is still permitted, increasing the risk that women with disabilities will undergo treatment or procedures without their free and informed consent.

Women with disabilities are not only more exposed to such violence (two to five times more) but also face greater difficulties in escaping it due to disability-related discrimination that leads to them being infantilised, ignored and not believed, making the phenomenon even more sensitive and urgent[7]. The exposure of persons with disabilities to a higher risk of violence is directly linked to factors that increase their dependence on others or deprive them of power and rights. Many of these factors also lead to **impunity and invisibility of the problem**, and cause violence to continue for long periods of time. The inability of professionals, relatives and friends to recognise the circumstances resulting from violence – as they are often considered inherent to disability – is another factor that contributes to making violence invisible.

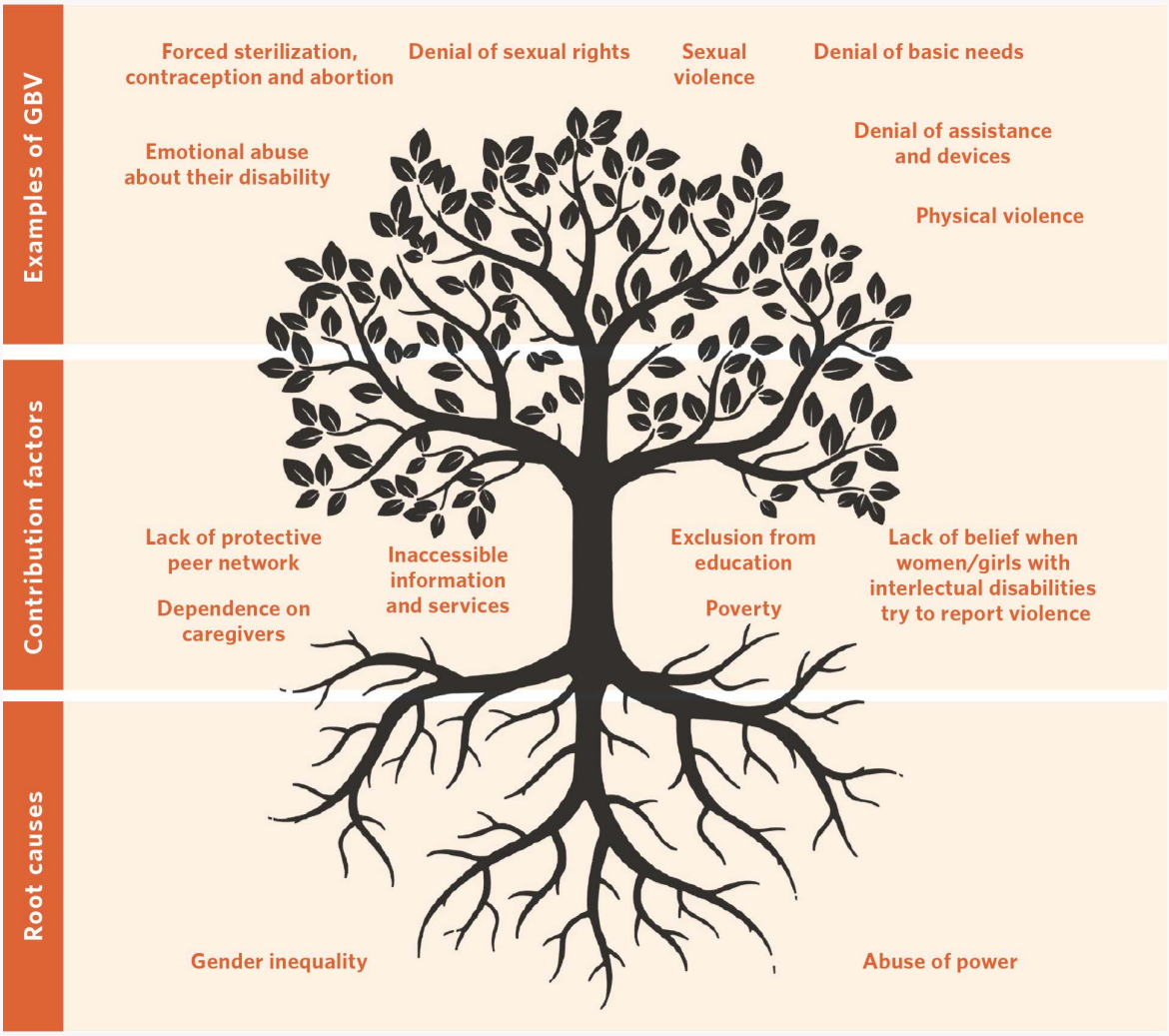
4 UN WOMEN, Sexual harassment against women with disabilities in the world of work and on campus, 2020

5 EDF, European Human Rights Report, 'Legal capacity: Personal choice and control', 2024

6 The legal protection of persons with disabilities is the set of laws and rules that serve to protect their rights, but in some cases it can have problematic aspects relating to the restriction of personal freedom, which can turn into further abuse.

7 Pirkko Mahlamaki, Gender-based violence against women and girls with disabilities, 2021. CoE, Preventing and combating violence against women with disabilities, 2023

Figure 1[8] – Gender-based violence against persons with disabilities



Note: Not all types of GBV and factors contributing to GBV have been included in this tree.

The image depicts a tree whose branches are connected to various forms of violence that can affect women with disabilities (sexual and psychological violence or denial of basic needs); the trunk is associated with some of the risk factors that contribute to increasing the vulnerability of women with disabilities (limited access to services, difficulty in reporting abuse and dependence on other people); Finally, the roots are associated with the causes (gender inequality and abuse of power).

Addressing gender-based violence through **an intersectional analysis** helps us to better understand the multiple identities of women and girls, including those with disabilities, which can define how they experience gender-based violence and can in turn contribute to improving service delivery, advocacy and programme priorities.

Furthermore, the lack of sex education for women and girls with disabilities, who are mistakenly perceived as beings without sexuality, contributes to sexual violence against them, as they are unable to distinguish inappropriate or abusive behaviour. The intersection of gender discrimination and disability discrimination also contributes to stereotypical images of women and girls with disabilities as unintelligent, submissive and shy, who are often not believed when they report incidents, with the risk that perpetrators go unpunished.

8 UNFPD, DISABILITY INCLUSION IN GENDER-BASED VIOLENCE PROGRAMMING PROMISING PRACTICES AND INNOVATIVE APPROACHES FROM UNFPA ASIA AND THE PACIFIC COUNTRY OFFICES, 2023

It is widely recognised that **gender-based violence is a form of gender discrimination that violates fundamental rights**, including:

- The right not to be subjected to gender-based violence[9]
- The right to physical and psychological recovery, rehabilitation and social reintegration of victims of violence, abuse or exploitation[10]
- The right to equality and non-discrimination[11]
- The right to life[12]
- The right to be free from torture and other cruel, inhuman or degrading treatment or punishment[13]
- The right to liberty and security of person[14]
- The right to consent to marriage and equal rights within marriage[15]
- The right to freedom from practices that harm women and young people with disabilities[16]
- The right to equality before the law and access to justice[17]
- The right to an adequate standard of living and social protection[18]
- The right to protection and safety of persons with disabilities in situations of risk, including humanitarian emergencies[19]

9 protected by the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC)

10 protected by the CRPD and the CRC

11 protected by the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the CRPD and the CEDAW

12 protected by the ICCPR, the CRPD and the CRC

13 protected by the ICCPR, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the CRPD and the CRC

14 protected by the ICCPR and the CRPD

15 protected by the ICCPR, the ICESCR, the CEDAW and the CRPD

16 protected by the CRPD, CEDAW and CRC

17 protected by the ICCPR and the CRPD

18 protected by ICESCR and CRPD

19 protected by the CRPD

01

Regulatory framework and reference documents international institutions

Human rights are promoted and protected by a series of **international treaties** (the United Nations Conventions) and other instruments adopted since the Universal Declaration of 1948. There are also legal instruments that have been adopted at **regional level**, i.e. at continental level, which detail the regulatory framework within which human rights must be guaranteed by providing specific protection mechanisms. Most States, in turn, have adopted **constitutions and laws** that formally protect fundamental human rights.

International human rights law establishes obligations that States are required to respect: by becoming parties to international treaties, States assume obligations and duties to respect, protect and implement human rights and undertake to put in place national measures and legislation compatible with their obligations and duties under the treaties.

The international, regional and national regulations aimed at promoting and protecting women's rights are highlighted below in order to understand the regulatory framework within which they are guaranteed.

1.1 The global system of the United Nations[1]

International standards guarantee legal protection from violence for all persons without discrimination. The principle of equality and non-discrimination based, inter alia, on sex or other conditions is enshrined in several provisions, including the **International Covenant on Civil and Political Rights** and the **International Covenant on Economic, Social and Cultural Rights** of 1966. Articles 7, 9 and 10 of

1 Report of the Office of the United Nations High Commissioner for Human Rights, Thematic study on the issue of violence against women and girls and disability, 2012

the International Covenant on Civil and Political Rights enshrine the right to physical and moral integrity and the right to liberty and security of the person. In its **General Comment No.16**[2] on the right of men and women to enjoy all economic, social and cultural rights, the UN Committee on Economic, Social and Cultural Rights recognised that **gender-based violence is a form of discrimination that inhibits the enjoyment of rights and freedoms, including economic, social and cultural rights, on an equal basis**, and called on States parties to take appropriate measures to eliminate violence against men and women and to act with due diligence to prevent, investigate, mediate, punish and redress acts of violence against them by private actors.

Recognising the specific gender nature of violence, international law has incorporated norms prohibiting violence against women in different contexts, within the family, at the community level and at the state level. The **Convention on the Elimination of All Forms of Discrimination against Women** provides specific protection against discrimination for women and girls. The Convention reaffirms the rights of women and establishes a programme of action for countries to ensure the enjoyment of those rights, recognising in its preamble that "discrimination against women continues to exist" and emphasising that **such discrimination "violates the principles of equal rights and respect for human dignity**". As defined in Article 1, "discrimination against women" means "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, the enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." In its **General Recommendation No.19**[3] on violence against women, the UN Committee on the Elimination of Discrimination against Women noted that, **by ratifying the Convention, States have assumed a legal obligation to prevent and eliminate violence against women and**, therefore, gender-based violence constitutes discrimination within the meaning of Article 1 of the Convention. Furthermore, the Committee urges States to adopt a series of **measures to address gender-based violence**, including:

- criminalising all forms of gender-based violence in all settings (public and private);
- ensuring that laws addressing sexual violence include marital rape, rape by acquaintances and by persons with whom the victim is in a relationship, and other scenarios where consent is not freely given;
- repealing "laws that prevent women from reporting gender-based violence, such as guardianship laws that deprive women of legal capacity or limit the ability of women with disabilities to testify in court".

General Recommendation No.35, adopted in July 2017, updates Recommendation 19 on gender-based violence, identifying **new forms of violence linked to technology and cyberviolence**, and addressing multiple and intersectional forms of violence. It affirms the need for ongoing training for judicial operators and the prohibition of mediation and conciliation in cases of gender-based violence.

Particular attention has been given to **older women with disabilities**, as they may be particularly dependent on their abuser for daily assistance. **General Recommendation No.27**[4] of the Committee on the Elimination of Discrimination against Women recognises that age and sex make older women vulnerable to violence and that age, sex and disability make older women with disabilities particularly vulnerable.

---

2 General Comment No. 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights (Art. 3 of the Covenant) | Refworld

3 CEDAW General Recommendation No. 19: Violence against women | Refworld

4 General recommendation No. 27 on older women and protection of their human rights | OHCHR

The **Convention on the Rights of Persons with Disabilities** recognises that women and girls with disabilities are often at greater risk, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, and expresses concern about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination. In Article 16, the Convention requires States to adopt laws and policies and to ensure that cases of exploitation, violence and abuse against persons with disabilities, including women and girls, are identified, investigated and prosecuted. Article 28 (b) calls on States to ensure access for persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection and poverty reduction programmes. In its **General Comment No.3**, the UN Committee on the Rights of Persons with Disabilities emphasises the effect of social structures, power imbalances, cultural attitudes and family structures on the enjoyment of human rights, in particular the right to be free from violence. This was confirmed by the report '[5] ' by **the UN Special Rapporteur on the Rights of Persons with Disabilities**, which addresses the sexual and reproductive health and rights of girls and young women with disabilities.

Article 19 of **the Convention on the Rights of the Child** requires States Parties to take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse. The UN Committee on the Rights of the Child has recognised that **children with disabilities may be subject to particular forms of physical violence, such as forced sterilisation (particularly girls) and violence in the form of treatment** (e.g. electroshock and electric shocks used as 'aversive treatment' to control children's behaviour). Article 37 of the Convention requires States Parties to ensure that no child is subjected to torture or other cruel, inhuman or degrading treatment or punishment. This provision is closely related to Article 39 of the Convention, which establishes that a child who has been a victim of, among other things, torture or any form of cruel, degrading treatment or punishment, shall have the right to receive physical and psychological care and to social reintegration. In Article 23, the Convention on the Rights of the Child addresses the rights of children with disabilities, stating that a **child with intellectual or physical disabilities should enjoy a full and dignified life, in conditions that ensure dignity, promote autonomy and facilitate his or her active participation in the community**. In its **General Comment No.9**[6] on the rights of children with disabilities, the Committee on the Rights of the Child noted that **girls with disabilities are even more vulnerable to discrimination** and called on States Parties to take additional measures, where necessary, to ensure that girls with disabilities are adequately protected, have access to all services and are fully included in society.

1.2 The European Union regional system

The Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) recognises gender-based violence against women as a violation of human rights and a form of discrimination.

5 Special Rapporteur on the rights of persons with disabilities, Sexual and reproductive health and rights of girls and young women with disabilities, 2017

6 General comment No. 9 (2006): The rights of children with disabilities | Refworld

By providing a holistic approach to addressing violence against women and girls, the Convention aims to:

- protect women from all forms of violence;
- prevent, prosecute and eliminate violence against women and domestic violence;
- promote real equality between women and men;
- provide assistance to organisations and law enforcement agencies to cooperate effectively in order to adopt an integrated approach.

The Council of Europe Convention stipulates, in Article 4.3, that the protection and support provided for in the Convention must be accessible to all women without discrimination, including on the basis of age, disability, marital status, membership of a national minority, migrant or refugee status, gender identity or sexual orientation. In this regard, it is important to note that Article 39 of the Council of Europe Istanbul Convention on forced sterilisation establishes that performing a surgical intervention that terminates a woman's ability to reproduce naturally without her prior informed consent constitutes a criminal offence.

The document **A Union of Equality: The Strategy for Gender Equality 2020-2025**[7] clearly states that 'all EU policies will address the intersectionality between gender and other grounds of discrimination. Women are a diverse group and may be subject to intersectional discrimination based on multiple personal characteristics. For example, a migrant woman with a disability may be a victim of discrimination on three or more grounds. EU legislation and policies and their implementation should therefore respond to the specific needs and situations of women and girls belonging to different groups. The next action plan for integration and inclusion and the EU strategic frameworks on disability, LGBTI+ people, Roma inclusion and children's rights will be linked to this strategy, as well as to each other. The intersectional perspective will also always be taken into account in gender equality policies.

The **EU Strategy on Victims' Rights (2020-2025)**[8] sets out the Commission's work for the period 2020-2025 and calls on EU Member States and civil society to take action. It pays particular attention to the specific needs of victims of gender-based violence and is committed to preventing and combating gender-based violence by assisting and protecting victims. "The EU's strength lies in its diversity. The EU will therefore do everything in its power to prevent and combat hate crime in all its forms, including those motivated by racial, anti-Semitic, homophobic or transphobic hatred."

Finally, the **EU Directive of the European Parliament and of the Council on combating violence against women**[9] , the first law adopted by the EU to address and prevent violence against women and domestic violence, requires Member States to adopt specific laws and policies to protect women from violence. The Directive requires all EU countries to criminalise female genital mutilation, forced marriage and certain forms of cyber violence and harassment. The Directive also lays down provisions on prevention, protection and prosecution, ensuring that women victims of violence have access to adequate support services and that perpetrators are held accountable. One of the main objectives is to improve support for victims by providing shelters, psychological support and legal assistance, while promoting coordinated action between Member States. 29The strength of this legislation lies in its inclusiveness and comprehensiveness, particularly for women and girls with disabilities. In fact, the law makes specific reference to women with disabilities and the UN Convention on the Rights of Persons

7 eur-lex.europa.eu/legal-content/ENG/TXT/PDF/?uri=CELEX:52020DC0152

8 eur-lex.europa.eu/legal-content/ENG/TXT/PDF/?uri=CELEX:52020DC0258

9 Directive (EU) 2024/1385 of the European Parliament and of the Council of 14 May 2024 on combating violence against women and domestic violence

with Disabilities (CRPD). This is crucial because women with disabilities are disproportionately affected by violence, with higher rates of violence and abuse than women without disabilities. In addition, they often face additional barriers to reporting violence, such as inaccessible services or a lack of adequate support to navigate legal systems.

It should be remembered, however, that the European Union and its Member States do not have adequate legislation, policies and programmes to combat gender-based violence and domestic violence. This includes a lack of research and data on how different forms of violence affect various groups of women, including women and girls with disabilities, as well as a lack of funding to develop measures to prevent, combat and punish violence.

1.3 The national system

1.3.1 ITALIAN LEGISLATION[10]

Sexual violence was one of the first forms of violence against women to be addressed by Italian law, which interpreted this crime as a violation of human rights. The adoption of **Law No. 66/1996** on sexual violence led to the reformulation of the entire Chapter I of Title IX of Book II of the Criminal Code, and sexual violence was classified as a crime against personal freedom rather than a crime against public morality. Subsequently, the authorities carried out a thorough review of the legal framework applicable to cases of domestic violence. Although **Law No. 154/2001**, containing measures to combat violence in family relationships, is gender-neutral in its wording, it filled an important gap in the protection of women victims of violence by introducing criminal and civil restraining and exclusion orders that can be imposed on the violent member of the family. Female genital mutilation is another form of violence against women, for which a specific law, **Law No. 12 7/2006**, has been enacted, laying the foundations for a comprehensive approach to this harmful practice against women and girls. Italy has adopted several measures to implement the Istanbul Convention. A series of legislative reforms has created a comprehensive set of rules and mechanisms that strengthen the capacity of the authorities to take action in line with the Convention's aims to end violence:

1. the **2009 Law on Stalking**, which has helped to raise awareness of the dangerous nature of this criminal behaviour and the need to offer victims adequate protection by introducing the possibility for victims to request a warning to the stalker from the police before and/or without having to file a criminal complaint against the perpetrator;

2. **Law No. 119/2013**, known as the Femicide Law. The law was adopted in parallel with Italy's ratification of the Istanbul Convention and contains a series of measures aimed at bringing the Italian legislative and policy framework into line with the requirements of the Convention, including the duty of the authorities to support and promote, including through the allocation of financial resources,

10 GREVIO, Baseline Evaluation Report Italy, 2020

a comprehensive network of support services for victims. This law recognises the experience and achievements of years of commitment by women's organisations, which were the first in the country to set up anti-violence centres and communities to provide shelter for women and their children.

3. **Law No. 69 of 19 July 2019** (known as the 'Red Code') has contributed to the development of a solid legislative framework in line with the requirements of the Convention in terms of civil and criminal law available to victims of violence. This new code introduced a number of new offences, such as forced marriage, disfiguring a person's physical appearance through permanent facial injury, and the illegal dissemination of sexually explicit images or videos or 'revenge porn'. In addition, the Red Code law has toughened penalties for stalking, sexual violence and domestic violence and increased the penalties applicable for aggravating circumstances.

1.3.2 LEGISLATION IN THE NETHERLANDS[11]

A key issue is the implementation of the Istanbul Convention throughout the country, which is why the Dutch government aims to ensure that the Istanbul Convention also applies to the BES (the islands of Bonaire, Sint Eustatius and Saba in the Caribbean) as soon as possible. In June 2017, an administrative agreement was concluded, '**Approach to domestic violence and child abuse in the Caribbean Netherlands 2017-2020**'. The agreement focuses on prevention, improving the skills of professionals, strengthening assistance, including the creation of safe shelters for victims of domestic violence and child abuse, and establishing a reporting structure and legal framework. The action plan is funded with €1.3 million per year. In 2018, the Advisory Council on International Affairs recommended that, since human rights and freedom of expression (BES) are part of the Dutch constitutional order and a divergent human rights system cannot be justified by a 'fundamental distinction' within the meaning of Article 132a of the Constitution, any differences between the Caribbean and European parts of the Netherlands should be eliminated.

Fundamental to understanding the Dutch approach to implementing the Istanbul Convention is the definition of domestic violence in Dutch legislation and policy, defined as 'violence in a relationship of dependence'. The **Social Support Act** of 2015 covers physical, mental or sexual violence or threats by a family member, housemate, spouse, ex-spouse or guardian. In **the Youth Act** of 2015, child abuse is defined as any form of threatening or violent interaction of a physical, psychological or sexual nature with parents or other persons with whom the child is in a relationship of dependence. The definition also specifies forced marriage, 'honour-based violence', female genital mutilation and elder abuse.

Violence (other than sexual violence) committed by strangers is not covered by any specific action plan or policy, but it is criminalised and actions to prevent violence through cultural change are implemented by the Ministry of Education and the Gender Equality Plan.

11 GREVIO, Baseline Evaluation Report Netherlands, 2020

02

Analysis of the **phenomenon**

2.1 Context

Perspectives on the rights of persons with disabilities are often absent from debates on violence against women. A comprehensive understanding of violence against women must include an **intersectional approach** that examines how gender and disability, together, influence women's experience of violence, including sexual harassment.

A poor understanding of violence against women with disabilities makes it difficult to conceptualise certain behaviours as violence, including sexual violence and violence perpetrated and/or tolerated by the state. Forced sterilisation and abortion are permitted in some legislation and jurisdictions and may be rationalised as 'protection' of women with disabilities. Women with disabilities have repeatedly defined forced sterilisation and abortion as violence. Behaviour such as intentionally neglecting women with disabilities by denying them assistance for long periods of time in order to 'punish' or manipulate them is not always considered violence against women. This also applies to sexual harassment, where some abusive behaviours may have a sexual dimension in certain contexts, such as inappropriate medical examinations or the denial of mobility aids, communication devices or medication, but do not easily fall within general definitions of sexual harassment.

Violence against women and girls is one of the most systematic and widespread violations of human rights: it is rooted in gender-based social structures rather than in individual and random acts; it transcends age, socio-economic, educational and geographical boundaries and represents a major obstacle to ending gender inequality and discrimination globally.

The United Nations (UN) defines violence against women and girls 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'.

2.2 Definitions of violence

The definition of violence has been the subject of numerous scientific and legal publications. Violence has been defined from three different perspectives[1]:

- From a **legal perspective**, violence is defined as all violations and crimes described in criminal law. Specific acts may be described in criminal law, such as rape, assault, abuse, etc. A specific penalty may be provided for when these acts are committed.
- From a **psychological perspective**, violence is recognised as all acts perceived by the victim as violent, intimidating and offensive forms of behaviour that transcend ethical boundaries. In this perspective, violence can include much more than the acts described in criminal law.
- The **sociological perspective** considers violence in the context of social structures and power balances between groups and individuals. For example, relationships between social and healthcare workers and people living in institutions are strongly influenced by the extreme dependence of the person from the caregiver, as well as by organisational requirements, institutional culture and the legal status of the person living in the organisation.

2.3 Violence as discrimination

Violence against women is recognised as discrimination, which **hinders women in the exercise of their human rights** and their ability to develop on an equal basis with men. According to the Council of Europe: "Stalking, sexual harassment, sexual violence (including rape), physical and psychological abuse by a partner, forced marriage and forced sterilisation are deeply traumatic acts of violence. The vast majority of victims are women. Adding female genital mutilation and forced abortion to the forms of violence to which only women can be subjected shows the shocking level of diversity in the cruel and degrading behaviour to which women are subjected. If we consider the fact that most violence is perpetrated by men, it is a small signal to understand that violence against women is structural violence, violence that is used to sustain male power and control[2]."

The **Special Rapporteur on the rights of persons with disabilities**, in relation to sexual and reproductive health and the rights of girls and young women with disabilities, highlighted[3] the greater risks to which they are exposed. Children with disabilities are almost four times more likely to experience violence than children without disabilities. The risk is consistently higher for deaf, blind and autistic girls, girls with psychosocial and intellectual disabilities, and girls with multiple disabilities. Sexual assault is often underreported, especially in cases involving women with disabilities, as reported in paragraph 36 of the report: "When, as survivors of sexual violence, they report abuse or seek assistance or

1 Inclusion Europe, Life after violence – a study on how women with intellectual disabilities cope with violence they experienced in institutions, 2018

2 Istanbul Convention

3 Special Rapporteur on the rights of persons with disabilities, *Report on the sexual and reproductive health and rights of girls and young women with disabilities*, 2017

protection from judicial or law enforcement officials, their testimony, particularly that of girls and women with intellectual disabilities, is generally not considered credible and they are therefore disregarded as competent witnesses, with the result that perpetrators avoid prosecution." Furthermore, the lack of accessibility and reasonable and procedural accommodations (e.g., sign language interpretation, alternative forms of communication, age- and gender-sensitive support services) often results in serious physical and communication barriers in the justice system, which in turn hinder girls' and young women's with disabilities' access to justice and their ability to seek and obtain redress. As highlighted in the United Nations Report (paragraph 37): "[...] due to prejudice and stereotypes, courts commonly discredit the testimony of girls and young women with disabilities in cases of sexual violence, questioning the ability of girls and young women with intellectual disabilities to understand the oath when testifying, discrediting the testimony of blind witnesses because they are 'unable' to know/perceive the sequence of events."

Another aspect to consider is that women and girls who face multiple and intersecting forms of discrimination and inequality are among the most vulnerable to entering, engaging in or remaining in prostitution and, therefore, to experiencing violence. Disability, age, social class, race, ethnicity, migration and legal status, sexual orientation and gender identity are factors that increase the risk of entering prostitution. As a result, women and girls in prostitution often have an irregular status and do not have access to effective assistance, protection, services or livelihood opportunities. Many are homeless, live in insecure housing and are often evicted. Many suffer from poverty, negative childhood experiences, destitution and substance abuse, and have limited or no education, while having to provide for their families. Many are deceived by false or lucrative job offers, or financial incentives in exchange for sexual acts. A large majority have a history of sexual and physical abuse, neglect and child abuse, including incest. Overall, these conditions increase the risk of further exploitation, sexual violence and coercion for women and girls. Women and girls are also sold by their families or partners into prostitution, marriage and child or forced marriage for the purpose of sexual exploitation[4] . All of this has enormous consequences for gender **equality and the empowerment of women and girls**, including: increased pressure on marginalised women and girls, worsening racism, undermining the equality of women and girls and their participation in society, and an increase in the consequences of digital prostitution.

There are several **social factors that contribute to placing women with intellectual disabilities in a vulnerable situation**, especially when they live in institutions. For example, these women may be directly dependent on potential perpetrators, legally, financially or emotionally. They are often isolated, with little or no outside social interaction, and fear that reporting abuse could lead to institutionalisation, retaliation, further violence (including verbal abuse and intimidation) and a loss of support and assistance. The **lack of effective access to justice**, reporting and prevention mechanisms makes it very difficult for them to combat violence. Especially when they are deprived of legal capacity, barriers in the justice system are almost insurmountable. Even when they report abuse, victims are often not perceived as credible.

Women with intellectual disabilities often find themselves in a vulnerable position in society, which makes it easier for perpetrators of violence to abuse them. This is rooted in their experiences of segregation. They may:

- never have had the opportunity to understand when someone is using them for gain or personal satisfaction;
- not have encountered opportunities for education and dialogue, for example about sexual relationships;

4 Report of the Special Rapporteur on violence against women and girls, its causes and consequences, Prostitution and violence against women and girls, 2024

- have felt a sense of inferiority, which develops from childhood;
- never have had the power to express their opposition, to say 'no' to others;
- never have learned to defend themselves physically.

Sometimes, women with intellectual disabilities report situations that are often not recognised as violence. However, these cases have a significant impact on them, as they perceived the incident as violent or at least harmful enough to have a lasting effect. There are several reasons why care itself is sometimes perceived as violence by women:

- Women receive insufficient information to understand what is happening;
- Care staff do not have enough time or skills to get to know the women well enough to work with them;
- Care staff are pressured to work quickly;
- Care staff are not seen as trusted figures in the person's life.

All of this may have led to situations where women have been subjected to interventions or care measures without their valid informed consent. In the context of the Convention on the Rights of Persons with Disabilities, this clearly constitutes 'forced treatment' and a violation of the law. Some of the reasons why women have perceived what was intended as care as violence can also be classified as **structural violence**. There seems to be a gap between what women with intellectual disabilities perceive as violence and the perceptions and intentions of support staff. Although most support staff carry out their care role without any clear intention to use violence, it is important that they listen to what women themselves perceive as violence, even if, from their perspective, they do not recognise violence in the experience. Structural violence can occur without one person intending to harm another. Most of the time, people are not even aware of its impact.

03

Available data

3.1 Context

Data on violence against women and girls with disabilities is very limited. This is due to a lack of disaggregated data collection by disability, including data on violence that occurs in closed settings (e.g. institutions, shelters or psychiatric hospitals), on disability-specific violence (including forced sterilisation), the relationship between the victim and the perpetrator(s) of violence, and the barriers to reporting violence that keep women and girls with disabilities silent and invisible. The available data indicate that gender-based violence affects women and girls with disabilities to a much greater extent than most other women. Disability does not protect against or prevent acts of violence against women.

Women and girls with disabilities are two to five times more likely to be victims of such violence than women and girls without disabilities[1]:

- 6 out of 10 women with intellectual disabilities report having experienced sexual abuse;
- 34% of women with health problems or disabilities have experienced physical or sexual violence from their partner during their lifetime (compared to 19% of women without disabilities),
- 61% of women with health problems or disabilities have experienced sexual harassment since the age of 15 (compared to 54% of women without disabilities).

Women and girls with disabilities face greater difficulties in reporting violence and claiming their rights due to a number of factors, and this is certainly one of the reasons why it is difficult to obtain accurate and reliable data on violence against women with disabilities. Factors influencing the lack of reporting include:

- **Lack of awareness of their rights**: women and girls with disabilities, especially those in institutions, may not be aware of their rights and may not receive support in identifying and reporting violence.
- **Myths and stereotypes**: many myths and stereotypes about women and girls with disabilities prevent them from being considered credible by the police and the criminal justice system. These

1 European Disability Forum – EDF, Violence against women and girls with disabilities in the European Union, 2021

include, for example, the myth that women with disabilities, particularly those with intellectual disabilities, are asexual or that women with psychosocial disabilities are hypersexual.

- **Fear**: Women and girls with disabilities may fear stigmatisation and victimisation when reporting violence, including fear of not being believed. They may also be afraid to inform those closest to them about the violence. Power imbalances, for example between a woman with a disability and her legal guardian, her support persons or someone working in an institution, can also create fear of retaliation.
- **Inaccessibility**: Reporting mechanisms, police stations and courts are often not accessible to women and girls with disabilities. For example, a police station may not be accessible to women in wheelchairs, or emergency numbers may not be accessible to deaf and deafblind women.

In addition to the obstacles encountered in reporting, women and girls with disabilities also face barriers in accessing justice. When a case is brought forward, it is essential that they are supported from the outset of the process. Inaccessibility, fear and costs are deterrents for women with disabilities who wish to take their case to court and obtain legal protection .

Some countries, such as the Netherlands, provide alternative dispute resolution mechanisms, such as mediation, in cases of gender-based violence, which may include direct confrontation with the perpetrator. In such cases, there is a risk that women and girls with disabilities will be forced to accept such alternatives. It is important to remember that violence against women and girls is often the result of a relationship of dominance and control, which is just as often perpetrated by legal guardians, carers, support persons or persons working in institutions or other closed settings, and this aspect must always be taken into account when initiating proceedings following reports and/or complaints.

In some countries, criminal law discriminates against victims with disabilities by providing for reduced penalties for the perpetrator when the victim is a person with a disability.

3.2 EU survey on gender-based violence against women and other forms of interpersonal violence (EU-GBV)

An **EU survey on gender-based violence (EU-GBV)**[2] has revealed a series of interesting and worrying findings. The data collection was conducted on a voluntary basis between September 2020 and March 2024 in EU countries, with **Eurostat** coordinating the data collection in 18 Member States[3]. The main objective of this survey was to **assess the prevalence of violence in order to meet the requirements of the Istanbul Convention**. The survey as a whole covered psychological, physical and sexual violence by a partner, physical and sexual violence by persons other than a partner, sexual harassment at work, violence experienced during childhood and stalking by any perpetrator. The **target population** of the

2 Violence experienced by total population (gbv_vtp)

3 Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Germany, Ireland, Greece, Spain, France, Croatia, Cyprus, Latvia, Lithuania, Luxembourg, Hungary, Malta, Netherlands, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, Finland, Sweden, Montenegro, Serbia. Italy has shared the main indicators from its national survey.

EU-GBV survey consists of persons **aged 18 to 74** living in private households, with a focus on women, while **the indicators focus on violence by perpetrator**, disaggregated by type of violence, frequency, severity, seriousness and reporting of violence experienced, as well as by personal characteristics of the respondent, such as age, level of education, **activity limitations** and degree of urbanisation.

Our analysis focused on data relating to women with disabilities who responded to the questionnaires and who had experienced violence:

- by their partner
- by someone other than their partner
- by a domestic aggressor
- by any perpetrator

Disability status was measured using a concept of general activity limitation (limitation of activities that people usually do because of health problems in the last 6 months[4]). The indicator is based on data collected by **the Global Activity Limitation Instrument** (GALI) with three dimensions: severely limited, limited but not severely limited, or not limited at all:

- **Severely limited**[5] means that performing or completing an activity cannot be done or can only be done with extreme difficulty, and that this situation has persisted for at least 6 months. Individuals in this category usually cannot perform the activity on their own and would need additional help from other people.
- **Limited but not severely** means that performing or completing a usual activity can be done but only with some difficulty, and that this situation has persisted for at least 6 months. Individuals in this category usually do not need help from other people.
- **Not limited** means that performing or completing usual activities can be done without any difficulty, or that no limitation in activities has occurred for at least the last 6 months.

A first table (**Table 1**) shows the gross and net sample of women who were interviewed, highlighting the percentage of valid data compared to the total number of interviews conducted. The subsequent analyses are therefore based on the net sample provided in this table.

4 The period of the last 6 months is closely related to the duration of the activity limitation and not to the duration of the health problem. The limitations must have started at least 6 months before and persist at the time of the interview. The respondent's self-assessment of their limitation (in 'activities that people usually do') due to any ongoing physical, mental or emotional health problem, including diseases or impairments, and advanced age is measured. All consequences of accidents/injuries, hereditary conditions, etc. are included. Only limitations directly caused by or related to one or more health problems are considered. Limitations due to financial, cultural or other causes unrelated to health should not be taken into account. An activity is defined as the performance of a task or action by an individual, and therefore activity limitations are defined as 'the difficulties that the individual encounters in performing an activity'.

5 Methodological manual for the EU survey on gender-based violence against women and other forms of inter-personal violence (EU-GBV), EUROSTAT, 2021- Methodological manual for the EU survey on gender-based violence against women and other forms of inter-personal violence (EU-GBV)

Table 1 – Gross and net sample size[6] s for women.

Country	Gross sample	Net sample	Percentage of respondents (net/gross*100)
BELGIUM	2702	4529	23.5
BULGARIA	8240	4529	23.5
CZECH REPUBLIC	4123	4529	23.5
DENMARK	40016	12740	32.20.00
GERMANY	8885	2419	27.20.00
IRELAND	2808	994	35.40.00
ESTONIA	6800	4573	67.30.00
GREECE	49045	11557	24.00.00
SPAIN	14370	6310	44.30.00
FRANCE	11447	6889	60.20.00
CROATIA	11430	3416	30.30.00
CYPRUS	3144	1500	48.10.00
LATVIA	6261	3941	63.30.00
LITHUANIA	5020	3186	63.50.00
LUXEMBOURG	9970	1924	19.30
HUNGARY	4687	2002	43.10.00
MALTA	7194	3014	42.30.00
NETHERLANDS	15635	4184	27.20.00
AUSTRIA	16162	6240	39.00.00
POLAND	12839	5190	40.40.00

6 The gross sample is the total number of women interviewed, while the net sample is the set of women whose responses were valid and therefore used in the study. The EU-GBV is a random sample survey of people living in private households. The sampling units are dwellings, households or individuals, depending on the sampling frame.

Country	Gross sample	Net sample	Percentage of respondents (net/gross*100)
PORTUGAL	Data not available	634	Data not available
ROMANIA	4244	2003	47.20.00
SLOVENIA	2452	1282	52.30.00
SLOVAKIA	9588	5000	52.10.00
FINLAND	1500	4597	31.00.00
SWEDEN	11933	2562	21.50
MONTENEGRO	2232	1608	72.00.00
SERBIA	7,000 families	4,1	58.0
KOSOVO	3,000 families	2,452	82.10.00

Below are the data broken down by different reference terms for women whose responses were considered valid with regard to the perpetrator of violence and the level of functional limitation.

Table 2 shows the percentage of women with disabilities who have experienced violence from four different perpetrators. It shows that in almost all countries, violence is mainly perpetrated by the partner, while the lowest percentage is in the case of a person known to the victim but not the partner. Denmark, Estonia, the Netherlands and Finland differ from these findings, where a high percentage remains even when the violence is perpetrated by someone other than the partner, but who is nevertheless known. Hungary, Finland and Slovakia have very high percentages of women who have experienced violence by their partner (one in two women).

Table 2 – data relating to the net sample broken down by perpetrator of violence.

Country	Women interviewed	Violence by partner	Violence by someone other than partner	Violence from a family member or relative	Violence from a stranger
BELGIUM	4529	31	19	19	29
BULGARIA	5580	20.5	5.9	9.5	11
CZECH REPUBLIC	2043	33.5	9.7	14.5	19.7
DENMARK	12,74	45	38.2	27.6	47.5

Country	Women interviewed	Violence by partner	Violence by someone other than partner	Violence from a family member or relative	Violence from a stranger
GERMANY	2,419	31.9	14	18.3	25.6
IRELAND	994	41.2	20.6	26.3	33.1
ESTONIA	4,573	35	27.6	24.1	40.7
GREECE	11,557	41	24	24.7	36.5
SPAIN	6310	28.6	20	15.9	2
FRANCE	6,889	30.2	26.1	19.4	34.5
CROATIA	3416	28.1	18.7	15.3	25.3
CYPRUS	1,5	44.5	14.6	30.3	36
LATVIA	3941	30.1	13.9	16.9	25.1
LITHUANIA	3186	30.7	13.6	17	25.2
LUXEMBOURG	1924	47.4	33.7	30	45.4
HUNGARY	2002	54.6	19	43.8	49
MALTA	3014	26	15	16.2	24.4
NETHERLANDS	4184	33.4	35.5	19.9	41.2
AUSTRIA	6,24	37.8	27.5	20	35
POLAND	5,19	19.6	8.2	11.5	16
PORTUGAL	6348	22.5	13.1	11	19.7
ROMANIA	2003	48.9	14.1	39.2	42.2
SLOVENIA	1282	27.9	16	14.9	22.5
SLOVAKIA	5000	50.8	16.9	32.7	37
FINLAND	4597	52.6	46.5	36.3	57.1

Country	Women interviewed	Violence by partner	Violence by someone other than partner	Violence from a family member or relative	Violence from a stranger
SWEDEN	2562	48.2	42.0	32	52.5
MONTENEGRO	1608	20.2	6.2	7.5	11
SERBIA	4,1	21.6	10.1	11	17
KOSOVO	2,452	25.6	6.1	6.4	10

The following analyses will show the results of the survey in detail with regard to the individual perpetrators of violence, broken down according to the reference term for the level of disability.

3.2.1 WOMEN WHO HAVE EXPERIENCED VIOLENCE FROM THEIR PARTNER, ACCORDING TO LEVEL OF DISABILITY (ACTIVITY LIMITATION)[7]

An analysis of the data on women with disabilities who have experienced violence by their partner clearly shows that those who suffer the most violence are women with severe disabilities, with a percentage that is significantly higher than other categories and the national average. Among all countries, Bulgaria, Denmark and Germany stand out negatively, where women who have experienced violence by their partner and who have severe disabilities exceed 60% of those interviewed (60% of women interviewed with severe disabilities have experienced violence).

Table 3 – Data relating to women who have suffered violence at the hands of their partner.

Country	**Total** (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
EUROPEAN UNION	32.7	32.2	48.1	30.4
BELGIUM	31.3	30	47.5	26.7
BULGARIA	20.5	18	61.6	17

7 The results of the EU-GBV survey are reported in terms of prevalence rates (percentage of individuals in a population who have a given condition. In our case, therefore, the indicators are calculated as the percentage of women with a given personal characteristic (e.g. severely limited) who have experienced violence (e.g. by a partner) out of the total number of women with that personal characteristic (e.g. severely limited).

Country	Total (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
CZECH REPUBLIC	33	3	42	32
DENMARK	45	44.6	67.1	40.7
GERMANY	31.9	31	64.1	29
IRELAND	41.2	40.6	49.7	39
ESTONIA	35	34.6	:	32
GREECE	41.8	41.4	54.8	39.9
SPAIN	28.6	28	50.6	26.4
FRANCE	30	30.3	33.9	29
CROATIA	2	28	32	2
CYPRUS	44.5	43.8	58.7	43.0
LATVIA	30.1	29.4	48.3	27
LITHUANIA	30.7	30.7	43	29
LUXEMBOURG	47.4	47.2	53.5	44.6
HUNGARY	54.6	54.8	:	54
MALTA	26	25.4	52.4	24.7
NETHERLANDS	33	33.4	45	31
AUSTRIA	37.8	37.5	47.4	36.4
POLAND	19.6	19	25	18
PORTUGAL	22.5	22.3	29.2	19.3
ROMANIA	48.9	47.9	60.2	45.6
SLOVENIA	27.9	27	:	26

Country	Total (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
SLOVAKIA	50.8	49.8	64.6	45.9
FINLAND	52.6	51.2	82.1	47.2
SWEDEN	48.2	47.1	67.4	43.9
MONTENEGRO	20.2	19.9	26.8	17
SERBIA	21	21	27	20
KOSOVO	25.6	25.5	29.9	23

3.2.2 WOMEN WHO HAVE EXPERIENCED VIOLENCE BY SOMEONE OTHER THAN THEIR PARTNER, BY LEVEL OF DISABILITY (ACTIVITY LIMITATION)

In the context of violence perpetrated by someone other than the partner, but known to the women who suffered the violence, the data confirms what is described in Table 3, in the sense that, even in cases where the perpetrator is someone other than the partner but known to the woman, the highest percentage of women who suffer violence remains that of women with severe disabilities. Denmark, Luxembourg, Finland and Sweden stand out among all countries with percentages exceeding 50%. The only difference is Greece, where the percentages are very similar and, therefore, there is not much difference in terms of functional limitation, as the values range between 24% and 26% for the three categories of disability.

Table 4 – Data on women who have experienced violence by someone known to them but not their partner.

Country	Total (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
EUROPEAN UNION	19.6	19.1	29.4	17
BELGIUM	19	18	26.8	16

Country	Total (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
BULGARIA	5.9	4	41.8	3
CZECH REPUBLIC	9.7	9.2	:	9
DENMARK	38.2	37.9	56.2	34.7
GERMANY	14	13.7	:	12
IRELAND	20.6	19.9	29	18.7
ESTONIA	27	27	:	26.6
GREECE	24.8	24.7	26	2
SPAIN	20	19	30	1
FRANCE	26	25	33.9	2
CROATIA	18.7	19.5	:	23
CYPRUS	14.6	14.5	:	14.5
LATVIA	13.9	13.7	19	13
LITHUANIA	13	13	:	13
LUXEMBOURG	33.7	32.9	56.9	31
HUNGARY	19.2	19.3	:	19
MALTA	15.1	15.0	:	14
NETHERLANDS	35	36	51.6	34
AUSTRIA	27.5	27.3	33	26

Country	Total (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
POLAND	8	8	:	7
PORTUGAL	13	13.2	13.4	11
ROMANIA	14.1	13	:	12
SLOVENIA	16	16	:	15
SLOVAKIA	16.9	15.8	31	1
FINLAND	46.5	45.0	76.6	41.2
SWEDEN	42	41.3	56.2	39
MONTENEGRO	6.2	6	:	6
SERBIA	10.1	9.9	14.8	9
KOSOVO	6.1	6	:	5

3.2.3 WOMEN WHO HAVE EXPERIENCED VIOLENCE BY A FAMILY MEMBER OR RELATIVE, BY LEVEL OF DISABILITY (ACTIVITY LIMITATION)

An analysis of data on violence against women with disabilities by a family member or relative also clearly shows that women with severe disabilities are the most affected. Denmark, Finland and Sweden stand out again among all countries, with percentages exceeding 50%.

Table 5 – Data on women who have experienced violence by a family member or relative.

Country	Total (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
EUROPEAN UNION	20.1	19.6	35	18
BELGIUM	19.7	18	39.5	14
BULGARIA	9.5	7.5	46.7	7
CZECH REPUBLIC	14	13	25	1
DENMARK	27.6	26.9	56.2	2
GERMANY	18.3	17.5	45.1	1
IRELAND	26	25.4	39.2	23
ESTONIA	24.1	23.8	:	21
GREECE	24.7	24.3	36	23
SPAIN	15.9	15	33	1
FRANCE	19.4	19.3	25	1
CROATIA	15.3	15	18	15
CYPRUS	30.3	29.7	45.5	29
LATVIA	16.9	16.3	34.4	14.7

Country	Total (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
LITHUANIA	17	17	27	15
LUXEMBOURG	30	29	38.3	27
HUNGARY	43	43.9	:	43
MALTA	16.2	15.7	31.9	15
NETHERLANDS	19	19	40.8	1
AUSTRIA	20.0	19.6	32.9	18
POLAND	11.5	11	18	1
PORTUGAL	11	11	21	9
ROMANIA	39.2	38.6	45.6	36.6
SLOVENIA	14.9	15	:	14
SLOVAKIA	32.7	31.5	48.6	27
FINLAND	36	34.8	67.4	31.7
SWEDEN	32	30.8	54.7	27
MONTENEGRO	7	7	:	7
SERBIA	11.7	11.4	22	10
KOSOVO	6.4	6.3	:	4

3.2.3 WOMEN WHO HAVE EXPERIENCED VIOLENCE BY A STRANGER, BY LEVEL OF DISABILITY (ACTIVITY LIMITATION)

The situation of women with disabilities who experience violence by a stranger confirms the trend presented in the previous tables, but it also emerges that violence against women with limitations, even if not severe, is also increasing significantly. In almost all countries, these percentages are significantly higher than the percentages for the same category when the perpetrator of the violence was a partner, acquaintance or family member. Among these data, the situation in Finland stands out negatively, reaching 80% in cases of severe disability and over 50% in the other two cases of functional limitation.

Table 6 – Data on women who have experienced violence by a stranger.

Country	**Total** (Taken from Table 2)	**Limited but not severe**	**Severe disability**	**Not limited**
EUROPEAN UNION	30.5	29.9	46	2
BELGIUM	29	27	47.1	24
BULGARIA	11	9.9	48.4	9
CZECH REPUBLIC	19.7	19	32	19
DENMARK	47.5	47.1	69.9	43.5
GERMANY	25.6	24.8	53.2	22
IRELAND	33	32	45.1	30.2
ESTONIA	40.7	40.3	:	38.2
GREECE	36.5	36.2	45.1	35
SPAIN	28.2	27.6	49.8	2
FRANCE	34.5	34.3	41.8	33
CROATIA	25	25.6	18.6	2

Country	Total (Taken from Table 2)	Limited but not severe	Severe disability	Not limited
CYPRUS	36.1	35.7	47.6	35.5
LATVIA	25.1	24.5	39.9	23
LITHUANIA	25.2	25	34.4	24.3
LUXEMBOURG	45.4	44.8	62.4	42.5
HUNGARY	49.1	49.3	:	48
MALTA	24.4	23.9	45.1	23
NETHERLANDS	41	41	56.8	39
AUSTRIA	35.7	35.6	40.2	34
POLAND	16	16	23	15
PORTUGAL	19.7	19.5	28	17
ROMANIA	42.2	41.3	52	39
SLOVENIA	22	22.6	:	21
SLOVAKIA	37.9	36.3	56.6	32
FINLAND	57.1	55.9	80.4	52.1
SWEDEN	52.5	51.6	69.4	48
MONTENEGRO	11	11.9	:	11
SERBIA	17.5	17	26.2	16.3
KOSOVO	10.3	10.3	:	9

In conclusion, it can be said that, in general, women with severe disabilities are the most affected by violence, given that it increases in cases of violence by a partner compared to other perpetrators and remains high even in cases involving strangers. Some European countries have serious situations of violence with respect to all perpetrators and with respect to the three reference terms of functional limitations, while others have a lower incidence of violence among the total number of women interviewed.

ANNEX

Explanation of the reference terms used in the survey.

Violence by type of perpetrator: the type of perpetrator of violence is defined according to the relationship:

- **Violence by a partner** includes psychological violence, threats, physical and sexual violence. Partners are persons with whom a respondent has or has had an intimate relationship. With regard to the indicators disseminated by type of perpetrator, the prevalence of violence by a partner is calculated on the basis of persons who have ever had an intimate relationship.
- **Violence by persons other than partners** includes threats, physical and sexual violence. Non-partners are all perpetrators with whom a respondent does not or has never had an intimate relationship:
- '**Family member or relative**' includes close relatives such as parents and children, and other close relatives who may or may not live with the respondent, as well as other family members or relatives by marriage or adoption (e.g. siblings, grandparents, uncles, aunts, cousins, nieces, nephews, in-laws, etc.); "**Non-family or relative but other acquaintance**" such as friends, family friends, schoolmates, colleagues, co-workers, supervisors, bosses, professors, teachers; any person with some authority such as a military or police officer, a priest, a religious leader, a judge, a doctor; any other person known to the respondent;
- "**Stranger**" is a person completely unknown to the interviewee.

Type of violence:

- **Psychological violence** by an intimate partner includes a range of behaviours, including emotional abuse and controlling behaviour towards the interviewee: belittling and humiliating; forbidding the interviewee from seeing friends or family members, or from engaging in hobbies or other activities; tracking the interviewee via GPS, telephone or social networks; forbidding the interviewee to leave the house without permission or locking them in; constantly accusing the interviewee of being unfaithful or in getting angry if the interviewee talks to another person; forbidding the interviewee to work; controlling the finances of the entire family and the interviewee's personal expenses; withholding or stealing the interviewee's identity card/passport in order to control them; shouting and breaking objects or behaving in a certain way with the aim of frightening or intimidating the interviewee; threatening to harm the interviewee's children or other people close to them; threatening to take away the interviewee's children or deny them custody; and threatening to harm themselves if the interviewee abandons them.
- **Threats** means behaviour that implies fear, such as threatening to harm the interviewee in a way that actually frightens them. With regard to the indicators used for each type of violence, threats refer only to threats and not to physical or sexual violence.
- **Physical violence** refers to a range of violent behaviours or acts that involve harm and fear, such as pushing or shoving the interviewee, pulling their hair, slapping them or throwing something at them;

punching the interviewee or hitting them with an object; kicking; burning (with fire, acid or other means); attempting to strangle or suffocate the interviewee; threatening to use or actually using a knife, gun, acid or similar; or using force against the interviewee in any other way with the aim of causing them harm. With regard to the indicators used for each type of violence, physical violence refers only to physical violence and not sexual violence.

- **Sexual violence** includes unwanted sexual intercourse committed by force or physical violence or by taking advantage of a situation in which the interviewee is unable to refuse sexual intercourse because they are under the influence of alcohol or drugs. It also includes unwanted sexual intercourse that the interviewee is too afraid to refuse and cases where the interviewee is forced into unwanted sexual intercourse with another person or other persons. Attempts to commit any of the above acts or any other unwanted sexual behaviour that the interviewee considers degrading or humiliating are also included. Finally, this type of violence also includes unwanted sexual harassment by persons other than the partner.

Personal characteristics. The indicators are calculated based on the following personal characteristics:

- **Disability status** is measured using a concept of general activity limitation (limitation in activities that people usually do because of health problems in the last 6 months).
- **The level of education** refers to the highest level in the International Standard Classification of Education (ISCED) that an individual has successfully completed.
- The **degree of urbanisation** of the area in which a person has their usual residence is classified in local administrative units at level 2 as cities, towns and suburbs, or rural areas, based on the share of the local population living in urban agglomerations and urban centres.
- **Country of birth** is defined as the country of usual residence of the respondent's mother at the time of birth (according to current national boundaries and not those in force at the time of birth). The main categories include: born in the reporting country; born abroad in an EU country; born abroad in a non-EU country or with unknown country of birth.

The indicators are calculated as the percentage of women with a given personal characteristic (e.g. severely limited) who have experienced violence (e.g. by a partner) out of the total number of women with that personal characteristic (e.g. severely limited).

04

Role of professionals in Italy and in the Netherlands

4.1 Context

Since violence and discrimination are often perpetrated by caregivers and family members, the role of professional caregivers who intervene in the home can be crucial. **Professional training** must provide them with the knowledge and skills to recognise signs of violence and discrimination and to intervene to protect the fundamental rights and freedoms of persons with disabilities.

Training is an important component of a comprehensive response by the health system to violence against women. Health service managers and health policy makers also have a responsibility to strengthen planning, coordination and human resource management; to define policies and protocols; and to monitor and evaluate the provision of care to victims of violence. For these reasons, training is needed to assess and improve the preparedness of facilities, including the capacity of health and social care staff, to improve the integration of prevention interventions into existing health services or interventions[1].

Healthcare professionals are in a unique position to respond to the psychosocial and health needs of women who have experienced violence. They are able to provide assistance by facilitating communication (of abuse), offering support and referral points, providing appropriate medical services and ongoing care, or collecting evidence for legal purposes, particularly in cases of sexual violence. For this reason, it is essential to provide them with specific skills to address violence against women with disabilities, including appropriate care for women who are victims of intimate partner violence and sexual violence, clinical and emotional support interventions, and greater awareness of violence against women, in order to promote scientifically informed health responses.

1 It may also be useful to consult the document "Strengthening health systems' response to women's experiences of intimate partner violence and sexual violence: a manual for health managers" (WHO, 2017) for comprehensive guidance on how to improve health system preparedness.

4.2 Comparison of the two training courses in Italy and the Netherlands on professional roles

	ITALY - OSS COURSE, REGIONAL QUALIFICATION (VENETO REGION)	NETHERLANDS - SOCIAL WORKER
Objectives	The training of the *Operatore Socio-Sanitario* (OSS – Social and Healthcare Operator) falls under the responsibility of the Regions and the Autonomous Provinces of Trento and Bolzano. Courses may be organized directly by the Regions and Autonomous Provinces or delivered through healthcare authorities, other entities belonging to the Regional Health Service, or accredited training providers. The objective of the course is to provide the knowledge, skills, and core frameworks necessary to train social and healthcare operators capable of meeting primary needs, promoting well-being, and supporting the autonomy of individuals within healthcare, social-healthcare, and social settings. The program prepares professionals able to perform their duties in collaboration with healthcare and social professionals, working in integration with multidisciplinary teams. (*State–Regions Agreement No. 13/2024, Rep. Atti No. 1161, Art. 3 and Annex 1, p. 10 of 17*)	Provide the knowledge, skills and ethical framework necessary to promote social well-being and facilitate positive social change. This includes empowering individuals and communities, addressing social issues and promoting social and economic justice. Provide support to people who need help to participate in society, support people in the areas of housing, employment, money management and health, and help people increase their independence.
Tasks	The OSS's professional activities cover the following areas of competence: • Assisting individuals in meeting basic needs and managing daily living activities. • Ensuring hygiene, safety, and comfort in living and care environments. • Performing healthcare and social-care support activities. • Collaborating and integrating with other professionals and working effectively in teams. *(State–Regions Agreement No. 13/2024, Rep. Atti No. 1161, Annex 1, p. 11 of 17)*	These vary depending on the training programme chosen by the student
Training	**Regional Professional Qualification Path**	Social Sciences study programme (from 16 years of age)

	ITALY - OSS COURSE, REGIONAL QUALIFICATION (VENETO REGION)	NETHERLANDS - SOCIAL WORKER
Duration of training	**Total Duration**: 1,000 hours, divided as follows: **Basic Module**: 200 theoretical hours **Professionalizing Module**: 800 hours (250 classroom theory, 100 laboratory practice, 450 internship) (*DGRV 883/2025, Annex C, p. 2 of 23*)	3 years (full-time) In total: 4800 hours Each year contains 1600 study hours (lessons in school, internship and homework)
Admission requirements	**Article 7 – Admission Requirements** • Applicants must be at least 18 years old at the time of enrollment and hold a lower secondary school diploma. • Candidates with an equivalent qualification obtained abroad must present a Declaration of Value or equivalent document certifying the level of education, as well as proof of Italian language proficiency (oral and written) at least at B1 level of the Common European Framework of Reference for Languages (CEFR), or another valid certification. • Foreign citizens holding an Italian lower secondary school diploma or higher-level qualification are exempt from submitting the above certification. • Admission is subject to passing both a written and oral selection test. • Accepted candidates must undergo a medical examination to verify fitness for the role, according to current regulations and regional/provincial health surveillance protocols. Students must also comply with the vaccination requirements provided by current legislation. *(State–Regions Agreement No. 13/2024, Rep. Atti No. 1161, Arts. 7 and 9)*	• VMBO diploma[1] (theoretical, mixed or vocational course) • Certificate of transition from the 3rd to the 4th year of HAVO or VWO[2] • Completed MBO diploma level 2 or 3[3] • An admission interview is usually part of the application process to assess motivation and suitability.

1 Voorbereidend Middelbaar Beroepsonderwijs – VMBO (pre-vocational secondary education) is aimed at pupils aged between 12 and 16 and is considered the basic course for a general and pre-vocational component. VMBO provides the basis for further vocational training.

2 The 'certificate of transition from the 3rd to the 4th year of HAVO or VWO' refers to the document certifying that the third year of HAVO (Higher General Secondary Education) or VWO (Pre-university Education) in the Netherlands has been passed, and that the student has been admitted to the fourth year. This certificate is important because it marks the transition to the next stage of upper secondary education, which can lead to higher professional education (HBO) in the case of HAVO, or to university in the case of VWO.

3 A completed MBO level 2 or 3 diploma refers to a qualification obtained in the Dutch vocational education system (MBO, Middelbaar Beroepsonderwijs). Levels 2 and 3 represent two levels of professional qualification within this system, with level 3 generally requiring a longer and more in-depth course of study than level 2.

	ITALY - OSS COURSE, REGIONAL QUALIFICATION (VENETO REGION)	NETHERLANDS - SOCIAL WORKER
Qualification obtained	**Regional Qualification**: Recognized by the Veneto Region for the related experimental program. **EQF Level**: 3 (Vocational Training Path) (*State–Regions Agreement No. 13/2024, Rep. Atti No. 1161, Annex 1, p. 10 of 17*)	MBO Level 4 Diploma - Social Services (this diploma provides direct access to higher professional education (HBO), such as a three-year degree in Social Services or Pedagogy)
Student profile	The Regions and the Autonomous Provinces of Trento and Bolzano define the criteria for admission tests. (*State–Regions Agreement No. 13/2024, Rep. Atti No. 1161, Art. 8*) **Selection Test Objectives** The selection process assesses candidates': a. Aptitude b. Motivation c. Role orientation d. Personal, family, and work compatibility with course commitments and long-term engagement (*Decree 1009, Annex A of 08/08/2025, DGRV 883/2025*)	• Empathetic, communicative and socially committed person who enjoys working with people, especially those in vulnerable situations; • A person who is able to manage stress and work independently • Motivated to make a difference in society.
Areas of expertise/ Subjects	**Curriculum Structure** The modules are organized into three main areas: **A) Socio-Cultural, Legislative, and Institutional Area (minimum 100 hours)** • National and regional legislation in the healthcare and social sectors • Labor law • Organization of healthcare, social-healthcare, and social services • Health, illness, and disability • Professional ethics, bioethics, and deontology • Role orientation • Workplace health and safety • English language • Applied informatics **B) Technical and Operational Area (minimum 250 hours)** • Hygiene measures and prevention of healthcare-associated infections • Care approaches and methods in healthcare, social-healthcare, and social contexts • Principles and care methods addressing basic human needs • Assistance procedures for individuals in various health, illness, and disability conditions across life stages • First aid	• Communication and interview skills: learning to interact in professional dialogues with clients. • Psychology and sociology: understanding human behaviour and social structures. • Methodical work: developing structured support and guidance plans. • Legislation and policies: introduction to laws and regulations relating to care, youth services and social support. • Teamwork: facilitating and guiding group activities. • Observation and reporting: learning to observe clients, write accurate reports and reflect on actions. • Preparation for work experience: professional conduct, reflection, ethics. • General subjects: Dutch, arithmetic, citizenship education and English (optional).

	ITALY - OSS COURSE, REGIONAL QUALIFICATION (VENETO REGION)	NETHERLANDS - SOCIAL WORKER
Areas of expertise/ Subjects	**C) Relational Area (minimum 50 hours)** • Fundamentals of psychology • Communication and relationships with patients, caregivers, and the care team (*State–Regions Agreement No. 13/2024, Rep. Atti No. 1161, Art. 10 and Annex 1, pp. 16–17 of 17*)	
Skills acquired	**Core Competencies** Competencies defined by the essential skills and knowledge include: • Assisting individuals in meeting basic needs and performing daily living activities. • Ensuring hygiene, safety, and comfort in living and care environments. • Performing healthcare and social-care assistance activities. • Working collaboratively and integrating within multidisciplinary teams. *(State–Regions Agreement No. 13/2024, Rep. Atti No. 1161, Annex 1, p. 10 of 17)*	• Develop critical thinking skills and academic reasoning skills. • Openness to new experiences and paradigms and commitment to lifelong learning.
Internship	**Internship (450 hours)** Internships must be completed in the following areas: • **Healthcare Settings** (150–180 hours): inpatient medical/surgical units for adults, semi-intensive care, short-stay observation units, community hospitals, territorial rehabilitation units, home healthcare. • **Social-Healthcare Settings** (150–180 hours): residential and semi-residential facilities for non-self-sufficient elderly, healthcare and social facilities for persons with disabilities, hospices. • **Social or Educational Settings** (100–130 hours): day centers, community homes, residential or semi-residential facilities for persons with disabilities or addictions, mental health services, social and educational inclusion services, home assistance. *(DGRV 883, Annex B, p. 11 of 20)*	Each year, students complete an internship that increases in duration and responsibility. Internship opportunities include: • Assistance to young people and families • Support services for people with disabilities • Refugee support organisations • Community and neighbourhood centres • Addiction support and recovery services • Mental health institutions (GGZ)
Work areas	**Reference – National Work and Qualification Framework** • Support activities in nursing care settings (Hospitals or Nursing Homes) – **ADA.19.01.22** • Social care support services for disadvantaged individuals (canteens, social transport, basic goods distribution, personal hygiene services) – **ADA.19.02.14**	• Social worker • Residential support worker • Youth care worker • Support worker in shelters or mental health centres Students can continue their studies at higher professional education (HBO) institutions in fields such as: • Social work • Education • Applied psychology

	ITALY - OSS COURSE, REGIONAL QUALIFICATION (VENETO REGION)	NETHERLANDS - SOCIAL WORKER
Work areas	• Implementation of home assistance interventions for individuals with limited care needs – **ADA.19.02.15** • Primary care and basic needs support in semi-residential and residential facilities – **ADA.19.02.17** *(State–Regions Agreement No. 13/2024, Rep. Atti No. 1161, Annex 1, p. 10)*	

4.3 Strengths and challenges to be addressed in order to improve the training offer

Based on their experience, the project partners have identified a number of strengths and challenges for improving the current training provision.

STRENGTHS	
Experience in Italy	**Experience in the Netherlands**
Nationally Recognized Qualification The qualification obtained through the OSS (Social and Healthcare Operator) course is awarded following a regional training program with a final examination that certifies officially recognized competencies. This qualification is valid at the national level and can be applied in various care settings, including healthcare, social and healthcare, social care, and educational environments.	**Strong focus on practical training** • Starting in the second year, students undertake two days of work experience per week at recognised organisations, providing solid practical experience and alignment with professional practice. • Assignments, conversation exercises and portfolios help students develop professional behaviour and skills.
Extensive Structure of the Curriculum in Three Areas • Socio-Cultural, Legislative, and Institutional Area • Technical and Operational Area • Relational Area Each area combines theoretical and practical content, ensuring a comprehensive acquisition of the professional profile.	**Emphasis on general and social skills** • In addition to the main subjects, the curriculum includes Dutch, mathematics and citizenship. • Specific training in communication, conversation and presentation techniques develops skills that are directly applicable in the field of social work. behaviour and skills.

STRENGTHS

Experience in Italy

Solid practical experience

- OSS courses include compulsory internships at healthcare and social care facilities (hospitals, nursing homes, communities), offering practical experience before entering the world of work.
- Work experience is often rich and varied thanks to the wide range of contexts in which an OSS can operate.

Broad applicability of the professional profile

The OSS CV can be submitted in healthcare settings (hospitals, local health authorities), social services (family homes, day centres) and the private sector (home care, cooperatives).

Well-developed transferable skills

1. OSS professionals develop key interpersonal and work skills, such as:
   - Empathy and communication with vulnerable patients
   - Ability to work in multidisciplinary teams
   - Stress resistance
   - Precision in hygiene and health procedures
   - Flexibility with shifts and workload

Willingness to work shifts (including nights and holidays) is a valuable requirement for many facilities and should be highlighted in your CV.

Experience in the Netherlands

Flexibility through optional modules

Students can choose specialised or broader optional courses, helping them to stand out in the job market or move more easily on tion to higher professional education (HBO).

UNESCO vision and 21st-century skills

As a UNESCO school, the programme integrates global, social and sustainability themes throughout the curriculum. Critical thinking, media literacy, entrepreneurship and active citizenship are fundamental to this future-oriented approach.

Modular and flexible training

- The college emphasises modular and flexible learning, independent of time and place.
- Students can follow modules at their own pace, promoting autonomy and self-determination.

Extensive student support

Support services include coaching for study techniques, planning, emotional well-being, financial guidance and academic mentoring. Programmes such as Actieplan Leerbanen and Route X help students balance study and work or change paths if necessary.

CHALLENGES

Experience in Italy

Standardisation of the profile

- OSS training programmes are very similar across regions, making it difficult to stand out from other candidates based solely on qualifications.
- As a result, CVs can often appear generic or lacking in originality.

Experience in the Netherlands

Level of interdisciplinary collaboration

- Although interdisciplinary projects are increasingly being implemented, only a minority of programmes currently offer them as standard practice.
- Impact: Social Work students may not have the opportunity to work with colleagues from other sectors such as healthcare or public administration.

CHALLENGES	
Experience in Italy	**Experience in the Netherlands**
Difficulty highlighting soft skills • Interpersonal and personal skills, which are essential in OSS work, are difficult to represent objectively in a CV. • There is a risk of using generic phrases (e.g., 'I am an empathetic person') without concrete examples.	**Implementation of modular flexibility** • The transition to modular education is still ongoing and requires a clear and consistent structure across programmes. • Impact: students may encounter differences in expectations, organisation and personalised options.
Limited access to professional growth roles • Career advancement is limited for OSS professionals without additional qualifications (e.g., becoming a nurse, educator, or coordinator). • This can lead to static CVs over time, with little evolution in role or responsibilities.	**Integration of AI and digital tools** • Pilot projects involving AI in curriculum design and instruction are underway. • Impact: Effective use of AI in teaching requires both teacher training and student acceptance.
Employment gaps or precarious contracts • iMany OSS professionals work through cooperatives or on fixed-term contracts, which can make their CVs appear fragmented. • Recruiters may perceive the profile as unstable.	**Ensuring the admission of motivated and qualified students** • Matching students' expectations and motivation with the programme's requirements remains a challenge. • Impact: Unmotivated students can affect the quality and success of internships and group projects.
Poor digitisation of professional profiles • OSS professionals are not always familiar with digital tools for creating an effective CV or using online job platforms. • Often, there is no up-to-date LinkedIn profile or well-designed digital presentation.	**International and intercultural experience** • Although the school integrates global awareness (UNESCO vision, virtual exchange), opportunities for physical mobility have decreased during the pandemic. • Impact: students may lack valuable intercultural experience, which is essential in today's diverse social work contexts.

05

Good practices from United Nations agencies[1]

There are very few examples of plans, programmes and policies that address the root causes of violence against women and girls with disabilities. A series of United Nations documents provide guidance on this issue, setting out general and specific measures to promote and protect the rights of women with disabilities who experience any form of violence.

Below are some guidelines that can be followed.

5.1 Strengthen the capacity of gender-based violence practitioners to work with victims of violence with disabilities

Ensuring that staff have the appropriate knowledge, attitudes and skills regarding disability inclusion is the responsibility of those involved in gender-based violence. Practices and approaches for disability inclusion in gender-based violence programming should integrate disability into the development or revision of gender-based violence curricula and training.This means that support for victims of gender-based violence must be part of the core activity of gender-based violence service providers.

1 UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0; UNFPA, WOMEN AND YOUNG PERSONS WITH DISABILITIES - Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights, 2018; UNFPA, DISABILITY INCLUSION IN GENDER-BASED VIOLENCE PROGRAMMING PROMISING PRACTICES AND INNOVATIVE APPROACHES, 2023; WHO, Caring for women subjected to violence: A WHO training curriculum for health care providers. Revised edition, 2021

To ensure that gender-based violence service providers and staff have the essential basic knowledge on the subject, a good practice would be to include technical knowledge on gender-based violence and disability inclusion as a desirable competence in terms of reference and job descriptions.

Ensuring that programmes for gender-based violence and sexual and reproductive health and rights are non-discriminatory and disability-sensitive requires comprehensive assessment and continuous monitoring of all stages of the programme life cycle to ensure that barriers do not arise and that existing barriers are addressed for women or young people with disabilities in accessing services.

5.2 Capacity building: rights holders and duty bearers

Capacity building: develop the capacities of both **rights holders** (women and young people with disabilities) and **duty bearers** (service providers and support staff):

RIGHTS HOLDERS

Support women and young people with disabilities in understanding and asserting their rights through targeted capacity-building programmes. Such programmes generally fall into three categories: (1) programmes developed for women and young people with disabilities to improve their knowledge and understanding of their rights and the services available to them; (2) ongoing feedback and engagement between women and young people with disabilities, service providers and support staff; and (3) leadership and empowerment programmes for women and young people with disabilities.

- **Establish support groups and peer-to-peer networks** led and structured by women and young people with disabilities, paired with ongoing support as needed.
- **Create safe and inclusive capacity-building spaces** for women and young people with disabilities from diverse backgrounds and identities.
- **Involve persons with and without disabilities** in age- and gender-appropriate capacity development programmes and involve other actors, such as caregivers and family members, in these programmes.
- **Develop programmes** that accommodate different communication and engagement styles, recognising that participation is different for everyone. For example, a service user with an intellectual disability may need more time to provide feedback or alternative communication formats. Programmes should be structured to allow space and flexibility for different forms of participation.

DUTY BEARERS

Provide comprehensive training programmes for service providers and support staff on disability inclusion, including the needs and experiences of women and young people with disabilities, accessibility mechanisms and techniques, and reasonable accommodation.

- **Ensure that training programmes address all different forms of disability** and related accessibility needs and provide specific and actionable guidance.
- **Make training and supportive supervision a constant job requirement**. Offer continuous training to assist service providers and support staff, for example in developing additional and relevant communication skills.

- For service provider roles that require a certificate or degree, such as a medical degree, **create teaching modules and programmes that teach students how to provide services to people with disabilities**. Programmes should focus on skills development and practical experience and not be limited to disability inclusion concepts.
- **Involve instructors with disabilities** where possible, as this increases the effectiveness of training and contributes to changing power dynamics that might otherwise contribute to stigma and discrimination.
- **Provide experiential learning opportunities** for service providers and support staff to enable them to gain confidence in providing services to people with disabilities.

5.3 Effective identification of needs

Develop effective and supportive **partnerships** focused on improving capacity and service integration to avoid dilution of funding and resources.

- Commit to coordinating with organisations for persons with disabilities led by women and young people and with services that prioritise and reflect gender equality.
- Establish clear protocols and agreements with relevant social, health and judicial sectors.
- When developing referral networks, identify clear responsibilities for each service and organisation in the network.
- Ensure that coordination procedures are consistent, known to all service providers and support staff, and clearly communicated to women and young people with disabilities.
- Develop safeguards to make service providers and support staff accountable for providing necessary referrals, where available and appropriate. For example, a checklist with required identification questions or supervision.
- Create referral systems that require informed consent before a referral can be made and that include safeguarding for the privacy and confidentiality of the person making the referral.
- Use trained case coordinators to respond to the needs of women and young people with disabilities to ensure continuity of care across networks.

Develop relationships with local rehabilitation service **providers**. Local rehabilitation service providers can be effective resources for sharing knowledge and resources, as well as for connecting women and young people with disabilities to services. Community-based rehabilitation service providers generally have a good understanding of the accessibility needs of persons with disabilities in their communities and, in many cases, have built relationships with women and young people with disabilities in the community, which gender-based violence and sexual and reproductive health and rights (SRHR) service providers can rely on.

Take steps to identify service users with disabilities who have experienced or are experiencing gender-based violence or sexual and reproductive health and rights (SRHR) violations. Service delivery, particularly in the area of sexual and reproductive health services, is a valuable point of contact for identifying victims/survivors of violence, assessing risks and developing a plan to manage and mitigate them.

- Operators and staff must be trained on how to provide frontline support. It is essential that routine screening for gender-based violence or sexual and reproductive health and rights (SRHR) violations is only conducted when service operators and support staff have solid training and effective referral networks, otherwise operators and staff risk causing further trauma to a victim/survivor. Appropriate

and effective referrals must be in place to immediately connect the victim/survivor with the services they need.

- Develop specific guidelines for identification that service providers and staff can use when identifying a person at risk of safety, including in situations where the survivor is dependent on the perpetrator. Service providers and staff should also be trained on safety planning and mitigating any risks to the woman or young person that identification may entail.
- Establish consistent and coordinated identification procedures and inter-agency coordination.
- Promote the creation of spaces where women and young people with disabilities can feel safe and supported.
- Respect the right to confidentiality and privacy of women and young people with disabilities.

Bibliography

- Report of the Office of the United Nations High Commissioner for Human Rights, Thematic study on the issue of violence against women and girls and disability, 2012
- UN WOMEN, Sexual harassment against women with disabilities in the world of work and on campus, 2020
- General Comment No. 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights (Art. 3 of the Covenant)
- CEDAW General Recommendation No. 19: Violence against women
- Special Rapporteur on the rights of persons with disabilities, *Report on the sexual and reproductive health and rights of girls and young women with disabilities*, 2017
- Report of the Special Rapporteur on violence against women and girls, its causes and consequences, Prostitution and violence against women and girls, 2024
- UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0
- UNFPA, WOMEN AND YOUNG PERSONS WITH DISABILITIES - Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights, 2018
- UNFPA, DISABILITY INCLUSION IN GENDER-BASED VIOLENCE PROGRAMMING PROMISING PRACTICES AND INNOVATIVE APPROACHES, 2023
- WHO, Caring for women subjected to violence: A WHO training curriculum for health care providers. Revised edition, 2021
- CoE, Preventing and combating violence against women with disabilities, 2023
- Directive (EU) 2024/1385 of the European Parliament and of the Council of 14 May 2024 on combating violence against women and domestic violence
- European Disability Forum – EDF, Violence against women and girls with disabilities in the European Union - Recommendations on EU policies to combat violence against women and girls with disabilities, 2021
- EDF, European Human Rights Report: Legal capacity: Personal choice and control, 2024
- EDF, Transposing the EU Directive on combating violence against women, 2025
- Inclusion Europe, Life after violence – a study on how women with intellectual disabilities cope with violence they experienced in institutions, 2018
- GREVIO, Baseline Evaluation Report Italy, 2020
- GREVIO, Baseline Evaluation Report Netherlands, 2020
- Pirkko Mahlamaki, Gender-based violence against women and girls with disabilities, 2021. CoE, Preventing and combating violence against women with disabilities, 2023

Web

- www.ohchr.org
- EU law - EUR-Lex
- Home - Eurostat

CARE-INT

cbm

FONDAZIONE LIBELLULA

IREA Fondazione ETS
Morini Pedrina Pelà Tono

KONING WILLEM I COLLEGE

Co-funded by the European Union

Erasmus+
Enriching lives, opening minds.