

# A Crisis within a Crisis: How Gender and Disability Impact the Opportunities Available to Women with Disabilities in Cambodia and Rwanda.

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# Declaration

I, JENNIFER BYRNE, hereby declare that this thesis is my own work and effort, and that it has not been submitted elsewhere for an award. Where other sources of information have been used, these have been acknowledged.

Signature:

Date:

# Abstract

The experiences of women with physical disabilities have long been overlooked in the fields of both gender and disability studies (Liasidou, 2013). Much of the literature which does exist to explore disability and gender is based in the Global North and tends to take a medical or clinical approach to disability. This thesis therefore takes a more participatory approach to gender and disability research, relying on the stories of women with disabilities themselves, through empirical evidence from two countries in the Global South.

The aim of this thesis is to explore the relationship between gender and disability, and to understand how these factors of identity combine to limit the opportunities available to women with disabilities, especially in relation to education and employment. Utilising a mixed methods approach, which is rooted in participation and empowerment, and framed by critical disability studies and intersectional feminism, I consider the experiences of 36 women with physical disabilities, their advocates, communities, and support structures.

These interviews highlight the discrimination faced by women with disabilities in their everyday lives, due to the social and institutional perceptions of both gender and disability in Cambodia and Rwanda. These are influenced by patriarchal norms and assumptions about the capabilities of women with disabilities, and tend to preclude them from education, employment, marriage, and personal relationships. In order to overcome these obstacles, women stressed the need for self-confidence and support from those around them. This thesis therefore argues for an increase in support for women with disabilities through both formal and informal channels.

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## Glossary of Terms

People with disabilities - I have chosen to use the term 'people with disabilities' in this research, as it is now commonplace in disability literature, and is an example of 'person-first language', which recognises that disability is just one of many components to a person's identity (Cobley, 2018). I recognise however, that others may prefer the term 'disabled people', as it emphasises the role of society in creating and reinforcing disability. This perspective argues that disability should not be viewed as an added appendage, as the term 'people with disabilities' might imply, but as an intrinsic part of one's identity (Oliver, 1990). People with disabilities are often referred to as 'PWDs' by women in this study, so I have not changed these direct quotes. I have also noted that certain expressions or terms may be considered appropriate in different languages and cultures, even if these contrast with Western views, and certain languages may use terms to describe disability which Western academics would consider outdated. With this in mind, I have chosen to adhere to local customs as far as possible when discussing disability in interviews and focus groups.

Livelihood opportunities - These opportunities are defined as the activities, assets, and access that jointly determine the living conditions of an individual or household. In other words, livelihood opportunities represent the opportunities that individuals engage in with the main purpose of sustaining or improving their living conditions (Mphande, 2016).

Intersectionality - This concept recognises that people's lives are influenced by many different factors, and are shaped not by a single axis of social division, such as race, gender or class, but by many axes that work together and influence each other (Collins & Bilge, 2016)

Patriarchy - At its core, patriarchy is about the valuing of maleness and masculinity, and the devaluing of femaleness and femininity (Johnson, 2004). Sylvia Walby (1989) further describes patriarchy as a system of social structures and practices in which men dominate, oppress, and exploit women. This can be true to a greater or lesser extent in different countries and cultures, and in different circumstances.

**Global South** - The Global South is a geographical, geopolitical, historical and developmental concept, widely used by academics to group low- and lower-middle income countries, but which can constitute different areas according to different people. In general, the Global South refers to developing countries across the globe, but can also refer to countries which were previously colonised, or those with a low per-capita GDP (Scheyvens, 2014).

**Cultural norms** - Cultural norms are the standards people live by. They are the shared expectations and rules that guide the behaviour of people within social groups. These norms are learned and reinforced through social structures including parents, friends, teachers and others while growing up in a society (Sieck, 2021). These standards can also take the form of social or gendered norms - referring to the cultural phenomena that prescribe behaviour in specific circumstances (Hechter & Opp, 2001); and to the social rules and expectations placed on men and women (Cislaghi et al, 2020), respectively.

**Discrimination** - The concept of discrimination refers to the unfair or prejudicial treatment of people and groups based on characteristics such as race, gender, age, or sexual orientation. An act or policy is seen to be discriminatory if it treats person A differently from person B on the basis of person A having or lacking some trait. The reason that differentiation among people is cause for moral concern is that all people are equal, and matter in society (Hellman, 2017).

**Stigma** - Stigma is a social phenomenon where individuals or groups are labelled and negatively stereotyped by those around them, in particular by those who hold more social capital than them. It is a way of separating one group from another, thus leading to discrimination (Link & Phelan, 2001).

**Marginalisation** - Marginalisation represents the exclusion of certain groups of people from mainstream society, and manifests itself in a wide range of ways. People who experience marginalisation may be disenfranchised through poverty and lack of opportunities, race or religion, sexual orientation, disability, or through personal circumstances. Further, marginalisation can only be fully understood within the

context of what is 'normal' in any given society, and may be defined differently according to different countries (Mowat, 2015).

Multiple disadvantage - People facing multiple disadvantage tend to experience a combination of difficulties or issues. For many, their current circumstances are shaped by long-term experiences of poverty, exclusion, trauma, and neglect. These structural inequalities intersect with experiences of discrimination and isolation, and manifest in exclusion from society. Multiple disadvantage is a systemic issue, where individuals are often failed by services and systems which focus only on singular issues, without accounting for the intersectional identities of every person (MEAM, 2018).

# Acronyms

ADD - Action for Disability and Development

AFD - Agence Francaise de Development

APOPO - Anti-Persoonsmijnen Ontmijnende Product Ontwikkeling (Anti-Personnel Landmines Detection Product Development)

CBM - Christian Blind Missions

CDC - Centres for Disease Control

CEDAW - Convention on the Elimination of All Forms of Discrimination against Women

CRPD - Convention on the Rights of Persons with Disabilities

DFID - Department for International Development

DPO - Disabled Person's Organisation

DRF - Disability Rights Fund

GBV - Gender Based Violence

IFAD - International Fund for Agricultural Development

IFP - International Forum on National NGO Platforms

ILO - International Labour Organisation

IWDA - International Women's Development Agency

KILT - Khmer Independent Life Team

NDA - National Disability Authority

(I)NGO - (International) Non-Governmental Organisation

NISMP - National Institute of Statistics of the Ministry of Planning

NISR - National Institute for Statistics Rwanda

NUDOR - National Union of Disability Organisations in Rwanda

PTSD - Post-Traumatic Stress Disorder

PWDs - People with Disabilities

RGB - Rwanda Governance Board

SDGs - Sustainable Development Goals

UNABU -Umuryango Nyarwanda w'Abagore Bafite Ubumuga (Rwandan Organization of Women with Disabilities)

UNFPA - United Nations Population Fund

UNGEI - United Nations Gender Equality Index

UNICEF - United Nations International Children's Emergency Fund

USAID - United States Agency for International Development

VSO - Voluntary Services Overseas

WHO - World Health Organisation

WWF - World Wildlife Fund

# Chapter 1: Introduction

## 1.1 Rationale & background of the study

Disability is not a rare phenomenon. As of 2021, approximately 1.3 billion people – about 16% of the global population – experience disability. According to the WHO, this figure has grown significantly over the last decade, and will continue to rise due to demographic and epidemiological changes, underscoring the urgency for action on disability inclusion (WHO, 2022). People with disabilities also face significant levels of discrimination, stigma and prejudice, which may result in their invisibility in society, and prevent them from participating fully in the lives of their families and communities (WHO, 2011). In many countries in the Global South, people with disabilities are perceived in negative ways due to cultural norms and stereotypes, and this can affect everything from their self-confidence to their capacity to engage in the labour market (CBM, 2012; Grech et al, 2023).

People with disabilities are internationally reported to experience numerous barriers to their full participation in society, including negative attitudes, communication barriers, lack of access to training and information, and inaccessible workplaces when seeking employment (CDC, 2018). As well as this, people with disabilities are currently the group least likely to benefit from development programmes designed to reduce poverty and marginalisation, due to a lack of consideration for the unique dangers and challenges faced by people with disabilities in their everyday lives (CBM, 2012).

International literature has recently begun to give more weight to the gendered experience of disability, recognising that women with disabilities face the intersection of gender and disability, which combine to create a distinct and particular experience of disadvantage and discrimination, not suffered by others. This means that women with disabilities are often socially excluded, as they are part of a group which is physically and mentally divergent from the standards and values expected of

individuals in their society (Wayack-Pambé & Kouanda, 2022). Women with disabilities in these cases are described as experiencing significant discrimination, often being considered as the 'Other' to social norms and cultures (Meekosha, 2004). Meekosha also notes that the perception and experience of disability is often intensified by gender - where people see women with disabilities as passive and helpless, and men with disabilities as emasculated and dependent. This gendered experience of disability has had real consequences in terms of the opportunities available to women with disabilities in education, employment, living arrangements, and personal relationships, and further alludes to the importance of intersectionality in disability discourse (Meekosha, 2004).

Disability inclusion is defined as understanding the relationship between the way people with disabilities function and participate in society, and ensuring that everyone - regardless of gender, disability, race, age, etc. - is afforded the same opportunities to participate in every aspect of life (CDC, 2020). Providing opportunities for women with disabilities to engage in education and employment, and encouraging them to hold roles in similar capacities to their non-disabled peers is one method of achieving disability inclusion. However, this involves more than simply encouraging people; it also requires a process of shifting attitudes towards disability, ensuring that adequate policies and practices are in place, and that these are properly implemented by governments (Cobley, 2018).

Since the ratification of the CRPD by many countries in (or after) 2006, as well as the inclusion of disability and equality in the SDGs, governments have increasingly begun to recognise disability inclusion as a priority. I have chosen Cambodia and Rwanda as focus countries for this research specifically because both governments have demonstrated strong political will for the inclusion of women and people with disabilities in society, as evidenced by both countries having ratified both the CRPD and CEDAW early in their inception.

The Kingdom of Cambodia is a lower-middle income country in South-East Asia. The capital city is Phnom Penh, but most of the tourism, local business, and international NGOs in the country are located in the second city, Siem Reap. Prior to the Covid-19 pandemic, Cambodia had one of the fastest growing economies in the world, driven

largely by tourism, manufacturing exports, real estate, and construction (World Bank, 2024). Despite progress slowing during and after the pandemic, the Cambodian economy presents many opportunities for employment. Buddhism is the largest religion in the country, with over 97% of the population actively practising, and influences much of the day to day lives of Cambodian people, including cultural beliefs around gender and disability (Harris, 2017).

According to the UNFPA, in Cambodia, gender norms remain heavily rooted in society, creating inequality between men and women and depriving women of their basic rights. This is especially obvious in terms of education, where girls consistently have lower school completion rates than boys. This lower level of education often correlates to the opportunities available to women later in life, where they may lose out in terms of training, employment, and even reproductive choices (UNFPA, 2024).

Recent data shows that one in five women in Cambodia report having experienced emotional, physical, or sexual violence by an intimate partner in their lifetime, but gender-based violence isn't something that is easily discussed, owing to the culture of privacy and saving face (UNFPA, 2023). This under-reporting of GBV is often due to harmful gender and social norms, combined with a lack of adequate reporting and response systems. Data shows that over 50 percent of women that experienced physical or sexual violence had not told anyone, because they saw violence as normal or not serious, or they had concerns of shame for the family (UNFPA, 2023).

Rwanda on the other hand, stands out globally for its commitment to gender equality at parliamentary level, although here too, gender-based discrimination is deeply ingrained in the culture. The country aspires to become a middle-income country by 2035, and has a constitutional agreement that at least 50% of seats in parliament must be held by women (USAID, 2023). The capital city, Kigali, is the main hub for business and technology in the country, although most ordinary people live in the suburbs and rural areas, and still rely on agriculture as a primary source of income (World Bank 2024). While Rwanda continues to see growth in the economy year-on-year, a number of challenges remain, including a need to improve the quality of infrastructure, essential basic services (education, health, and social safety nets),

and effective support for entrepreneurship and private-sector job creation. The main religion in the country is Christianity, and Rwandans are described as 'extremely spiritual', with church services and teachings influencing much of the culture around gender and disability (AFD, 2024).

Despite major gains in the political sphere, the culture of Rwanda is still deeply patriarchal, and the high-level examples of gender equality do not always reflect the lived experiences of women who continue to be left behind. This is mainly due to persisting gender inequity at regional and community levels, often in combination with other forms of discrimination. Women and girls with disabilities, of ethnic and racial minorities, or identifying as LGBTQI+ for example, are still prevented from realising their rights (UNFPA, 2024).

GBV also remains a pervasive problem in Rwanda, and is a complex issue, deeply rooted in the patriarchy, which itself is enshrined in the cultural and religious notions of the country. As well as this, there are also additional social conditions at play, which create and perpetuate unequal gender norms and power relations (World Bank, 2018). According to AFD, in 2017 almost 40% of young women in Rwanda had experienced some form of violence, and the majority of these were girls and women with disabilities (AFD, 2024). Similar to Cambodia, many survivors of GBV fail to report their cases, sometimes due to a lack of understanding about gender equality, as well as a culture of stigma and shame that pushes them to remain silent (World Bank, 2018).

This study has been influenced by these findings on gender equality in both countries, as well as by the broad discourse around disability inclusion in the international development sector as a whole. I am interested in how gender equality and disability inclusion overlap in the day-to-day lives of women with disabilities, and whether the policies set out by governments are implemented, and reach the most vulnerable women in society. In order to gain a deeper understanding of how gender and disability intersect to create marginalisation, and how best to include women with disabilities in all areas of life in Cambodia and Rwanda, this thesis will explore the opportunities available to them in both societies, with a particular focus on opportunities in education and employment.

## 1.2 Research questions & objective:

The broad aim of this research is to understand the intersections between gender and disability in Cambodia and Rwanda in relation to experiences of discrimination, marginalisation, and denial of opportunities. In particular, it focuses on education and employment opportunities for women with physical disabilities in suburban areas of Siem Reap, Cambodia, and Kigali, Rwanda, in order to understand the barriers they face when entering the labour market. This thesis will further explore how women with disabilities can be better supported to participate in society and to improve their livelihood opportunities in the Global South context.

The main objectives of this research are to:

- demonstrate through empirical evidence, the relationship between gender and disability, as experienced by women with physical disabilities in the Global South.
- understand the factors which may influence how, and to what extent, women with physical disabilities participate in education and the labour market.
- explore the socio-cultural understandings of women with disabilities in Cambodia and Rwanda.

To address these objectives, the following research questions will be answered:

1. What is the relationship between gender and disability in Cambodia and Rwanda? And how do societal perceptions of these identities shape the experiences of women with physical disabilities in both countries?
2. What opportunities for education and employment are pursued by women with physical disabilities in Cambodia and Rwanda?
3. Do women with physical disabilities receive support in pursuing livelihood opportunities? And if so, where does this support come from?

This thesis therefore explores the concepts of gender, disability, and empowerment from the perspectives of women with disabilities in the Global South. It also addresses the interactions between women with disabilities and the structures,

attitudes, and ideas around them, which may serve to advantage or disadvantage them in different settings.

### 1.3 Thesis structure

This thesis is comprised of 7 chapters, opening with this introduction. Chapter two outlines the key conceptual literature which underpins this research, including defining the key terms of gender and disability, as well as some of the most prevalent understandings of disability globally. This provides a background and an evidence base on which to build more culturally specific understandings of gender and disability.

In Chapter three, the review of theories and research, I consider previous discourse and scholarship around gender and disability, with a special focus on the Global South. I first explore literature on the broad topic of opportunities for people with disabilities, to understand how societal perceptions and economic trends can impact the lives of people with disabilities and the opportunities they are able to pursue. This leads into literature on intersectionality, which prompted me to consider how being a woman and having a disability may serve to disadvantage women with disabilities in the context of the Global South. Finally, I combine these two ideas to examine the real consequences of living as a woman with a disability in the Global South, and how these identities are reported to lead to experiences of marginalisation and violence.

Chapter four situates this research within the context of Cambodia and Rwanda, linking the disability movement of today with the broader culture and history of both countries. In this chapter, I aim to provide a broad introduction to both countries, to show where the disability movement emerged in Cambodia and Rwanda, with a view to framing later discussions on attitudes towards disability, cultural norms, and patriarchal expectations.

In Chapter five, methodology, I discuss the theoretical framework which underpins this research, and frames my own understanding of gender and disability. This

chapter then further builds on the base of intersectional feminism and critical disability studies, to include participation and empowerment, as I describe in detail how I conducted this research. After setting out my research questions, I describe how my own beliefs and understandings influence this research, with a particular focus on reflexivity. Using participatory and emancipatory research tools, I take a mixed methods approach to research, focusing on qualitative empirical evidence, grounded in quantitative data, mostly from large-scale census reports. I then describe my fieldwork journey in two phases: the preparatory work before leaving Ireland, and the fieldwork which took place in Cambodia and Rwanda, as well as the ethics process, methods of analysis, and the problems I faced during this study.

I then present my findings and discussion in Chapter six, opening with the current trends for inclusion in both countries, as well as a profile of participants, and further citing empirical evidence from 36 interviews with women with disabilities, 2 focus group discussions, and 24 key informant interviews. This chapter addresses the key research questions about intersectionality, opportunities, and support for women with disabilities under four major themes, using quotes and experiences of women with disabilities themselves. In this way, I explore the attitudes towards disability in the context of Cambodia and Rwanda, the opportunities available to women with disabilities, the identity constraints that women with disabilities face because of their intersecting identities, and the types of support they receive from both formal and informal channels.

Finally, in Chapter seven, I draw conclusions from these findings about the overall experiences of women with disabilities in Cambodia and Rwanda, to further answer the research questions. These findings and conclusions then inform the recommendations of this thesis, which are derived from the ideas of participants on how best they can be included in society. These recommendations are intended for international and local NGOs, governments, and communities to advance disability inclusion while also accounting for the specific cultural understandings of disability in different countries. I conclude with a discussion of how this thesis contributes to the literature on gender and disability studies, as well as identifying areas for future research.

## Chapter 2: Review of Conceptual Literature

This chapter will explore some of the key concepts and theories underpinning both gender and disability studies. In order to base this study on current thinking and realities, I will consider the general definitions of gender and disability, especially as they relate to the field of international development. Broadly, this chapter explores the current thinking surrounding gender from a disability point of view, and considers the use of an intersectional approach to understanding disability, which values all of the different identities that make up an individual. This chapter also examines the different models of disability which frame and influence thinking around disability at an international level, and how they relate to women with disabilities. It further explains the background to disability inclusion within the sphere of international development, and progress that has been made over the last 20 years, before finally discussing the conventions and tools which are already at our disposal for advancing disability inclusion internationally.

### 2.1 Defining gender

According to the World Health Organisation, gender refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours, and roles associated with being a woman, man, girl or boy. As a social construct, understandings of gender vary from society to society and can change over time (WHO, 2022). USAID goes on to add that gender is an acquired identity, which is relational and refers not simply to women or men, but also to the relationship between them (USAID, No Date).

Meekosha (2004) explains that gender is a complex and ever-evolving way of making meaning of people's bodies and life experiences. Gender identity and expression are not fixed entities, and may change over time, and in different societies. This, she argues, is similar to the disabled identity, which is often reduced to the binary categories of 'disabled' and 'non-disabled', failing to account for the full

spectrum of experiences of people with disabilities, and how these identities may shift over time and in different geographical areas.

A major characteristic of the growing body of literature on women with disabilities is that it highlights this spectrum of ever-changing identities: it crosses borders and politics, and is often interdisciplinary. It examines the perspectives of women from many different corners of society, and reflects the diversity in the lives of women with disabilities themselves, who are presented in the literature by the type and severity of their disability, the wide variety of issues they face, as well as the other factors of identity which influence their lives such as class, race, ethnicity, and sexual orientation (Majiet & Africa, 2015). Thomas (2006) describes that gender and disability are inextricably linked as identity factors, and that the different forms of living with a disability are impacted in many ways through the lens of the gendered experience and gender relations in particular cultural settings. She further explains that women with disabilities often tell their stories with reference to the gendered norms which prevail in their societies, and tend to construct their narratives with reference to public attitudes about “what it means to be a woman”, including motherhood, caring, and household responsibilities (Thomas, 2006).

Gender is therefore an important concept within this research, because despite the fact that all human rights and development norms and standards apply to women and girls with disabilities, historically, they have not enjoyed their full rights on an equal basis with others, due to these intersecting identities. This has led to women and girls with disabilities feeling invisible, both as advocates of women’s rights, and of disability rights, which has in turn increased their vulnerability. As a result, women with disabilities often must confront additional disadvantages even in comparison to men with disabilities and women without disabilities, thus emphasising why conceptualising gender is so important within the disability sphere (UN Women, 2018).

It is therefore vital that gender equality and disability inclusion should be considered as intersecting issues, and the gender dimensions of disability inclusive development should be addressed. To advance the rights of women with disabilities in society and development, it is essential that their perspectives be included in all aspects of work

for women's empowerment, and that all work on disability incorporates a gender perspective. Without the meaningful participation of women with disabilities in the disability dialogue, the goal of "nothing about us without us" cannot be achieved (UN, 2004).

## 2.2 Defining disability

According to the ILO, the word disability is a general term which refers to any restriction, or lack of ability to perform an activity in the range considered normal for a human being (ILO, 1999). The WHO further builds on this, explaining that disability is part of being human and is integral to the human experience. It results from the interaction between health conditions and/or impairments that a person experiences, such as dementia, blindness or spinal cord injury, and a range of contextual factors related to different environmental and personal factors such as societal attitudes, access to infrastructure, discriminatory policies, age, or gender (WHO, 2022).

Across cultures, defining disability is complex and often disputed, since the category itself is a Western concept which emerged out of particular historical circumstances in Europe (Grech, 2009). As well as this, the meaning of disability varies based on the socio-cultural contexts in which it is placed. Nevertheless, the need for a definition remains important for both measurement and policy purposes. Therefore, the UN Convention on the Rights of Persons with Disabilities (CRPD) describes disability as 'the interaction between persons with impairments, and the attitudinal and environmental barriers they face' (United Nations, 2006, p. 1). But - like gender - disability is defined differently according to different people, often varying widely across cultures, languages, and even professions. As discussed in the next section, disability has historically been conceptualised differently by different locations, cultures, and sectors. Copley (2018), uses the example that medical and rehabilitation professionals have tended to identify people with disabilities through their impairments, while others in the charitable or religious sectors may view people with disabilities as victims of circumstance or in need of pity.

Defining disability is therefore not such a clear-cut task, and many different definitions exist based on different models of disability, as well as across cultures. According to an IFP brief (2016), the term disability is so difficult to define not only because of the wide range of experiences that it encompasses, but more importantly because disability is so context-dependent. This brief stresses that disability resides in society, not the person, and that an individual who is regarded as having a disability in one setting may not be viewed this way in another.

## 2.3 Models of disability

The particular way in which the concept of disability is interpreted in a society can determine how people with disabilities are perceived by others. These understandings have evolved over time, from locating disability within the individual in the religious, welfare, and medical models, to now focusing more on the disabling impacts of society in the family, social, human rights, and biopsychosocial models. These earlier models are underpinned by 'personal tragedy theory', which views disability as some chance event which occurs at random to certain individuals (Oliver, 1996, p. 23), and contrast heavily with more recent thinking based on collectivism and advocacy.

### Religious Model of Disability

The religious model of disability is the oldest individual model of disability, and is found in a number of religions, including the Judeo-Christian and Buddhist traditions (Pardeck & Murphy 2012). The religious model ties disability to faith, and often suggests that disability is the result of divine retribution for past sins or misdemeanours, committed by either disabled people themselves, or their families and ancestors (Cobley, 2018). Cobley also states that in some cultures people with disabilities are held accountable for 'wrongdoings', and are considered to be deserving of their impairments.

Retief and Letšosa (2018) counter that in some cultures the religious model of disability perpetuates the myth of disability as 'mysticism' or some kind of blessing,

whereby the fact that one of the senses of a person is impaired, inevitably heightens the functioning of other senses. Overall, Clapton and Fitzgerald (2014) summarise that themes which embrace notions of sin or sanctity, undesirability and weakness, care and compassion, healing and burden have formed the dominant bases of conceptualisations of, and responses to, people with disabilities within the religious model.

This model is also of major relevance to current disability discourse - and to this study - owing to the ways in which religion still influences daily life for many people, and to the ways that disability was institutionalised in many nations of the Global South under colonialism. McEwan and Butler (2007) explain that in many pre-colonial societies, people with disabilities were accommodated based on what they could contribute to their communities, whereas under colonialism, humanitarian systems were imposed on societies. Under these systems, churches and charities often filled the gaps in provision of services, funding and equipment for people with disabilities, while also importing attitudes that emphasised the welfare model of disability.

In this way, the welfare model was borne out of the religious model of disability, and the two are still closely linked, often operating in tandem in the Global South.

### Welfare Model of Disability

In the welfare or charity model of disability, disability is viewed in terms of 'suffering', where people with disabilities are dependent on the sympathy and assistance of others (Cobley, 2018). According to this model, people with disabilities are victims of circumstance who should be pitied, and able-bodied people should assist them, since 'they need special services, special institutions, etc., because they are different' (Duyan, 2007, p. 70 - 77). It relies heavily on the charity and benevolence of others, rather than on justice and equality for people with disabilities. This model accepts the marginalisation of people with disabilities from social arrangements and services in the public domain, and justifies the exclusion of persons with disabilities from mainstream education and employment (Bhanushali, 2007).

As mentioned above, this model has been very influential in much of the Global South, due to the long history of disability services being provided by charitable organisations. Dos Santos-Zingale and McColl (2006) argue that this model has contributed to the creation of a culture of dependency among people with disabilities, where they are viewed as passive individuals who cannot function without the help of others.

### Medical Model of Disability

This culture of dependency is reinforced even further in the medical model. Here disability is seen to arise from mental, physical or sensory impairments that are attributed to medical causes (McEwan & Butler, 2007). In this model, which remains particularly prominent in the Global North, impairments are viewed as biological or physiological defects which require medical treatment to restore 'normal' functioning (Cobley, 2018). This model can still be seen in many countries, where disability is considered to be little more than a health competency. Creamer (2009) argues that terms such as 'invalid', 'cripple', and 'handicapped' are all derived from the medical model, and used to denote how people with disabilities deviate from the norm, and cannot be compared with their non-disabled peers.

According to Thomas & Woods (2003), medical professionals who subscribe only to the medical model tend to treat people with disabilities as 'problems to be solved' and impairments to cure, often failing to take into account other aspects of a person's life which may contribute to disability. Kasser & Lytle (2005) highlight the medical model's exclusive focus on the limitations associated with a person's disability, which essentially disregard environments that might intensify or adversely affect a person's functional abilities. Accordingly, this model tends to regard the person with disability as the one who should be supported to conform to the norms of society.

These three 'individual' models of disability are still common in certain contexts, and are often referenced in Government policies in both the Global South and the Global North. Within disability studies however, NGOs, DPOs, and disabled academics

have moved beyond these models, to focus more on broader understandings of disability.

## Family Model of Disability

When considering a broader and more collective approach to understanding disability, the family model provides a useful base. Although this model is not formally established in the literature, the family model influences discussions around disability in the Global South by recognising that each member of a family or community shares and experiences disability to some degree due to the context in low- and middle-income countries, be this in terms of economic, social or political exclusion (Woodcock & Tregaskis, 2008).

In more collective and less individualistic societies - such as many countries in the Global South - this can be a more pertinent analysis than models focusing solely on the individual with impairments, especially where there are high degrees of inter-dependence on and within the extended family. This approach, as with many community development approaches, affirms a broader understanding of the primary stakeholders involved in disability (Hunt & Watermeyer, 2017).

In cultures where identity is not purely an individual matter, and with stronger affiliations to wider family networks and kinship groups, the impact of disability on family members and communities can be much stronger. Some examples of this include: shared economic impact on the whole family where there is little or no social protection mechanisms provided by the state; reduced educational and economic participation where family members are required to provide assistance and care roles; reduced social and political participation, affecting opportunities such as the marriageability of a person with disability as well as their siblings, and exclusion of the family in part or as a whole from key social gatherings and decision making events in the community (Hunt & Watermeyer, 2017). This is an important consideration especially for women with disabilities, who often play a central role in family life, and may therefore need broader support in living with or caring for a family member with disabilities.

Despite all this, the family model also recognises that the understanding of disability affecting a family member does not compare or equate with the direct lived experience of a person with disability. Rather it recognises the wider impact on the immediate and wider family and community network, as well as the individual (Woodcock & Tregaskis, 2008). This approach also naturally lends itself to a community development approach, typical of many community-based rehabilitation programmes, which support a more sustainable participatory approach to inclusion.

## Social Model of Disability

Increasing dissatisfaction with individual models of disability led to the rise of the formalised social model in the UK during the 1970s, which eventually overtook individual models in international disability discourse, and still remains the most popular conceptualisation of disability today. In contrast to earlier models, which locate disability within the individual, the social model suggests that a person is disabled because of architectural, attitudinal and social barriers created by society itself (Bhanushali, 2007). The social model presents disability as a consequence of oppression, prejudice and discrimination by society against people with disabilities. As Oliver (1990) points out, the implication of this model is that society itself should adapt to the needs of people with disabilities, rather than the other way around.

This model has its origins in the UK, through the Union of the Physically Impaired Against Segregation (UPIAS), who made a clear distinction between disability and impairment, stating:

*We define impairment as lacking all or part of a limb, or having a defective limb, organism or mechanism of the body, and disability as the disadvantage or restriction of activity caused by a contemporary social organisation...*

(UPIAS, 1976, p. 14)

This definition, later widened to include psychosocial impairments, marked a shift away from focusing on the physical limitations of individuals, towards examining the way the physical and social environments impose limitations on certain groups of people (Cobley, 2018).

This model has now become the primary driver of thinking around disability, and also influences the UNCRPD definition of disability. This definition locates disability not within the individual, but within the wider society which has failed to accommodate the needs of people with disabilities. Accordingly, a person's environment has a huge effect on the experience and extent of disability. Inaccessible environments therefore create barriers that often hinder the full and effective participation of persons with disabilities in society on an equal basis with others (ADD, 2001). In this way, and in the context of Cambodia and Rwanda, this definition of disability recognises the disabling impact of environmental factors including the physical environment, poverty, lack of education, accessibility of information, and other factors specific to countries in the Global South. Progress on improving social participation can therefore be made by addressing these barriers and facilitating persons with disabilities in their day to day lives.

Although the shift in thinking towards social responses to disability has largely been progressive, the model has been criticised by many actors. McEwan & Butler (2007, p. 449) describe the model as imposing 'Western-centric' social ideals of disability in developing countries without consideration for local customs and practice. They also argue that these models are based on the assumption that technical and environmental solutions are widely available, and do not acknowledge the costs to individuals, institutions, and governments.

Retief & Letšosa (2018) also point out that the social model seems to ignore the often painful realities of living with impairment, and that the models' strong focus on the disabling impact of society has led to the experience of impairments being diminished. This reiterated earlier criticism of the model, where authors such as Crow (1996) argued that the personal experience of impairment had to be downplayed in the social model, because acknowledging individual pain and oppression did not necessarily accord with the view that disability was entirely a product of social barriers.

## Other Models of Disability

Since the popularisation of the social model of disability, various other models have also emerged, to be used alongside or instead of the social model. These include the human rights model of disability, which highlights the disabling role of society in allowing people with disabilities to access their rights in all aspects of their lives (Degner, 2017); and the biopsychosocial model of disability, which was developed by the World Health Organisation as a conceptual basis for the International Classification on Functioning, and focuses on the lived experience of disability (WHO, 2002). While both of these models are useful in specific concepts, and help to move understandings of disability forward, they have not taken root in the same way as the social model, as they can be seen as too specialised, and detracting from the wider disability discourse (McEwan & Butler, 2007). It is for these reasons that the social model of disability remains the most popular.

## 2.4 Background of the Disability Movement

Historically, disability has been a neglected topic within the field of international development. More recently, with the growth of a coordinated disability movement, supported by the models described above, and a greater policy focus on inclusion, the need to respond to disability is now emerging as a development priority. Disability is explicitly mentioned in 5 of the 17 Sustainable Development Goals, compared with none of the Millennium Development Goals. At the time of writing, 182 countries have ratified the Convention on the Rights of People with Disabilities (CRPD), and this number is continuously growing (UN, 2020). This shift has largely been down to the advocacy of people with disabilities themselves, in both the Global North and South. Disability rights movements worldwide have campaigned for access, inclusion, and human rights, most notably under the banner of the 'nothing about us, without us' campaign (Shakespeare, 2018).

Despite these policy shifts, the UN Disability and Development Report (2019, p. 32) highlights that people with disabilities still face physical, social, economic and environmental barriers to participation in society, which may lead to greater

experiences of poverty and hunger. An example is provided, whereby lack of accessibility in the physical environment as well as discrimination and prejudice may prevent people with disabilities from entering education, thus restricting their skills, knowledge, and future ability to engage in productive work. Those same barriers may also prevent people with disabilities from entering the labour market, or may limit the kind and amount of work they can do, thereby lowering their incomes. Authors such as Meekosha (1998), Kiani (2009), and Wayack-Pambé & Kouanda (2023) also highlight that women and girls with disabilities frequently face a double burden of inequality and discrimination in both their public and private lives.

An estimated 19% of women across the world have a disability, compared to 12% of men (WHO, 2011), and in the Global South, women constitute around three quarters of people with disabilities (UN Women, 2017). As the world's largest minority, an estimated one in every six people in the world live with a disability. People with disabilities, their carers, and family members make up around 25% of any given population, and around 80% of people with disabilities live in developing countries (WHO, 2022). These figures, in combination with the recent work of large multilateral bodies such as the UN, WHO, and IFAD, as well as the push from disabled persons' organisations, point to a near-global consensus on the need to remove these discriminatory barriers that hinder the full participation of people with disabilities in society. Yet many people with disabilities continue to experience discrimination and stigmatisation, in both the Global North, as well as the Global South. These experiences are often reinforced by social exclusion and economic deprivation (Cobley, 2018).

## 2.5 Disability in the Global South Context

As described above, perceptions of disability vary greatly across cultures, due to the ways in which the concept of disability has been socially and historically constructed, as well as being influenced by the social, political, and economic context within which people with disabilities live (Cobley, 2018). Groce (1999) argued that these cross-cultural differences in the interpretation of disability show that the lives of

people with disabilities are limited more by the social interpretation of disability within a society, than by the specific type of disability with which they live.

This often means that discrepancies exist in disability data between the Global North and the Global South, and most likely arise from these different understandings of disability, where people with disabilities themselves may perceive their impairments differently, and may therefore report different levels of impairment. Often, prevalence of disability is presented as much higher in the Global North because this definition of disability is broader, and usually includes chronic illnesses and psychosocial disabilities which are not considered in the Global South. Differences in healthcare also play a role, as access to quality healthcare in many countries in the Global North means that people are likely to be diagnosed with conditions and disabilities far more frequently than those who do not have access to robust health systems. Grech (2009) therefore argues that disability can ultimately only be understood within the confines of the larger context, taking into account local perspectives, cultures and histories.

The social identity of people with disabilities can also be determined by the roles that people with disabilities perform in society, such as being a parent, or having a particular job, but people with disabilities may also identify with a number of other social groups, based on shared characteristics (Kidd & Teagle, 2012). Groce (1999) also highlights that people with disabilities are not a homogenous group, and that their experiences are shaped by individual factors such as type of impairment, gender, religion, and societal roles. Their experiences are ultimately bound to what is valued culturally, socially and ideologically. It is also important to recognise that women with disabilities have different experiences and perspectives than men with disabilities. Palmer and Woodcroft-Lee (1990) argue that patterns of disadvantage are also most often associated with the differences in the social position of women and men in different countries.

## 2.6 Conventions, Agreements & Tools

The 1948 Universal Declaration of Human Rights was the first major global declaration on the basic rights to which everyone is entitled. The declaration makes

only one reference to disability, by proclaiming the right to security 'in the event of unemployment, sickness, disability...' (United Nations, 1948, p. 7). While there are no other mentions of disability specifically, exclusion is clearly not intended, as it is heavily emphasised that these rights should be afforded to everyone.

The United Nations Declaration on the Rights of Disabled Persons (1975) was the first of its kind to promote the civil and political rights of all disabled people, while also highlighting the need to consult with disabled persons' organisations 'in all matters regarding the rights of people with disabilities' (United Nations, 1975, p. 2). This, for the first time, acknowledged the importance of actually involving people with disabilities themselves in the process of promoting and protecting their own rights.

Following this, a number of actions were taken globally for the promotion of the rights of people with disabilities, including: the International Year of Disabled Persons (1981), the World Programme of Action Concerning Disabled Persons (1982), and the Sapporo Declaration (2002). Each of these actions aimed to empower people with disabilities to advocate for their rights, and increasingly sought mainstream acceptance of the social model of disability.

The most relevant international agreement surrounding people with disabilities is the 2006 United Nations Convention on the Rights of Persons with Disabilities (CPRD). While this declaration did not afford any new rights to people with disabilities, it did provide an opportunity for real progress to be made in terms of enabling people with disabilities to access their rights through a legally binding agreement (Cobley, 2018). The CRPD also reflects a trend of framing disability as a human rights issue, and although the social model is not explicitly mentioned, the influence it has is clear in the intersectional way disability is framed. Article 6, for example, explicitly relates to women with disabilities, and acknowledges that they are subject to multiple discrimination. It also advocates for the advancement and empowerment of women globally (UN, 2006). This approach, based on both the social and human rights models of disability, has been influential in promoting the rights of people with disabilities all over the world. The declaration has now been signed and ratified by the vast majority of nation states, representing a near-global consensus that the rights of people with disabilities are important, and should be recognised.

Countries which have ratified the CRPD have a clear duty to take the necessary measures to ensure effective policy implementation. However, recent reports show a number of failures in this area, most notably, a failure to define implementation strategies, or where strategies do exist, a failure to supply adequate resources (Cobley, 2018). Additionally, the most recent report finds that many governments still define disability in medical terms, have failed to set up appropriate mechanisms for consulting with DPOs, and have failed to establish procedures to combat disability discrimination (United Nations, 2020).

As with many international agreements, there are issues with effective implementation, as well as monitoring and evaluation. In many cases, policies for inclusion exist within government frameworks, yet there persists a large 'implementation gap'. In Uganda, for example, the Persons with Disabilities Act was passed in 2006. However, to date there have been no regulations or standards passed for its subsequent implementation (Lang et al., 2011). This is often heavily linked to weak governance structures in the Global South, where the capacity of states to implement human rights-based laws may be undermined. Progress on implementation can also be hindered in low- and middle-income States, by corrupt officials, lack of financial resources, and - most often - a lack of political will (Cobley, 2018).

## 2.7 Conclusion

Current thinking on gender and disability is influenced by a number of key concepts, as outlined in this chapter. Both gender and disability are not fixed entities, and are constantly evolving, while also being influenced by social and cultural norms in different countries. This thesis argues for an intersectional approach to gender and disability, which considers all the different factors of identity that make up a person, and where both gender and disability are given equal weight in discussions. In this way the two disciplines are brought together, so that gender is integrated into disability studies, and vice versa.

Understandings of disability have now begun to reflect these complex lived realities of people with disabilities, and this is demonstrated in the evolution of the models and conceptualisations of disability described above. These have evolved and grown over time, moving from locating disability within the individual, towards locating it more within society, in keeping with the social model, and the CRPD. Many of these models continue to cross-over, and perceptions vary based on context. For example in Cambodia, and other countries in the Global South, much of the thinking around disability is still framed by the medical and charity models, with little attention given to the social and human rights models. Despite some countries lagging behind, the social model of disability is now preferred by many organisations and governments (Cobley, 2018). Discussions around disability in many countries are also influenced by the dearth of conventions, laws, and policies advocating for disability inclusion. In many cases these instruments are progressive and useful, but most often lack implementation and structure.

This chapter highlights that disability and all of these conventions must be understood in context. Considering that understandings and prevalence of disability vary greatly between the Global North and the Global South, it is extremely important that local context be considered in all conventions, policies, and programmes targeting people with disabilities. Groce (1999) argued that culturally specific understandings of disability have a strong bearing on the success of inclusive interventions, and that these local understandings underpin either the inclusion or exclusion of people with disabilities in society. This thesis therefore argues for a culturally sensitive approach to understanding disability, which takes into account how different cultures interpret disability.

With these global and local conceptualisations of gender and disability in mind, the next chapter reviews previous research which has been conducted on the specific issues faced by women with disabilities, especially in the Global South.

# Chapter 3: Review of Theories and Research

## 3.1 Introduction

Building on the literature explored in Chapter 2, in this chapter, I aim to dive deeper into current disability discourse, to frame my research questions against broader research. This section further highlights the importance of intersectionality, and demonstrates a gap in the literature surrounding the lived experience of women with disabilities. It opens with a review of the literature on opportunities available to people with disabilities more generally, highlighting the poverty they often face, and outlining their exclusion from education, employment and welfare. This is important, as the interactions between gender and disability in the Global South cannot be studied without first understanding the reciprocal relationship between disability and poverty, since poverty often has a very profound impact on the lives of people with disabilities in low-income countries. Secondly, this chapter explores the concept of intersectionality as it applies to disability, highlighting how all of the different factors of identity influence the experiences of people with disabilities. Finally, following the identification of gender and disability as two of the most important intersecting factors of identity, the relationship between gender and disability is explored in more detail, highlighting the discrimination and marginalisation faced by women with disabilities in the Global South.

## 3.2 Opportunities

Globally, around 1.3 billion people live with a disability, and over 80% of these live in the Global South (WHO, 2022). Many of these people experience discrimination and marginalisation on a daily basis, and this often manifests in a lack of opportunities offered to them. Most people with disabilities living in the Global South experience compounded livelihood challenges related to general economic and social disadvantage, as well as disability. In many cases, social support grants and programmes to provide access to opportunities for people with disabilities are absent

in these regions, raising questions about how people with disabilities can maintain livelihoods and be integrated into mainstream society, including income-generating activities such as employment and training (Hannas-Hancock & Mitra, 2015).

Many of the current studies on disability and opportunities are based in the Global North, but as referenced above, most people with disabilities live outside of these geographical areas. As a result, anthropologists, sociologists, and scholars (e.g. Grech, 2014; Emmet & Alant, 2006; Goethels et al, 2015) have recently directed their attention to understanding disability in context, exploring how disability and other forms of impairment are perceived, experienced, and lived by individuals belonging to diverse social categories and classes in regions of the Global South. These alternative conceptions of disability and poverty not only serve to broaden knowledge about different ways of experiencing disability in relation to social norms, but also challenge prevailing Global North assumptions about social, economic, and political aspects connected to disability (Brocco, 2024).

### 3.2.1 Poverty

Disability and poverty are inextricably linked, and poverty can never be eradicated until disabled people enjoy equal rights with non-disabled people (Lee, 1999; Eide & Ingstad, 2013; Banks & Polack, 2017; WHO, 2022). In essence, the lived experience of poverty for many people with disabilities is characterised by a lack of resources to fulfil basic needs and participate fully in community life. This is the basis for much of the marginalisation and exclusion faced by people with disabilities in other areas of life.

With the aims of this research in mind, the interactions between gender and disability in the Global South cannot be studied without first understanding the reciprocal relationship between disability and poverty, because poverty as a contextual factor has such a pervasive impact on the lives of many people with disabilities in low-income countries (Brocco, 2024). If a further focus is to be on livelihoods and supports, then it is fundamental to first understand the basic situation of people with disabilities in the Global South, and how they are excluded from labour markets.

In terms of data, much of the evidence that has been gathered on the living conditions of people with disabilities has generally come from the Global North, and usually involves analysis from a primarily medical perspective (Eide & Ingstad, 2017). Despite this, these studies can be useful in providing an overall picture of the links between disability and other contextual factors people may face in everyday life, including poverty. In Ireland, as of 2016, around 11.6% of the population self-report experiencing disability, with the majority experiencing “difficulty with pain, breathing or any other chronic illness or condition”, “difficulty with basic physical activities”, or a “psychological or emotional condition” (Kelly & Maître, 2021, p. xiv). Within EU countries, people with disabilities are more than twice as likely to experience poverty and deprivation than those without disabilities. Even when engaged in full-time work, 16% of people with disabilities still experience poverty, compared with 11% of people without disabilities. According to the NDA in Ireland, “the lack of transition support from second-level to further education and training or employment has been identified as a big issue” for people with disabilities entering the labour market (Kelly & Maître, 2021, p. xvii). Overall, in developed countries, the evidence suggests that persons with disabilities have lower educational attainment and experience lower employment rates, have lower wages when employed, and are more likely to be income poor than persons without disabilities.

In the Global South the trends are similar, although data is far less robust, relying on smaller-scale, often anecdotal studies. For example, in Cambodia, disability prevalence is around 5% but this is not further disaggregated by impairment, gender, age etc. (NISMP, 2020). It is also likely that this is an underestimate, as the way that data is collected on disability is not standardised, and different contextual understandings of disability may contribute to prevalence rates. Again people with disabilities in the Global South face difficulties in the transition between education and employment, as many lack comprehensive education or applicable vocational training (Cobley, 2018).

Due to the lack of opportunities, the World Bank estimates that globally, 82% of all people with disabilities live below the poverty line, and are not active in the labour market. In the Global South in particular, job opportunities tend to be more accessible for non-disabled people than their disabled peers in both formal and

informal sectors of the economy (Boutros & Fakih, 2023). This is due to a discriminatory trend in the labour market against individuals with disabilities, who are perceived as requiring more accommodations than people without disabilities, and therefore participate in the workforce at significantly lower rates. Those who do participate in employment often report lower wages and longer working hours than their non-disabled peers. Despite the poor pay, people with disabilities continue to work in these jobs because it is often the only source of income available to them, and the ability to find work outside of the home tends to increase status in families and communities (Sarmaa, 2023).

Research in high income, industrialised countries has demonstrated that people with disabilities tend to perform far worse on several indicators of living conditions, even in times of overall improvements in the economy. These same patterns of systematic differences are also at work in low income countries, as have been documented in similar studies undertaken in other parts of Sub-Saharan Africa (e.g. Loeb et al, 2007; Banks & Polack, 2017). Economic participation can play a vital role in lifting people out of this kind of poverty, as well as boosting self-esteem, and creating a sense of purpose in life (Cobley, 2018). Despite this, according to the WHO World Report on Disability (2011), people with disabilities are far less likely to be economically active than the general working age population, due to the existence of a wide range of barriers to training and employment - not least the absence of basic education. This report also highlights that the main impediments to employment for people with disabilities are discrimination and prejudice in the labour market. The removal of these barriers is vital to reducing the economic dependence of many people with disabilities on welfare benefits, but can also be beneficial for the economy as a whole. Powers (2008) proposed that people with disabilities represent a sizable pool of labour which could be mobilised to boost overall productivity. A desk-based analysis by Bukup (2009) further examined this theory, and found that economic losses resulting from the exclusion of people with disabilities from work ranged from 3% of GDP in Vietnam, to 7% of GDP in South Africa. Although these findings may be somewhat incomplete due to the lack of reliable data on disability prevalence, they still highlight the significant costs of excluding people with disabilities from work.

Without this equitable access to work, Banks et al. (2017) reported that people with disabilities in low- and middle-income countries are poorer than their non-disabled peers in terms of access to education, healthcare, income, etc., and are much more likely to experience multiple deprivations when it comes to poverty. Elwan (1999) also notes that in many communities, people with disabilities are regarded as the most disadvantaged by other community members, and in low income countries, people with disabilities are among the poorest of the poor. Parish et al. (2008) also highlight that the relationship between poverty and disability is likely to be undercounted in most analyses, as income-based poverty measures do not account for all the material and social costs of living with a disability. Ghosh et al. (2016) also note that - in line with the family model of disability - families of people with disabilities need resources over and above what is needed by other families with similar incomes, in order to attain the same level of well-being. All of this evidence points to a strong and reciprocal relationship between disability and multidimensional poverty, which impacts multiple facets of the lives of disabled people.

Poverty, however, is a complex phenomenon, and encompasses far more than just monetary deprivation and exclusion from the labour market. Barnes and Sheldon (2010) argue that poverty and underdevelopment are not merely the outcome of structural inequalities, but also of disabling attitudes, discrimination, and social processes that entrench oppression for people with disabilities in the Global South. For this study, following in the stead of many others, it is more useful to consider disability in relation to multidimensional poverty, which considers both financial and non-financial aspects of living conditions and poverty at both household and individual level (Mitra et al, 2013).

While financial and material indicators play an important role in defining poverty and deprivation, especially in industrialised countries, an individual's living conditions are not limited to their economic status, but also include the availability and accessibility of basic services and human rights, an ability to exercise choice, and to affect the course of their own life (Loeb et al, 2007). Amartya Sen's (1999) capability approach is widely used to understand this multidimensional nature of well-being and deprivation, and is highly applicable to analyses of disability in conjunction with other indicators of poverty. Capability poverty - where individuals find it difficult to convert

income into fulfilled ends - is a particularly relevant measurement for people with disabilities, because it underscores the impact of social exclusion on both income and wider functioning within society. So, in terms of capability poverty, it is important to evaluate what an individual can do, or is able to do, and not just what they actually do. Capabilities represent a person's opportunities and ability to achieve valuable outcomes, taking into account relevant personal characteristics and external factors which serve to enable or disable (Tefera et al, 2017). This approach to understanding poverty is more closely aligned with social and human rights models of disability, and can be used to understand poverty in relation to a number of intersecting identities, including gender, race, religion, and employment status, thus allowing for a more nuanced understanding of a person's situation, and especially the relationship that exists between disability and poverty.

Many authors consider that disability is 'both a cause and consequence of multidimensional poverty', and that poverty and disability reinforce each other, contributing to increased vulnerability and exclusion (Trani & Loeb, 2012, p. 2). Cobley (2018, p. 28-50) refers to this phenomenon as the 'vicious cycle of poverty and disability'. In this cycle, people with disabilities may face social exclusion, and a lack of opportunities for economic and human development, thereby increasing their risk of falling into poverty. For example, disability or ill health may prevent school attendance of children and youth with disabilities, and restrict their capacity development, thus leading to limited employment opportunities in adulthood. Conversely, poverty also increases vulnerability and the risk of ill-health and accidents which may lead to disability (Mitra et al., 2013). Mitra et al. also note that poverty, as a contextual factor, can increase the likelihood that a health condition may result in a disability, for instance if there is a lack of health care and rehabilitation services. It is also notable that in developing countries, there is evidence that malnutrition often leads to disability, along with preventable diseases, lack of adequate public health interventions like immunizations, poor sanitation, and environmental exposures (Maulik and Damstadt, 2007). This cycle of poverty and disability often has long-lasting impacts on the lives of people with disabilities, leading to increased rates of illiteracy, malnutrition and under- and unemployment (UN, N.D.). In addition to all of this, stigma associated with a health condition or disability - especially those acquired later in life - may lead to activity limitations and

participation restrictions in the labour market for people with disabilities, given attitudes towards them in a particular social and cultural context (Mitra et al, 2013).

### 3.2.2 Education

Filmer (2008) attributes a large part of the correlation between disability and poverty for people with disabilities to low educational attainment, due to prior exclusion from school. Mitra et al. (2013) also found a significant link between lack of education and poverty for people with disabilities in the Global South specifically.

Despite the Universal Declaration of Human Rights entitling all children to an education, many children with disabilities are still unable to access this basic human right. A UNICEF (2013) report estimated that 90% of children with disabilities in the Global South do not go to school. The WHO World Health Survey (2022) also showed that on average, children with disabilities spend significantly less time in school than their non-disabled peers. Lynch et al. (2017) found that in Cameroon, for example, children with disabilities were 20 times more likely to be out of school than children without disabilities. As well as this, Le Fanu (2014) found that young people with disabilities in low income countries are particularly disadvantaged in terms of education, as they tend to have lower enrollment, transition, and completion rates than children without disabilities. There are a number of reasons for this, including a lack of accessible education, poverty of families, and concerns about the safety of children with disabilities. Tefera et al (2017), found that negative attitudes of parents were also a factor in low educational achievement of children with disabilities. This study found that parents were reported to be hesitant to invest in the education of children with disabilities, seeing it as a bad investment, as many believe that children with disabilities do not have the ability to succeed at school, and will remain dependent on them in later life, whether they send them to school or not.

Singal et al. (2011) argue that this educational exclusion and marginalisation prevents young people with disabilities from accumulating not only knowledge, but also the various types of human capital which will enable them to lead successful adult lives. Schools also play an important role in developing personal qualities, and building the confidence of children with disabilities to embrace opportunities and

tackle challenges that they may face in life (Cobley, 2018). Trani et al. (2011) also propose that, especially in conflict affected regions of the Global South, education for all provides crucial protection measures such as landmine awareness, HIV prevention, feeding programmes, and psychosocial support, thereby working to prevent disability among communities. This means that these disparities in education that originate in childhood, subsequently translate into multidimensional poverty, reduced social capital, and under- or unemployment in adulthood (Ghosh et al., 2016).

But education also encompasses more than just traditional schooling, and vocational training is often cited as a viable opportunity for marginalised groups, as it empowers individuals to learn key skills which will facilitate them to take up decent work, including work-based learning and professional development. In addition to apprenticeships, skills development, and other approaches, vocational training is a bridge between education and employment (ILO, 2017). This is important because young people with disabilities in the Global South are more likely than their non-disabled peers to lack the skills required in the labour market, thus effectively excluding them from decent work (Tuomi et al. 2015). In order to overcome these barriers, programmes are designed to deliver education that enables individuals to find employment and to promote opportunities for people with disabilities (Bartram & Cavanagh, 2019). Women with disabilities also report seeing further positive outcomes from vocational training, where they not only learn skills, but are also able to identify as part of a team or community, which in turn instils confidence and independence, while simultaneously reducing isolation (Bartram & Cavanagh, 2019)

While they can be controversial, special schools also play a role in equipping people with disabilities for their futures. Research undertaken with young people with disabilities, who had grown up in poor communities and in families with low education, but had attended special schools, highlighted the significant value of these schools and teachers in their lives (Singal et al., 2014). These young people narrated accounts of how in these settings they had learned essential basic life skills (such as self-care, etc.), developed their literacy and numeracy skills through appropriate equipment (such as Braille), had strong, disabled, adult role models (such as blind teachers) who helped develop an awareness of their rights and their

own self-confidence, in spaces which acted as safe zones of learning and friendships (Singal & Muthukrishna, 2014).

Despite these many benefits of school attendance for children with disabilities, many barriers still exist to inclusive education. These include stigma and negative social attitudes towards people with disabilities, reinforced by a lack of political will by governments (Lynch & Jolley, 2017). Poverty can also prevent children with disabilities from attending school in the Global South, as evidenced by Singal & Muthukrishna (2014), who noted a significant education deficit in Ugandan households headed by a person with a disability. While this deficit may be attributed to children being pushed into adult carer roles in order to look after the family member with a disability, it could also be due to the reduced ability of the household to afford school fees because of the direct costs of disability.

Where schools are accessible to children with disabilities, Trani et al. (2011) found that teachers often lack training and awareness around the capabilities of children with disabilities, and as such may view the child as problematic or disruptive. The same report found schools in the Global South to be generally inaccessible to people with disabilities, in terms of both infrastructure and routes to schools, making the journey to school difficult and often dangerous, especially for young girls with disabilities.

Due to social norms and cultural bias in conjunction with these accessibility issues, the educational opportunities available to women and girls with disabilities are even further limited than those for men and boys with disabilities. The WHO World Report on Disability (2011, p. 206) found that globally:

50.6% of males with disabilities have completed primary school, compared with 61.3% of males without disabilities. Females with disabilities report 41.7% primary school completion compared to 52.9% of females without disabilities, a difference of 8.9% between males and females with disabilities.

According to the WHO 2022 report on Health Equity for Persons with Disabilities, these figures have held relatively steady over the past decade, and women are still at a disadvantage when it comes to health, education and employment (WHO,

2022). Considering that women globally face huge social barriers to their education, it is not surprising that women and girls with disabilities face even greater challenges when it comes to receiving quality education.

A 2017 report from the UNICEF found that while there has been evidence of greater numbers of girls with disabilities being enrolled and retained in school, there is also evidence of girls with disabilities dropping out of school at a higher rate than boys, and often due to gender-related challenges (UNICEF, 2017). Singal et al. (2018) argue that these challenges often include lack of accessible basic infrastructure including hygiene facilities, lack of gender-responsive teaching practices, and school-related gender-based violence. This same report also found that interventions relating to the education of girls with disabilities have often been concentrated on their enrollment and attendance, rather than on their meaningful participation and empowerment. Although the above study does consider students with a range of different types of disability including, physical, intellectual, sensory etc., there is little disaggregation by impairment in most of the literature surrounding girls with disability and their educational needs. Here it seems that disability is often viewed as a homogenous concept when it comes to girls' education, and there is little consideration for the nuances in their needs based on their impairments, as well as other identity-related factors. There is room in the literature for greater exploration of the needs of girls with different (and often intersecting) types of disabilities in education.

### 3.2.3 Decent Work

As well as education and skills, the workings of local and national institutions have the potential to hinder or help to facilitate the economic participation of people with disabilities (Cobley, 2018). Where structures such as government authorities, the judiciary, the education system, and financial institutions work in ways that promote inclusive practices, they are likely to create a culture of economic opportunities for people with disabilities, while discriminatory ways of working will create barriers. As mentioned in previous sections, globally, people with disabilities are far more likely than persons without disabilities to be unemployed, underemployed or economically inactive. This exclusion of people with disabilities from the labour market entails

social and economic losses which have been estimated by the ILO to be between 3 and 7 percent of global GDP (ILO, 2017). The ILO (2020) also highlights that the potential of a large number of women with disabilities remains untapped and unrecognised, leaving a majority living in poverty, dependence and social exclusion.

Characteristics of the local economy can also influence the types of economic opportunities that are available to people with disabilities. These may include the types of products and services that are in demand, and the skills or qualifications needed to produce or supply them. This relates to discussions of functional capacity in the literature, which are mostly reliant on heavily medicalised models of disability, but in reality, often have a profound impact on the everyday lives of people with disabilities in emerging economies. Functional capacity in relation to the economic activities of people with disabilities explains the level of difficulty people may face in conducting their daily tasks. Limitations in functional capacity in employment may reduce people's quality of life due to a lack of independence, higher healthcare expenditure, and increased mortality risks (Jacinto et al., 2024). People with intellectual impairments, for example, may face greater barriers to economic participation in societies where jobs require a high level of literacy and information technology skills. In cases like these, people with disabilities may be viewed as less competent than those with similar impairments living in societies where manual skills are more in demand (World Bank, 2007).

As well as an individual's own functional capacity, opportunities for decent work are also influenced by the balance between the formal and informal sectors of an economy. The formal economy comprises public and private sector jobs, which are covered by employment legislation relating to job security, minimum wage, and occupational health and safety (Coleridge, 2016). Formal sector jobs usually offer benefits such as pensions, health insurance, holidays, and trade union membership, as dictated by employment law. In a report for the ILO, Powers (2008) found that many people with disabilities in the Global South aspire to formal sector jobs, but may lack the qualifications, skills, and connections required to attain these, and therefore frequently lose out in competition for these against highly qualified, non-disabled applicants. This once again highlights the disparity in education and training available to people with disabilities, and can further be a symptom of discriminatory

attitudes by employers, who assume low functional capacities of employees with disabilities, thus leaving them no option but to engage with the informal economy (Coleridge, 2016).

The informal economy refers to the wide range of income generating activities of people not engaged in the formal economy. These often include small-scale enterprises, which are usually labour intensive, unregulated, and unregistered (Powers, 2008). The informal economy thrives in a context of high unemployment, underemployment, poverty, gender inequality, and precarious work. It is important to note that most people enter the informal economy not by choice, but out of a need for access to basic income-generating activities (ILO, 2013). Cobley (2018) found that the relative ease of entry, low capital costs, small scale of operation, and absence of formal education skills, make this the most realistic employment opportunity for many people with disabilities in low-income countries. Women with disabilities are especially likely to turn to the informal economy in search of employment, since they are less well educated, and often have lower functional capacity than men with disabilities.

As an example of this, there are an estimated 2 billion informal workers globally, and over 740 million of them are women (ILO, 2018a). In low-income countries, a higher proportion of women are involved in informal employment than men, especially in Sub-Saharan Africa, where 89.7% of employed women are in informal employment, in contrast to 82.7% of men. A later ILO report (2018b) also found that since women often bear the brunt of unpaid childcare and domestic work in the household, they may have little choice but to take on low-quality, flexible jobs that allow them to attend to these responsibilities outside of work hours.

A range of discriminatory social norms may also limit women's access to property, assets and financial services, as well as opportunities for education and skills development, and social protection, forcing them to turn to informal work (ILO, 2018b). Beyond this, there is very little available research on women with disabilities in the informal economy at this time. Neither of the above cited ILO reports include any analysis of disability, and any book chapters that deal with disability in the informal economy do not generally disaggregate by gender. Although the informal

economy itself is difficult to study, due to the nature of its processes, there is a gap in feminist disability literature surrounding the involvement of women with disabilities in the informal economy. Since informal work is often the only choice for women with disabilities, it would be useful to examine what kinds of work they engage in, how much time is devoted to work and caring responsibilities, and what benefits and challenges they might see to working in the informal sector.

In recent years, the lines between the formal and informal sectors have become increasingly blurred. Coleridge (2016) uses the example of the clothing industry, which relies not only on sweatshops employing hundreds of women and men mostly in the Global South, but also on piece work, where families complete orders at home, in conditions where they often have no rights at all. It may be more useful then, to understand employment on a continuum from formal to informal ends of the economy - with structured office work on one end, and ad hoc casual labour on the other. Coleridge (2016), goes on to explain that this continuum makes it difficult to estimate real figures on employment rates of people with disabilities, because many work in those grey areas of the informal sector. Because of this lack of reliable data, he supposes that whether national laws enshrine non-discrimination or not makes very little difference to the real employment prospects of people with disabilities on the ground. On the other hand, laws and policies can be very useful tools in advocating for change, so while Coleridge's analysis may be correct in many contexts, it can also be useful to view policies and laws of non-discrimination as tools rather than solutions.

Globally, many disabled advocates are using these tools to push for changes in both formal and informal sectors, and to improve the employment prospects of people with disabilities. The ILO's 'Decent Work Agenda' has been instrumental in changing the way the world of employment is understood. Decent work is a term used to describe employment that involves dignity, equality, a fair income, rights at work, and safe working conditions (ILO, 2020). This agenda has specific provisions for people with disabilities, and recognises the right to gain a living by work freely chosen or accepted in a labour market that is open, inclusive and accessible to persons with disabilities. Often, disability-related barriers or stereotypes have stopped people with disabilities finding decent work, however, when realised, it can be a pathway for

people with disabilities to achieve personal aspirations and to experience empowerment.

Within this agenda, the ILO further encourages employers and governments to recognise that both women and men with disabilities can be productive members of society, and should be treated as such (ILO, 2015). In both the Global North and Global South, promoting more inclusive societies and employment opportunities for people with disabilities requires improved access to basic education, vocational training relevant to the labour market, and jobs suited to their skills, interests and abilities, with adaptations as needed. Putting decent work into practice means promoting employment opportunities for people with disabilities based on the principles of equal opportunity, and equal treatment (ILO, 2015).

### 3.2.4 Social protection

In most societies around the world, those who cannot work due to the nature of their impairments become dependent on the State through passive assistance programmes, or on family members as caregivers. This dependency, however, is not intrinsic to their physical or medical condition, but is instead socially constructed, because of the aforementioned labour market discrimination, where people with disabilities are indiscriminately ruled out from actively participating in society (Dalley, 1998).

Social protection programmes therefore exist to protect households against two adverse outcomes:

chronic incapacity to work and earn an income (chronic poverty), and a decline in this situation that provides minimal means for survival with few reserves (transient poverty) (Subbarao et al., 1997, p. v).

Since disability is associated with both types of poverty, social protection programmes clearly have a role to play with regard to reducing poverty among people with disabilities, both by providing access to resources for poor people in the short term, as well as assisting in longer-term asset building (Mitra, 2005). These programmes should also be designed in a way that enables people with disabilities

to participate more in the world of employment, in order to improve their overall wellbeing. With this in mind, inclusive social protection should comprise not only of basic income for people with disabilities, but also compensation for healthcare costs, as well as other disability related costs if possible, to allow people with disabilities to function at the same level as others (Cote, 2020).

Although social protection schemes can help to alleviate and prevent poverty, people with disabilities tend to encounter various barriers in accessing these programmes. Barriers may include lack of accessible information about social protection programmes and how to apply for them; absence of the requisite documentation; limited accessibility of grant offices to persons with disabilities; pervasive discrimination by grant offices, in particular, towards those with psychosocial disabilities; and lack of clarity in the disability evaluation process (UN, 2018). Communication barriers are also particularly prominent for those who are deaf, hard of hearing, or do not communicate verbally. As well as this, countries also vary in their legislative and policy backgrounds with respect to disability. Therefore, the level of insurance against the negative economic consequences of disability likely varies significantly across countries (Maitra et al, 2013). These barriers often prevent people with disabilities from receiving vital welfare assistance.

In line with this, the UN Disability and Development Report (2019) suggests that, as of 2016, only 27% of people with severe disabilities received disability related social protection benefits. Further evidence from 9 developing countries indicated that, on average, among people with disabilities who needed welfare services, 76% were not able to receive them (UN, 2018).

Related to this, there are significant data gaps in the accessibility and impacts of social protection on people with disabilities. For example, there is very little available evidence of the impacts these programmes may have on women and girls with disabilities, as much of the literature refers to people with disabilities as a homogenous group, with little disaggregation by gender, race, impairment, etc. There is also very little available evidence on the types of welfare available to people with disabilities globally, and how difficult it is to obtain and remain enrolled within these services. Current reports on social protection in low-income countries could redress

this gap by including disability based analysis in their reports, and by disaggregating according to gender and impairment. This would be helpful in determining the applicability of social protection services, as well as providing insight into the types of services most needed by the diverse community of people with disabilities across the world. In line with the CRPD, disability-related social welfare should also move away from being solely a medical-based process, towards examining what supports are needed by people with disabilities to ensure their full participation in society (Cote, 2020).

Social protection should therefore take account of the various intersecting factors which cause the marginalisation of people with disabilities, and seek to redress these. It is important to remove existing barriers or disincentives which currently exist in social protection systems, and to create more positive links with finding and keeping work (Cobley, 2018). This may include viewing disability benefits as responding to the “extra costs” of disability, which will be there regardless of whether the person is in employment or not. Social protection may also address other disability-related barriers. If benefit eligibility is designed so that benefits can be combined with receiving income from work, this could remove one of the major barriers to people with disabilities finding employment (ILO, 2020).

The CRPD also stipulates that women and girls with disabilities should be given special consideration when designing social protection programmes, and should have equal access to welfare and poverty reduction programmes. Therefore, social protection programmes should aim to address the imbalances of power and the multiple forms of discrimination experienced by women and girls with disabilities, while also working to eliminate the barriers that prevent women from accessing social protection in the first place (Aguillar, 2017). Non-contributory schemes play an important role here, as women with disabilities are often excluded from the formal labour market, as discussed above, and are therefore unable to pay into schemes such as health insurance or pension plans. The role of women with disabilities as caregivers should also be acknowledged by providing them with appropriate assistance to perform care responsibilities without reinforcing patterns of disadvantage and negative stereotyping (Sepúlveda and Nyst, 2012).

If programmes are designed specifically with women with disabilities in mind, then social protection could play an important role in improving the livelihoods of women with disabilities of working age, by stabilising and protecting their income in the event of unemployment, illness or inactivity, and by ensuring at least a basic level of income security (Aguillar, 2017). Effective measures to support women with disabilities in finding and retaining quality employment are an essential element of non-discriminatory and inclusive policies, which may help them to realise their rights and aspirations as productive members of society, as well as protecting the whole family unit from chronic or transient poverty and shocks (ILO, 2014).

### 3.3 Intersectionality

Having explored how a lack of opportunities influences the experiences of people with disabilities above, it is clear that disability and intersectionality are fundamentally linked.

Intersectionality as a concept is a way of understanding and analysing the complexity of the world, of people, and of human experiences. It recognises that people's lives are influenced by many different factors, and are shaped not by a single axis of social division, such as race, gender or class, but by many axes that work together and influence each other (Collins & Bilge, 2016). At its core, intersectionality is used to describe how the major axes of social division in any given society operate not as discrete and mutually exclusive entities, but rather build on each other, and work together.

Everyone has multiple identities with different statuses, and some people identify as being a member of one or more marginalised identities concurrently. Thus identity is an ever-changing and flexible experience for most people. Additionally, there is variation and difference within groups of similar identities, meaning that not all disabled people will have experienced the same level of stigma within a community (Wickenden, 2023). An intersectional approach is therefore useful in understanding these variations, and how people's lives are shaped by these different interweaving factors.

Intersectionality in terms of disability, therefore, is used to understand and explore the issues faced by people who are seen to deviate from society's perception of normality. Where individuals' identities are marked by a number of different social factors, analysing any one factor - such as disability - in isolation will produce an incomplete picture of the experiences of the individual. Intersectionality calls attention to the limitations of this type of analysis, which may consider race, gender, religion, language, or disability - as if these factors of identity ever exist independently of one another. The reality is that everyone's experiences are complicated by their different identities. An intersectional approach aims to highlight hidden, interrelated oppressions that reproduce inequality and often cause the misrecognition of multiply marginalised groups (Wallace et al., 2018).

The experiences and needs of people with disabilities are often influenced by the way in which they are perceived, and others may respond to the different aspects of their identities in either positive or negative ways (Wickenden, 2023). When someone is a member of several disadvantaged or marginalised groups, as women with disabilities so often are, then their experience of exclusion is likely to be exacerbated. This is particularly relevant to experiences of women with disabilities in the Global South, where research shows that the intersectionality of gender and disability is particularly dire in some of the poorest parts of the world. Here, it is more than the identities, per se, but the nature of social restrictions on women, alongside the structural and economic lack of accessibility for people with disabilities, that negatively affect the lives of these populations as a whole (Pal et al, 2015).

### 3.3.1 Disabled identity

As described in earlier sections, society has historically viewed people with disabilities mainly from a medical model perspective, in which individuals were labelled as ill, dysfunctional, and in need of a 'cure' in order to restore their normal functioning (Peña et al, 2016). Such an approach perpetuates an ableist worldview, suggesting that people with disabilities should strive toward an able-bodied norm, and reflecting society's perceptions that certain bodies are less valuable than others. Current literature, however, proposes that disability, like other identities, is socially

constructed, and influenced by the society around us, as well as a number of other contextual factors. Despite this move towards an understanding of disability which is more aligned with the social model, many discussions about disability and intersectionality still take a simplistic additive approach, meaning that the shifting complexities and interactions between people's multiple identities are not considered with nuance (Wickenden, 2023).

For each person, the way that they do or do not self-identify as disabled is itself a complex and very individual process which may shift for each person over time, depending on their circumstances. Certainly, other contextual factors such as poverty, class, race, etc. all have a profound impact on what someone considers to be their 'primary identity', especially in low- or middle-income countries (although this is rarely addressed in the literature). Additionally, being labelled by others as 'different' in particular ways, and therefore earning the status 'disabled' can be fraught with potential wrong assumptions and often, oppression and marginalisation (Wickenden, 2023). It is common for people identifying as disabled to feel that others pay more or undue attention to this aspect of their identities rather than to others. Disabled people themselves may not always be keen on being classified in dichotomous ways (either disabled or not), and having most or all of the other intersecting parts of their identities overlooked.

Wickenden (2023) also proposes that once labelled as disabled, people's other ways of identifying seem to be erased, and they are no longer seen to belong to other identity groups, such as gender, religion, ethnicity, etc. In this way, people with disabilities may feel that disability is their 'primary' or most important identity, as others around them may not recognise the other identities that they possess. In this way, someone's status as disabled tends to draw attention away from other aspects of identity, and the response of others may even discourage people with disabilities from engaging in discourses or activities related to their other identities. For example, disabled women or men might not feel welcome at women's or men's groups which are not disability focussed.

Around the world, people with disabilities are frequently essentialised, and assumed to share the same views, experiences, and priorities, regardless of gender, age,

cultural background, socio-economic status, and other categories of difference. Consequently, primacy is given to “disability” over other key attributes of a person, meaning that the interactions among all factors are often neglected. In order to counteract this essentialism, an intersectional approach is needed (Goethals et al., 2015). The majority of studies that do exist to consider disability in interaction with other factors of identity most often focus only on a population experiencing a specific impairment type (e.g. blindness, cerebral palsy etc.) and tend to use clinical examinations or standardised, objective assessment tools. These methods give a very narrow, medicalised view of disability, without considering the broader context in which people with disabilities operate, and how differences between impairments may impact people’s lives and livelihood opportunities.

### 3.3.2 Functional Capacity

As mentioned earlier in this section, disability has a direct relationship with functional capacity, or a person’s ability to perform the activities necessary to their daily lives. Discourse around functional capacity and disability is highly medicalised, and the literature often takes a clinical approach to functioning, citing health conditions and impairments which change the way people engage in daily life and work. But, with social understandings of disability in mind, functional capacity also impacts how people with disabilities interact with the world, and how others in society perceive them. From this perspective, functional capacity also includes the degree to which individuals must rely on others for self-care assistance, and environmental barriers that create limitations for people with disabilities, as well as the need for assistive technology to perform every-day activities (Gilson et al, 2001). But function is not solely the capacity to physically perform activities, it also involves knowing when and how to act appropriately within specific socio-cultural contexts.

The difficulties that people with disabilities face in conducting their daily tasks tend to vary greatly based on functional capacity. Further to this, the barriers towards entering the labour market for people with disabilities also vary greatly depending on the type of disability, and how well people can function. Some groups may face extreme difficulties in securing employment (e.g., people with psychiatric disorders), while others face fewer difficulties (e.g., people with hearing impairments) (Boman et

al, 2015). For example, Clausen et al. (2004) studied the labour market in Denmark for groups with communicative, physical, medical and psychological disabilities, and found that the group with communicative disabilities, including hearing and vision impaired people, had the best opportunities on the labour market. Most problems entering the labour market were found in the group with a psychological disability. The authors hypothesised that this finding might be due to the lower education level in the group with psychological disabilities, along with attitudes of employers, and a lack of reasonable accommodations.

Limitations in functional capacity may also lead to a lack of opportunities in the labour market for people with disabilities. This is sometimes referred to in the literature as 'work disability', and occurs when a person's abilities become limited by a health condition, preventing them from meeting the requirements of their job, and resulting in costly short or long-term unemployment (Saunders & Nedelec, 2013). This is most common among people with acquired disabilities, but also relates to those whose condition may fluctuate or change over time. The costs for the worker can include financial hardship, pain, and limitations in what they are able to do, and may also impact the wider family unit. This is significant not only due to the financial cost associated with the inability to work, but also with the identity constraints that this places on individuals.

This is because work is an important aspect of identity for many people, and even for those limited by functional capacity, the importance and value of work does not decline. Many people with disabilities consider work to be a "foundation stone in the shaping of their identity" (Saunders & Nedelec, 2013, p. 4). Work was also found to be linked to self-confidence, self-esteem and self-image for many people with disabilities, owing to the respect they receive from themselves and others when they are perceived as productive members of society (Saunders & Nedelec, 2013). Work was also found to be a source for satisfying social interactions with colleagues and customers, and contributed to a sense of being valued by others. This is particularly important for women with disabilities, who are often ostracised from their immediate communities.

### 3.3.3 Gender & Disability in the Global South

As indicated above, disability - as a primary characteristic of identity - often intersects with other sources of social disadvantage, which can create compounding forms of oppression and exclusion depending on a variety of factors in a person's life, including age, gender, race, socio-economic status, etc. These intersections need to be understood and accounted for in order to understand the ways in which people with disabilities navigate the world around them, especially in the Global South (Liasidou, 2013). Further, discrimination against people with disabilities forms part of a complex web of culturally-specific social conditions which subjugate certain factors of identity, and create compounding forms of oppression and exclusion that have yet to be addressed through comprehensive policy and research. Intersectional understandings of disability expose the multiple dynamics that impact upon constructing disabled peoples' identities, and the many layers of discrimination they often face (Liasidou, 2013).

According to Moodley & Graham (2015), there has been relatively little research into the interactions between gender and disability in the Global South. However, data from the Global North shows that women with disabilities are more likely to be unemployed than men with disabilities, and also tend to earn less in cases where they are employed (Emmet & Alant, 2006). Welch (2002) also highlights that although poverty and disability affects both men and women with disabilities in the Global South similarly, long-standing, gender-based discrimination experienced by women in many societies compounds the impact. Women with disabilities may experience poverty and social exclusion due to any number of intersecting factors of their identities, which in many countries, serve to marginalise them from mainstream society. Similarly, as described in earlier sections, women with disabilities tend to fare worse than their male counterparts on educational outcomes, as well as access to social welfare assistance (Moodley & Graham, 2015). All of this quantifiably demonstrates the reciprocal relationships between gender, disability, and poverty.

As referenced earlier, the World Health Organisation (2011) found that disability may increase the risk of poverty and vice versa, and that this is especially true for women with disabilities, who often have fewer opportunities than their male counterparts.

Moodley & Graham (2015) also argue that disability and poverty are often manifestations of the same processes, whereby women with disabilities experience similar processes of marginalisation as poor people, due to a lack of opportunities and available resources. This paper suggests that theories of intersectionality provide a perfect lens to better understand the mutual processes of marginalisation and exclusion that pertain to poverty and disability. Cobley (2018) goes on to argue that issues around poverty and exclusion may often be more pressing for women with disabilities than impairment related concerns, as issues of power and agency are what tend to exclude women with disabilities from mainstream society, rather than their impairments alone.

Intersectionality can be used not only to account for the multiple discriminations experienced by women with disabilities, but also to identify the nature of power in social life. This is particularly relevant to the interactions between gender and disability in the Global South, as power is very often linked to the social and traditional roles that people with disabilities occupy (Wallace et al, 2018). For many women with disabilities, who occupy primarily caring roles within households, this means that their participation in the labour market is limited, thus also limiting their agency, as well as their income. Moodley & Graham (2015) also found that living with a disability serves to compound this experience of limited participation in the labour market, due to low perceived or actual functional capacity. These barriers to employment on the grounds of disability mean that women with disabilities are more likely to report increased disillusionment with the labour market, which often leads to a greater likelihood of women with disabilities opting out of the labour market altogether.

What is clear from the above studies is that a number of complexities exist in the intersectionality between gender and disability in the Global South. While policies in some countries do exist to address these complex issues, the results show that women with disabilities in the Global South are not benefitting optimally from these (Moodley & Graham, 2015). These women therefore need to be identified as a group requiring specific interventions so that inequalities based on their multiple, intersecting identities are addressed successfully.

### 3.4 Gender

As mentioned previously, none of the contextual factors which influence the lives of people with disabilities exist in a vacuum, and each of these intersects with disability to create patterns of advantage or disadvantage in different contexts. When considering livelihood opportunities for women with disabilities in the Global South - and having already discussed the lack of opportunities available to people with disabilities more generally - gender is one of the most critical identity factors identified by women with disabilities as having an impact on their day-to-day lives.

In terms of the broad interactions between gender and poverty, the IFAD (2020) have reported that gender inequality stems from systemic gender biases in the form of customs, beliefs and attitudes that confine women mainly to the domestic sphere in many countries. Gender gaps in the distribution of economic resources, combined with heavy workloads, continue to impose severe time burdens on women, especially in the Global South, thus limiting their opportunities. Women living with disabilities are often at a greater disadvantage than women without disabilities, due to the increased discrimination that emerges with the intersection of gender and disability (Groce et al., 2014). Groce et al. also suggest that within developing countries, women are at a higher risk of acquiring a disability, as well as - having acquired a disability - at higher risk of gender discrimination and disadvantage.

Cobley (2018) further highlights that consideration needs to be given to the gender aspect of disability, and how this serves as a main factor in determining the meaning and implication of disability, and its perception by the world of people without disabilities. Abu-Habib argued in 1997 that the worlds of both feminism and disability discourse had failed to make the necessary links between gender and disability, as two aspects of social identity which lead to potential marginalisation from a society which is essentially designed and run by able-bodied men. Despite this statement being made over 30 years ago, it is still true today, as evidenced by an analysis of 15 developing countries, where women were found to experience higher rates of multidimensional poverty than men (Mitra et al, 2013).

O' Reilly (2003) found that men with disabilities are almost twice as likely to be in employment as women with disabilities. The same study also found that when women with disabilities do work, they often experience unequal hiring and promotion standards, as well as lower access to training, credit and other productive resources, unequal pay for equal work, and they rarely participate in economic decision making. A 2018 UN Women Report also found that women with disabilities who experience intersecting forms of discrimination also experience higher rates of unemployment, and encounter other gender-based barriers such as precarious livelihoods, unequal access to and control over assets and resources, child care responsibilities, and a lack of access to maternity protection (UN Women, 2018). All of this points to a gendered experience of living with a disability, which needs to be explored in greater depth, in order to lift women with disabilities - one of society's most vulnerable populations - out of poverty.

### 3.4.1 Identity

As described by Johnstone (2004) most women with disabilities do not identify solely with their impairment, but rather through multiple descriptors that make up an individual. Disability, therefore, is unlikely to be the sole defining element in an individual's identity and should be seen as one of a number of factors challenging traditional narratives of gender, race, sexuality and age. These do not exist in separate compartments, and therefore cannot be seen in isolation from each other (Riddell et al, 2001). This suggests that disability interacts with gender (among other things) to form individualised identities based on overall life experience. When these two identity factors are taken together, in the context of the Global South, they can lead to marginalisation and ostracisation from communities.

Much of this marginalisation comes from women with disabilities being seen as deviating from the 'norm' in terms of gender identity. In many countries in the Global South, which rely on patriarchal structures of dominance, prescriptive gender identities are common. These stereotypes mean that most people believe that men and women should behave in ways that are gender-consistent, which prevents change by making it difficult for women and men to go against norms that enable them to 'fit in', for fear of social rejection and other negative consequences (Majiet &

Africa, 2015). In relation to disability, this means that women with disabilities are already considered to be deviating from the 'norm' in terms of their social roles and appearances, so they often compensate with performative femininity, in an effort to fit within their expected gender identity.

Wallace et al. (2018) further explore these identity constraints that come with living as a woman with disabilities, and come to similar conclusions. In their study based in Rwanda, participants explain the complex relational dynamics of gender inequality that disabled young women negotiate in everyday life. Some disabled women may concede to gender stereotypes (of being shy and calm in the Rwandan context) in order to offset widespread, negative views of their disability. This is common in societies where disability is perceived mainly through the medical model, where people with disabilities may feel that their impairments constitute a deviation from the norm, thus propelling women with disabilities to compensate in other areas. In this case, women with disabilities can be rendered 'normal' through their gendered performance, despite their perceived physical and socio-economic limitations.

This is also emblematic of wider constructions of femininity that fit well in patriarchal societies, and authenticate gendered performances which complement traditional understandings of manhood. This reiterates an earlier point made by Gerschick (2000, p. 1264), where culturally ascribed roles denote men as the "strong, assertive and independent" breadwinners of the household, while women are traditionally seen as having a more "weak, passive, and dependent" role, representing the wealth and honour of the family. In the context of women with disabilities, this often means that they feel pressured to perform in ways that are traditionally feminine, and in roles within the household which may not suit their impairments, in order to avoid breaking from traditional gender roles, so as to be considered 'normal' in the eyes of society.

### 3.4.2 Employment & Traditional Roles

In addition to the poverty that women with disabilities face alongside other citizens in low-income countries, the interactions between gender and disability tend to limit the livelihood opportunities available to them, and make it harder for them to compete for available resources with members of society without disabilities. In other words, most

governments and society at large in the Global South, prefer to invest the scarce resources available to them in the betterment of those without disabilities (Tefera et al, 2018). Women with disabilities therefore experience greater difficulties than other population groups with respect to education, employment, and traditional roles such as motherhood. These difficulties concern both obtaining and retaining these roles (of student, employee, mother), as well performing them. On a personal level, this means that many women with disabilities experience inequality, as they are excluded from achieving the full enjoyment of their rights, including the right to self-determination, and the right to autonomy (Tefera et al, 2018).

Palmer & Woodcroft-Lee (1990) also propose that society's resources tend to be unavailable to women with disabilities, because they have been structurally defined as unemployable, as well as unable to fulfil the traditional roles often associated with womanhood. As mentioned above, in patriarchal societies, such as many African countries, the social role of women and girls is often primarily reproductive. Djoyou Kamga (2011) found this role to be problematic, as women with disabilities are often considered to be asexual, unable to marry, or to have and raise children. The issue of marriage comes up often in literature surrounding women with disabilities, and appears to be of great concern in patriarchal societies. Naidu et al. (2005, p.15) found that women with disabilities "as compared with women without disabilities, and men with disabilities, are more likely to be unmarried, married later or divorced earlier." African women with disabilities also "tend to be shunned in the marriage 'market,' whereas more men with disabilities actually get married" (Kamga, 2011, p.3). For women and girls, the effects that disabilities have on health and beauty can also lower their status, and even devalue their families, both in terms of wealth and social standing (Abu-Habib, 1997). With fewer opportunities to fulfil this reproductive role, women and girls with disabilities usually experience more discrimination than their non-disabled peers (Chataika, 2013).

Sightsavers (2016) further argue that underlining every judgement made upon women with disabilities is the gender role that society carves out for women in general. Because of this focus on traditional roles in the Global South, a woman's main role is often still to be a wife, mother, and homemaker, while the man tends to be the main decision-maker and income earner. Since education and vocational

training are seen as investments for higher-value employment, a woman is less likely to have the opportunity to receive them. As mentioned above, societal misconceptions around disability tend to suggest that these roles are at odds with the capabilities of women with disabilities, and the general attitude in many countries is that women with disabilities have little hope of becoming a wife or a mother, or of getting a permanent job. They are therefore assumed to be dependent on the State or the family for the rest of their lives (ILO, 1999).

However, participation in employment and engagement with traditional household roles are linked for women with disabilities, as their limited participation in the labour force results in reduced power and influence in decision-making both at home and in the community (Tafera et al, 2018). Conversely, the financial power that women with disabilities acquire from their employment can contribute to the prosperity of the household at large, especially in the Global South where people with disabilities do not usually receive any welfare from the government. This, in turn, may minimise the 'fears' men with and without disabilities have about marrying women with disabilities, especially with regard to the cost of married life and raising children (Tefera & Van Engen, 2016).

### 3.4.3 Discrimination

As demonstrated above, in many societies in the Global South, women with disabilities face multiple forms of discrimination. Society predominantly views them through the lens of disability, neglecting to understand their intersecting needs as women, and excluding them from many mainstream spaces. This often means that the human capital of women with disabilities, encompassing their educational, professional, activist, artistic, political, economic, and all other potentials, remain invisible. In many patriarchal societies throughout the world, women with disabilities face gender stereotypes and prejudices about disability that limit their freedom and lead to violations of basic human rights (UNDP, 2023).

Disabled women and girls face a similar spectrum of human rights abuses to non-disabled women, but their social isolation and dependence magnifies these abuses and their consequences. Further, women and girls with disabilities fare less well on

most indicators of educational, professional, financial, and social success than their non-disabled female and disabled male counterparts. In some countries, laws overtly discriminate against disabled women and men, including by barring them from marrying if they have any form of mental disability. Even where the laws are not discriminatory, disabled women and girls may face a host of abuses at the hands of their families, communities, and the state (Human Rights Watch, N.D.).

Overall, the UN (2018) summarises that the systemic marginalization of women and girls with disabilities, coupled with the attitudinal and environmental barriers they face, lead to lower economic and social status; increased risk of violence including sexual violence; discrimination and harmful gender-based discriminatory practices; and barriers to accessing education, health care, services, and justice. These barriers hinder their full enjoyment of social and cultural rights on an equal basis with others. The report also states that women and girls who experience intersecting forms of discrimination as described above, also experience higher rates of unemployment, and tend to encounter other gender-based barriers such as precarious livelihoods, and unequal access to and control over resources. Further evidence from Ethiopia found that the intersection between gender and disability tends to lead to a denial of opportunities and choices for women with disabilities, particularly in the areas of education and employment. This is largely due to societal expectation that women with disabilities will fulfil traditional gender roles within the household and therefore do not need to be educated (Katusi & Mojtahedi, 2015).

It is clear from this data that cultural systems of dominance heavily influence the lives of women with disabilities in the Global South. The social institutions surrounding women with disabilities need to be examined and critiqued, in order to understand and combat the many barriers that exist to women with disabilities' full participation in society. Many of these institutions are based primarily on patriarchal standards and norms, which privilege male attributes over female attributes. This system of relationships, beliefs, and values is embedded in institutional systems throughout the world, but can be particularly pervasive in the Global South, and structures gender inequality between men and women. Attributes seen as 'feminine' or pertaining to women tend to be undervalued, while attributes regarded as 'masculine' or pertaining to men are privileged (Nash, 2020).

Patriarchal systems dictate that cultural and social attitudes are often unfavourable to women's participation in decision making at family and communal level. The intersection between gender and disability shows the complexity of how patriarchy and the male-dominated culture in many countries actively undermines women with disabilities in accessing opportunities (Majiet & Africa, 2015). This discrimination in opportunities, combined with the discrimination already experienced by women with disabilities in many cases, including attitudes towards women and their decision-making, rights, abuse, and the lack of opportunities that women face in homes and outside, are a byproduct of these patriarchal norms working in parallel with the intricate intersection of gender and disability (Sightsavers, 2016). All of this evidence demonstrates the deep-rooted, systemic, formal and informal structural constraints which so often govern the lives of women with disabilities.

#### 3.4.4 GBV

As well as the challenges outlined above, women with disabilities also face violations of their human rights more commonly than others. A number of sources, including CBM (2018), DFID (2000), Pearce (2015), & Plan (2013), cite the statistic that women and girls with disabilities are 2 to 3 times more likely to be victims of physical and sexual abuse than women without a disability.

The root causes of GBV are structural and systematic gender inequalities, which underpin harmful gender norms and reinforce abuses of power between men and women. Violence against women and girls is both a consequence and a cause of this inequality, reinforced by both economic disadvantage and dependence (World Bank, 2019). Most people, however, do not experience structural inequalities due to gender alone, and the intersection of other factors, such as ethnicity, religion, age, sexual orientation, socioeconomic status, and disability often contribute to an individual's marginalisation in society (Pearce, 2015). While GBV impacts women and girls universally, women with disabilities are often particularly vulnerable to violence due to social exclusion, limited mobility, a lack of support structures, and communication barriers (Plan, 2013).

Dunkle et al. (2018), found the relationship between disability and gender based violence to be reciprocal, where women and girls with disabilities are at increased risk of experiencing violence, while violence itself can lead to new or more severe experience of disability. This study also found that violence can significantly exacerbate mental health conditions such as anxiety, depression and PTSD. Many women may also have difficulties recognising or describing abuse, and as such are much less likely than their peers without disabilities to access services geared towards helping them.

Further to this, current investigation has demonstrated that women with disabilities experience unique forms of abuse emerging from the inherent vulnerability of living with a disability. This vulnerability results from factors such as limitations in ability to perform expected roles and age-normative activities, as well as experiences of dependency, devaluation, and low self-esteem, which are common to many women with disabilities. Therefore, because what may be considered abusive to women with disabilities does not fit traditional definitions, abuse of this population often goes unnoticed or unidentified (Gilson, 2001).

Globally, data on gender based violence against women with disabilities is very limited, which in itself speaks to the depth of the issue. Despite this, anecdotal evidence is telling, with CBM (2018) reporting that women with disabilities are more exposed to practices which qualify as torture or inhuman or degrading treatment; are more susceptible to violence and abuse; and are at an increased risk of poverty. Pearce (2015) reports that sexual violence was the most common type of GBV experienced by research participants with disabilities, with some women being subjected to rape on a regular basis, and by multiple perpetrators. The World Bank (2011, p. 33) also found that 'there are many cases of involuntary sterilisation being used to restrict the fertility of some people with a disability, particularly those with an intellectual disability, and almost always women...' These harmful practices are most often perceived as legitimate medical care for women with disabilities, and are condoned by legislation in many places (World Bank, 2019). Additionally, if women with disabilities do bear children, globally, mothers with disabilities are up to 10 times more likely to have their children removed from their care based on their disability, rather than on evidence of child neglect (Ortoleva & Frohmader, 2013).

The World Bank (2019) also reports that young women with disabilities are particularly at risk from sexual violence, this is often because women and girls with disabilities are perceived to be 'easy targets' by perpetrators, owing to their lack of education surrounding sexual and reproductive health, lack of access to information and reporting, and stigma in communities. Myths about disability are also particularly prevalent in rural areas, and include the belief that having sex with a girl with albinism may cure HIV/AIDS and other sexually transmitted infections, or that it brings luck and wealth (Chu et al, 2015; Massetti et al, 2024). Further, since women with disabilities are often perceived as asexual, girls and young women with disabilities are presumed to be virgins, thereby appearing more attractive to perpetrators of violence, while also being perceived as less in need of services surrounding sexual health and reproductive rights. Violence against women and girls with disabilities is an important aspect of understanding gender and disability as interrelated oppressions, as it is a clear indicator of where the power lies within patriarchal systems of dominance.

This is one of the major obstacles to the prevention, reduction and eradication of gender-based violence against women with disabilities, as it remains invisible and its victims largely silent, due both to a wide socio-cultural acceptance of this form of violence as well as the stigma attached to the victims, regardless of disability status (Ledingham et al, 2022). Due to a lack of accessible reporting mechanisms, and programmes teaching women and girls with disabilities their rights, gender-based violence among women with disabilities is difficult to quantify beyond anecdotal evidence. This means that it is often difficult to measure in quantitative terms, the extent of the problem or the progress made in preventing and reducing harm (ADD, 2023).

### 3.4.5 Multiple disadvantage

It is widely accepted that patterns of disadvantage are often associated with the differences in the social position of women and men, and that these gendered differences are reflected in the life experiences of many women and men with disabilities. Cobley (2018) states that women with disabilities face multiple

discriminations, and are often more disadvantaged than men with disabilities in similar circumstances. Palmer & Woodcroft-Lee (1990), on the other hand, argue that women with disabilities are not necessarily worse off than men with disabilities, but face problems which are different from men, because society's perception of them is complicated by widely held assumptions about the image and role of women. As explored above, both of these statements may be true in different contexts, as women with disabilities are not defined purely by their gender and impairment type, but by any number of other intersecting factors including where they live, their jobs, race, religion, educational attainment etc.

It is clear from the literature, that both men and women with disabilities are faced with daily struggles against socially- and culturally-imposed restrictions on their activities, as well as their identities. Examples of this include the inaccessibility of basic services, as well as negative attitudes, which create social barriers to integration and participation (Abu Habib, 1995; Tefera et al, 2017; Devkota et al, 2019). Despite the consensus that women with disabilities face different problems from men with disabilities, due to their intersecting identities, there has been disagreement over whether they are necessarily worse off than their male counterparts. Some authors have used additive approaches to describe women with disabilities as 'double disadvantaged', whereby women are discriminated against based on both their gender, and their disability status. Abu-Habib (1995) explains that in addition to suffering discrimination based on their disability, women with disabilities are also subjected to discrimination on grounds of sex, as experienced by women the world over. This double discrimination means that disabled women's experiences are profoundly different from those of disabled men (Tefera et al, 2017).

Arnade & Haefner (2006, p. 7) have also described women with disabilities as being doubly disadvantaged, stating that:

While women with disabilities have much in common with men with disabilities, women with disabilities have to face multiple discrimination in many cases, so that they are often more disadvantaged than men with disabilities in similar circumstances.

Authors such as Morris (1993) and Garland-Thomson (2005), however, warn that such an additive analysis can shift attention away from the socio-cultural problems at hand - as defined by the social model of disability - and risk human beings being looked at as mere passive victims of oppression. Price and Goyal (2016, p. 303-304) also present an interesting argument that generalised disability analysis surrounding multiple disadvantage has led to many myths surrounding women with disabilities. They propose that women with disabilities:

are almost universally believed to be: living in poverty, often close to destitution; without work and without education, thus lacking skills to support themselves; subject to widespread magical beliefs of fate and misfortune; asexual and unable to establish a relationship or have children...

While Price and Goyal do concede that generalisations such as the above do not emerge without there being some truth to them - mostly in terms of the poverty and lack of education women with disabilities often face - they nevertheless argue that the view of women with disabilities as victims of multiple disadvantage is a surface view of the issue, and that there is more contextual detail found in local epistemologies, which offer deeper perspectives on the intersecting components of lives of women living with disabilities in the Global South, "perspectives which have been commonly ignored or dismissed by international researchers" (p. 304).

With all of these arguments in mind, 'double' or 'multiple disadvantage' has now become a common term in the literature used to describe the situation of women with disabilities globally. While it is useful in highlighting how intersecting identities can influence the lived experience of people with disabilities in varied and unique ways, it should also be considered that studying 'multiple disadvantage' may cause the misrecognition of multiply marginalised groups. There are a myriad of factors that may cause the marginalisation of any one group of people, and these factors may influence and interact with each other to create new or heightened experiences of disadvantage for any one individual. Considering a person to be 'multiply marginalised' may risk taking away some of the critical discourse around what causes these intersecting forms of violence, and may in turn return some of the processes around inclusion to the charity model of disability, where women with disabilities are 'doubly discriminated' in society and therefore need pity.

### 3.5 Conclusion

In conclusion, this section has aimed to present an overview of the broad range of issues facing women with disabilities in the Global South, as presented in the literature. The theories presented here are useful in understanding the experiences of women with disabilities, and help to explain some of the discrimination they face. These experiences are nuanced, and differ based on context, as well as the different factors of identity with which women identify. Overall, according to this body of research, gender and disability combine to create disadvantage in the Global South, and this most often manifests in negative attitudes, and a lack of opportunities for women with disabilities. Due to the established reciprocal relationship between poverty and disability, people with disabilities are usually unable to pursue the same opportunities as their non-disabled peers. Marginalisation is then further compounded for women with disabilities, who may experience discrimination on the basis of both their gender, their disability, and a myriad of other factors.

This lack of opportunities is especially apparent in terms of education and employment, where people with disabilities consistently lag behind people without disabilities due to childhood exclusion from school (Filmer, 2008). A lack of physically accessible education, poverty of families, negative attitudes of parents, caring responsibilities, and concerns about the safety of children are some of the main reasons why children with disabilities are denied education. Due to the major disabling effect these experiences may have on a person's life, the literature often refers to disability as a person's primary identity, which controls or erases all other identity factors. Depending on the cultural context however, disability may only be one of many factors which make up a person's identity.

For women with disabilities, experiences of discrimination are even more pronounced as their two major identities intersect. In many cases in the Global South, this means that women are expected to fit into the cultural roles prescribed to women, and to take on traditional roles in the household, thus further limiting their livelihood opportunities. This means that a woman's main role is often still to be a wife, mother, and homemaker, while the man tends to be the main decision-maker

and income earner. Compounding this marginalisation is the fact that education and vocational training are seen as investments for higher-value employment, meaning that a woman is less likely to have the opportunity to receive them.

Understanding this background of discrimination and marginalisation helps to frame my research questions around intersectionality, opportunities, and support, and grounds the empirical evidence gathered for this study in current theory. Many of the themes described here are echoed by participants in later chapters, and are framed by their own cultural experiences. The next chapter therefore explores the historical and cultural contexts in which this research operates, to further situate discussions around disability and opportunities.

# Chapter 4: Context

## 4.1 Introduction

As previously discussed, context is very important in framing discussions around the lives of women with disabilities. This is because the culture, history, and religion of a country or area impact attitudes and perceptions of both women and people with disabilities, based on what is considered culturally acceptable. The societal expectations placed on women in patriarchal societies often combines with the structural discrimination faced by people with disabilities, and leads to greater marginalisation and isolation for women with disabilities in certain societies (Wallace et al, 2018). As well as this, other factors like history, government involvement in inclusion, and prevalence of impairments, further shape attitudes towards disability, and may exacerbate or diminish discrimination. With this in mind, this chapter focuses on the broad historical, social, and cultural backgrounds of Cambodia and Rwanda, and how these have influenced the inclusion agenda in both countries. This discussion will then be used as a background against which to frame the following chapters on Methodology and Findings.

## 4.2 Disability in Context

People with disabilities often face cultural and social barriers to inclusion, which can be even more difficult to overcome than physical or institutional barriers in society. These barriers, which can include things like physical inaccessibility, lack of education and training, and negative attitudes, are rooted in social norms, and can make it difficult for people with disabilities to enter the labour market, and limit their opportunities. The broader cultural context of a country also influences perceptions of disability, and this is normally based on factors such as disability prevalence, political will, and religious beliefs.

This section presents some of the cultural, social, and historical barriers and contextual factors that influence disability inclusion in both Cambodia and Rwanda, with the intention of facilitating culturally specific understandings of disability, as well as promoting cross-cultural learning which has allowed me to conduct research in a respectful manner.

#### 4.1.1 Rwanda

Rwanda has a long history of tribal traditions and beliefs, which still influence perceptions of disability today (Prunier, 1997). Despite a long tribal history, with roots in ancient civilisations, Rwanda underwent a series of significant societal shifts in terms of class and ethnicity during the colonial era, which eventually led to civil war, and to the genocide against the Tutsis in 1994 (Crawford, 2019). The brutality faced by many people during this period, as well as the breakdown in health and rehabilitation services, significantly contributed to the prevalence of disability in the country, as well as too much of the culture of privacy and mistrust that still exists today. The focus on local-level rehabilitation in the aftermath of this incredible tragedy has been important in rebuilding Rwandan society just 25 years after genocide, and also led to the emergence of a coordinated and centralised disability movement, spear-headed by the new government (Njelesani et al, 2018).

Economically, Rwanda aspires to become a middle-income country by 2035 and a high-income country by 2050. GDP continues to grow, and the economy remains resilient despite external challenges (World Bank, 2024). Rwanda's main exports are tea, coffee, and minerals, and both the domestic and export markets for these are strong and stable, although inflation and rising costs of living are impacting the population (key informant, 2023). Tourism is also becoming increasingly important to the Rwandan economy, where the focus has been on high-end, low-volume ecotourism, putting Rwanda on the map for safaris, mountain trekking, and gorilla watching (Crawford, 2019).

Despite recent major gains in the political sphere, including the criminalisation of discrimination on the grounds of mental or physical disability, as well as prohibiting discrimination in the workplace, some of the culture surrounding disability in Rwanda

is still based in traditional East African beliefs mentioned above, including proverbs, folk tales and traditional healers. Some of these beliefs consider disability as a curse, and underestimate the capabilities of people with disabilities. While many people now believe animism to be archaic, these beliefs stem from years of oral tradition and traditional religions, and continue to be described as part of the culture of Rwanda (MacDonald & Butera, 2012). These beliefs often surround the causes of disability, and include disability as a punishment for bad deeds, as an act of God's will, or as a test of the strength of the family or community (MacDonald & Butera, 2012).

Religion still plays a central part in the everyday lives of many Rwandans, and therefore underpins current conceptualisations of disability. In many cases, these ideas reinforce the medical model of disability, where people with disabilities are seen as passive victims of their impairments, who may only rely on divine intervention to find a 'cure' for disability. Christian organisations also provide services for people with disabilities, and support and run most of the specialised schools and centres for disabled people. However outside of these specialised facilities, people with disabilities, including regular churchgoers, appear to get very little or no support from their local church (Thomas, 2005).

Despite the reliance on charity and medical models of disability, Rwanda signed the United Nations Convention on the Rights of Persons with Disabilities in 2008, which marked national recognition of rights for people with disabilities, and is viewed as a landmark in the history of the disability rights movement in the country. The ratification of the CRPD in Rwanda was a major step towards changing long-held negative societal attitudes and beliefs around people with disabilities (Njelesani et al, 2018). The Rwandan government has since been guided by the CRPD in developing its discourse surrounding disability, and submitted a comprehensive report to the Committee in 2015. The government was due to report again in 2023, but has not yet done so.

The disability movement in Rwanda is therefore guided by an equality-driven government agenda, and supported by progressive policy efforts and legal framework, based on the CRPD. Clearly the political will to support the rights of

people with disabilities does exist within Rwanda, with the government having endorsed many legal instruments and policies, including the National Council of Persons with Disabilities - a forum for advocacy and social mobilisation for issues affecting people with disabilities in Rwanda. As well as this, 91% of the population has access to health insurance through the Mutuelle de Santé scheme, and a number of schemes exist within the Ministry of Health specifically for the benefit of people with disabilities – although these are not always easy to access (Njelesani et al, 2018). Although Rwanda is still operating under the medical model of disability to some degree - with disability still being considered a health competency at ministerial level - the health infrastructure for people with disabilities appears to be quite robust, and universal health insurance could reduce some of the extra costs associated with living with a disability, thereby helping to reduce the burden of poverty on people with disabilities. While the social model of disability is preferred by many Western academics, and an increased focus on the rights of people with disabilities is necessary, there is no doubt that the current supports available to people with disabilities in Rwanda are necessary, and there is ample evidence that the political will exists within Rwanda to progress the rights of people with disabilities beyond medical care.

The definition of disability, according to the National Policy on Disability and Inclusion (2021, p. vi) states that:

Persons with Disabilities include those who have long term physical, mental, intellectual or sensory impairments which in interaction with various attitudinal and environmental barriers hinders their full and effective participation in society on an equal basis with others. Disability is a result of the interaction between a person and his or her environment. Disability is not something that resides in the individual resulting in impairment, it resides in the society (UNCRPD).

This definition, in line with the CRPD - as referenced in the text - seems to be an effort on the behalf of the government of Rwanda to update its approach to disability inclusion, and to move more towards the social model of disability. This is a very positive shift, and will hopefully signal a more systemic move towards this model.

With the goals of the CRPD in mind, Rwanda conducts a population and housing census every 10 years, with the most recent taking place in 2022. Currently there are over 13,000,000 people living in Rwanda, of which 3.4% report experiencing a disability. This is well below the global average - at around 16% - and is likely due to underreporting of disability in communities, because of stigma, shame, and differing methods of data collection. This has decreased slightly from around 4% in the last census (NISR, 2012). Disability is more common among women than men in Rwanda, with 3.6% of women experiencing disability, compared to 3.1% of men, and it is also recorded that disability prevalence increases with age.

Information on disability is reported to have been collected using the Washington Group Short Set of Questions on Functioning, and this revealed that most people with disabilities in Rwanda describe their experience as 'slight disability', and that difficulty seeing is the most common type of impairment. Mobility issues, and hearing impairments are also widely reported (NISR, 2022). It should be noted that albinism is reported as non-existent in Rwanda, with a prevalence of 0 in the census. This is an anomaly, as the researcher has spoken with at least one Rwandan citizen who identifies as having albinism, and may be due to the stigma surrounding the impairment, or difficulty in identifying this condition using the Washington Group Questions. The census does not record how long people have had their impairments, how they came to live with an impairment, or if they receive any support in living with a disability. There are also no questions on employment or social welfare for people with disabilities - or for the population in general - so it is very difficult to determine the levels of poverty and social exclusion in Rwanda, and if people with disabilities are financially impacted by their impairments. Marital status of people with disabilities is also not recorded, so it is difficult to determine whether people with disabilities tend to live independently, or with family members or spouses.

65% of people with disabilities have received some kind of education, compared with 81% of the population without disabilities. It is also noted that more girls than boys are in education, in both populations with and without disabilities. Number of years of schooling and general literacy are not recorded, but it is reported that 54% of the population can only speak Kinyarwanda. This is not disaggregated by sex, age, or

ability (NISR, 2022). Disability is reportedly 2 times more common in rural areas than in urban areas of the country, which may be due to the large proportion of the population living outside of urban centres, as well as lack of access to education and healthcare in these areas.

This census also recognises the two way relationship between disability and poverty - whereby one can cause the other. Research found that people with disabilities are spread relatively evenly across all wealth groups, although there is a slightly higher representation of people with disabilities in the poorest quintile - at 20% - than elsewhere. However, it is pointed out here that 50% of households headed by a member with a disability are reported to live in poverty, which is much higher than those headed by a person without a disability (NISR, 2012).

As previously mentioned, while Rwanda is lauded internationally for its commitment to gender equality at parliamentary level, in reality, gender equality is still developing, and men and women tend to take on very traditional roles within the household (Crawford, 2019). There is a great deal of social pressure on women to fulfil the caring roles of mother, home-maker, and carer, and gender norms are generally still conservative, especially in rural areas. Gender-based violence is also still common in Rwanda, although the government has begun to take steps to redress this (Ntaganira, 2008).

#### 4.1.2 Cambodia

Similar to Rwanda, the history of pre-colonial Cambodia is steeped in myths and legends, and forms the basis of much of the modern Cambodian culture we know today, including the thinking around causes and impacts of disability (Etcheson, 2005). Under French colonial rule for almost 100 years, the country was unable to develop its own infrastructure and identity until independence in the 1950s. After this period, and following successive power struggles, the country suffered the brutality of the Khmer Rouge Regime into the 1990s. Cambodia has only known relative stability since the end of this decade, following a protracted civil war, and the legacy of genocide (Reavil, 2022). It is unsurprising then that the prevalence of disability vastly increased during these periods, and that infrastructure including healthcare,

education and transport was essentially non-existent. This increase in disability prevalence eventually led to the birth of the disability movement in Cambodia in the early 2000s, and many of the NGOs and DPOs that emerged during this time are still active (The Borgen Project, 2020).

Cambodia's economy is driven largely by tourism, manufacturing exports (including rice, textiles, and rubber), real estate, and construction, making it one of the fastest-growing economies in the world. After reaching lower middle-income status in 2015, it now seeks to become an upper middle-income economy by 2030 and higher-income economy by 2050 (World Bank, 2024). Despite the impact of Covid-19 on the economy, tourism continues to increase in popularity, and now provides around 38% of GNP. The country is also rich in minerals, and agriculture employs almost 75% of the population (Reavill, 2022).

Despite some cultural barriers to inclusion, the Royal Government of Cambodia ratified the Convention on the Rights of Persons with Disabilities in 2012, and is therefore committed to improving the rights of people with disabilities in the country. The country was due to submit a report to the Committee in 2015, but has not yet done so. In spite of this, the Cambodian government has been active on disability issues since ratification, and has begun the process of implementing measures to protect people with disabilities. Political will to address issues relating to disability is also strong in Cambodia, as evidenced by a number of mandates and laws which have recently been implemented. These include the Law on the Protection and the Promotion of the Rights of Persons with Disabilities, the National Education Law, and the National Disability Strategic Plan (NDSP) 2014-2018 (WHO, 2018). Ratification of the CRPD and the adoption of these disability rights laws are certainly significant milestones for protecting and promoting the rights of people with disabilities in Cambodia, and signify the government's commitment to disability inclusion. The challenges, however, lie in the effective implementation of these disability rights instruments.

The General Population Census of Cambodia 2019 was the first time that questions on disability were included in a Cambodian census questionnaire. The census used the ICF framework to measure disability, thus for the first time yielding internationally

comparable data - although not necessarily in line with data collected from Rwanda. The current prevalence of disability under this framework is 4.9%, and similarly to Rwanda, is well under the reported global levels, due to difficulties with collection and interpretation of data. The rate of disability is significantly higher for females (5.5%) than for males (4.2%). Disability prevalence also increases with age in Cambodia, with only 1.4% of under 34 year olds experiencing disability, while 25.6% of the population aged 60 and above reported experiencing disability (NISMP, 2020).

Difficulty with seeing is the most common type of disability in Cambodia, followed by difficulty in hearing. Cause of disability was not recorded by this questionnaire, but according to earlier findings from 1999, 32% of disabilities were caused by diseases, and 22% were caused by landmines or war (Ministry of Social Affairs, 2009). Despite these findings having emerged over 20 years ago, it is reasonable to assume that they have not changed much, as unexploded landmines continue to pose serious threats to the population of Cambodia, and the healthcare system is still inaccessible to most ordinary Cambodians due to cost. Interestingly, this census also reported that proportionately more women with disabilities were widowed, divorced and separated than males with disabilities in both urban and rural areas.

As well as this, data was also gathered on the economic activity rates of people with disabilities, showing that 52.9% of the population of people with disabilities are economically active (it's unclear whether this is formal or informal work). 62.7% of men with disabilities are employed, while only 49.5% of women with disabilities are in employment (NISMP, 2020). Despite income rates of people with disabilities not being measured in this most recent census, it is estimated that the rate of poverty among households with at least one disabled member is around 34% in Cambodia, if the additional costs associated with disability are taken into account. This is more than double the national rate of 13.5%, and is likely to be an underestimate, as it is difficult to gather this type of data (The Borgen Project, 2020).

Under the Cambodian Disability Law (2009, p. 5), a person with a disability:

Refers to any persons who lack, lose, or damage any physical or mental functions, which result in a disturbance to their daily life or activities, such as

physical, visual, hearing, intellectual impairments, mental disorders and any other types of disabilities toward the insurmountable end of the scale.

The language used here is not particularly well aligned to the CRPD, and places much of the burden of disability on the individual, without recognising the disabling factors that exist within Cambodian society. At the same time it is important to recognise that English is not an official language of Cambodia, so while this is an official translation, there is no doubt that some of this definition could be interpreted differently in the original Khmer. It is true, however, that many of these laws and strategies at a national level locate disability within the individual, mostly taking a medical model approach to disability.

At the level of implementation, research shows that awareness of international, regional and national disability rights legislation and policy frameworks (including the CRPD, national disability law, etc.) is limited among government officials, particularly at the provincial, commune, and village level. This means that implementation of these policies at the local level is often poor and disjointed across different provinces (Gartrell & Soldatic, 2016). As well as this, public awareness and mass education campaigns on the inclusion of people with disabilities in the country's mainstream have historically been non-existent, and have only recently begun to emerge. This lack of disability awareness means that numerous superstitions and misinformation regarding disability have lingered in Cambodia, especially in rural areas (Connelly, 2009). These beliefs and superstitions affect how Cambodians with disabilities are perceived in all areas of life.

Cambodia is a very religious country, with over 97% of the population following Theravada Buddhism. This adherence to religion can be seen in all aspects of life in the country. While recent advancements in understandings of disability have begun to take hold in Cambodia, it seems that perceptions around the causes of disability are often still influenced by both biomedical and traditional factors. It is reported that many Cambodians believe disability to be a result of karmic destiny, or the interference of Brahmic spirits (Morgan & Tan, 2011). Under this karmic rule, people with disabilities are believed to have committed bad deeds in a past life, and therefore are being 'punished' with disabilities in this life. As such, people with

disabilities are often discriminated against, and shown little sympathy by other people in society. This means that people with disabilities in Cambodia experience significant exclusion, including direct discrimination and social isolation, as well as exclusion from political processes and development (Thomas, 2005).

In Cambodia, gender norms remain heavily rooted in society, creating inequality between men and women and depriving women of their basic rights. In Cambodia today, there are still fewer girls than boys who complete school. The level of education often correlates to a woman's power to be able to exercise her reproductive rights (e.g. the right to decide the number and spacing of her children, when to get married and when to have children) (UNFPA, 2024). Again in Cambodia, traditional household roles are still very prevalent, and gender-based violence continues, especially in rural areas (Reavill, 2022).

### 4.3 Similarities & Differences

While the broad thematic contexts have already been explored here, certain aspects of these societies are more relevant to the everyday lives of women with disabilities, and warrant further exploration. There are also a number of socio-cultural similarities between Cambodia and Rwanda which make these countries appropriate for comparative analysis of the lives of women with disabilities.

Firstly, and most notably, both countries take similar overall positions with regard to cultural beliefs around disability. From a general perspective, both countries base their definitions of disability on the UNCRPD to some extent, although the Rwandan definition aligns much more closely to this than the Cambodian. Despite minor differences, it is clear that the goal of both definitions is the same - to understand disability within the context of the country. It is notable that Rwanda has chosen to 'copy' the CRPD definition almost exactly, as many other countries have, but Cambodia has not. It may be the case that the Cambodian definition will be updated in years to come, but for now this definition is interesting because it has been devised specifically with Cambodian disabled people in mind, in Khmer. While it may not align perfectly with the social model of disability, this culturally specific

understanding of disability may hold more weight in reality than that of Rwanda, which is internationally recognised. While this may be more applicable internationally, as well as an acceptable definition in terms of the social model of disability, in practice it may not reflect local attitudes and thinking around disability, and therefore may be limited in its applicability. There is room for more research into this cultural applicability of definitions of disability, which may include comparisons with other countries in the Global South.

While both countries should be commended for collecting disability-specific data in the most recent census, as well as for early adoption of the CRPD, there are some interesting differences in governmental approaches to inclusion between the two countries. Firstly in the CRPD, while Rwanda ratified in 2008 and Cambodia in 2012, both were expected to submit their first reports in 2015. Rwanda initially submitted a detailed report to the Committee, and was expected to do so again in 2023, but has yet to share this at the time of writing. Cambodia has not yet submitted any reports to the Committee (originally due in 2015). While political will appears to be strong in both countries when looking at factors such as CRPD ratification, buy-in to regional strategies, and policies aimed at improving the lives of people with disabilities, there is clearly a disparity in terms of action. On the one hand, the Rwandan government has taken the onus upon itself to take most of the action and reporting on disability in the country, while on the other, the Cambodian government has mainly left it up to the NGO sector - and this includes reporting on things like the status of the CRPD in the country. These differing approaches to disability also reflect the different governance styles of both countries, especially in terms of how they relate to the disability movement; in Rwanda the disability movement is largely centralised and led by the government in a very structured and controlled way, representing Rwandan governance structures more generally. On the other hand in Cambodia, the government has taken a much more 'laissez faire' approach, with much of the action on disability inclusion coming from the grassroots and NGO level. While these initiatives are certainly backed up by national government policies, it seems that most of the action comes from this lower level, reflecting a growing space for civil society in the country.

Interestingly, despite sitting on different continents, and developing vastly different sets of cultures and traditions, beliefs and attitudes towards disability are relatively similar in both countries. Religion plays a very important role in daily life in both countries, and also heavily influences thinking around disability, although it is difficult to find literature which explores this (see brief excerpts from Morgan & Tan, 2011 and MacDonald & Butera, 2012). Beliefs are generally based on ancient religions, and although these have different origins, they generally include traditional folk tales, proverbs, and the wisdom of ancient healers. The Buddhist belief in Karma also translates almost exactly into the East African culture of disability being viewed as retribution for bad deeds in a past life. In Rwanda, while many people no longer subscribe to ancient beliefs, they still influence thinking as they stem from years of oral tradition emanating from local religions, and continue to be described as part of the culture (MacDonald & Butera, 2012). With the recent move towards Christianity here, there is a view that only God or divine intervention can 'cure' disability, and these beliefs often influence thinking around the causes of disability, considering disability as a punishment for bad deeds, as an act of God's will, or as a test of the strength of the family or community. Meanwhile in Cambodia, it is reported that many Cambodians still believe disability to be a result of karmic destiny, or the interference of Brahmic spirits (Morgan & Tan, 2011). As a result of this, people with disabilities are seen mainly through charity and medical models of disability, where they should be pitied for their bad karma, or need medical interventions to restore 'normal functioning'. This attitude often means that people with disabilities face significant marginalisation and ostracisation from communities (Thomas, 2005).

Further, there are also similarities in the way that both countries consider gender as defining aspect of disability. This may be because research has shown that the intersectionality of gender and disability is particularly strong in poorer countries, but is also influenced by patriarchal structures and attitudes towards women in both countries. In Cambodia and Rwanda (as in many countries in the Global South), it is not just identities alone that cause discrimination, but the interactions of social norms and culture with these identities, which reproduce structural violence and ostracisation (Gartell & Soldatic, 2016).

In general in both Cambodia and Rwanda, women with disabilities face a significant amount of disadvantage in terms of access to services, education, and employment. While women in both countries face similar structural challenges in terms of the everyday discrimination and stigma they face, they each have unique 'primary concerns' as identified in the literature. In Rwanda, society continues to be dominated by patriarchal structures and norms, which influence how women both with and without disabilities behave on a day-to-day basis. This subordination of women more generally has meant that women and girls with disabilities often lack decision making power within the household, and as such are denied access to power and agency within society (DRF, 2021). In Cambodia meanwhile, disability-based discrimination seems to be the most pervasive problem facing women with disabilities, who are often judged based on their impairments. With such pervasive beliefs around disability and its causes, women with disabilities often face discrimination because of their gender, as well as their disabilities. This is in tandem with high rates of domestic violence from both intimate partners as well as family members, and means that women with disabilities can become extremely isolated and marginalised from their communities. It is however worth noting that GBV is reportedly more common in Rwanda (IWDA, 2017). So while some of the major issues facing women with disabilities are universal and apply across all continents, others are much more specific, and need to be tackled in a targeted way, with input from local communities.

One significant difference between these two countries is that there has been much more research into the experiences of women with disabilities in Rwanda than in Cambodia, and this is likely due to the strong political will for inclusion in Rwanda. This means that research surrounding women with disabilities in Cambodia is only beginning to develop, and relatively little is known about their experiences. Recent studies show that, in line with Rwanda, women with disabilities - and especially rural women with disabilities - are poorly included within their communities and continue to be the most marginalised from international, national and local disability-inclusive development initiatives and innovation, policy and practice (Gartell & Soldatic, 2016). It is therefore recommended that further research be conducted into the intersection of gender and disability in Cambodia specifically.

## 4.3 Conclusion

In summary, the culture, history, and religion of a country are very important in determining the attitudes and perceptions of society towards both women and people with disabilities. These ideas vary greatly from place to place, based on what is considered culturally acceptable. Long histories of war have contributed to the prevalence of disability, as well as the growth of the disability movement in both places. Data on the prevalence of disability varies in quality, depending on methods of collection, political will for inclusion, and the internalised stigma people with disabilities may feel about self-reporting their impairments. Perceptions of disability, and this stigmatisation of people with disabilities also tends to be based on ancient beliefs and religion, and influences the everyday lives of women with disabilities. This background information on the history, culture, and traditions of both countries are useful in framing the methods I have chosen to use in data collection for this research, which will be explored in more detail in the next chapter.

# Chapter 5: Methodology

## 5.1 Introduction

This research aims to understand the lived experiences of women with physical disabilities in Cambodia and Rwanda, especially as they relate to livelihood opportunities. I am interested in examining the issues faced by these women as they themselves see them, and understanding how best these could be tackled at programme and policy level. Using a mixed methods approach to data collection, which is both participatory and emancipatory, I aim to share empirical evidence gathered in collaboration with women with disabilities themselves.

As explained in Chapter 2, both feminist researchers and disability scholars working in this area have tended to keep the focus quite broad, often researching 'people with disabilities', but rarely disaggregating by age, gender, class, or nationality. Many of these studies have also been based in the Global North, with little attention paid to the Global South - home to approximately 80% of people with disabilities in the world (WHO, 2011; WHO, 2022). Additionally, it is notable that much of the research that does focus on people with disabilities in the Global South typically focuses on inter-group relations (exploring the differences between people with disabilities and people without disabilities), rather than on intra-group relations (differences between people with disabilities based on gender, nationality, class, etc.). This kind of intra-group study that I have conducted allows for a deeper understanding of the relationships between people with disabilities and how they relate to one another, and can often be more empowering for participants by giving them a space to share their thoughts and experiences, as well as to highlight their experiences as distinct from other groups. My research aims to fill this gap in the literature, by giving weight to the experiences of women with disabilities in two countries in the Global South, and comparing them to each other, rather than to women without disabilities, in order to develop a deeper understanding of the real issues facing these women, and how best they can be addressed.

For this research, I have chosen to focus solely on the experiences of women, and on the social behaviours and psychological aspects which relate to them, meaning that I am using gender - for the most part - to refer to women and girls. I am interested in the experiences of women with disabilities in Cambodia and Rwanda, and how they operate within these culturally ascribed gendered identities, as well as how they perceive themselves and each other. Due to the nature of patriarchal structures in these (and most) societies, gender also has a part to play in the distribution of power and resources within communities, and this understanding is fundamental to my research, as I look further into the lack of opportunities associated with being a woman with a disability. I have also chosen to focus solely on the experiences of women with physical disabilities during this research, and so I am considering physical disability to mean a long-term condition affecting a part (or parts) of a person's body that impairs and limits their physical functioning. Examples include (but are not limited to): loss of limbs, blindness, deafness, albinism, acquired injuries, cerebral palsy, etc. Also for the purposes of this study, opportunities are considered to be indicators of well-being for people with disabilities, as well as a more concrete measure of multidimensional poverty. Considering the opportunities available to people with disabilities in the Global South across various categories can paint a picture of the causes of poverty and deprivation faced by many, as well as the types of discrimination they face.

Working across two countries in the Global South also adds a comparative dimension to the study, as it allows for gender and disability to be understood in two different cultural contexts, which highlight the extent to which culture, beliefs, and attitudes play a role in the lives of women with disabilities. It is argued by Creswell & Clark (2016) that comparability of research across countries can be problematic because comparability may be compromised in a number of ways. These include minor differences in survey design due to contextual adaptation in each country or inherent cultural differences; changes based on experience in previous countries surveyed; refinements in the understanding of core concepts; differences among the data collection teams; or variations in training procedures. While these are all legitimate considerations for my research, I believe that since the survey design remained by and large unaltered, and the interviews were carried out by the same

researcher, differences in data collected are true reflections of living conditions in both countries.

With these justifications in mind, I first define my research questions and objectives, as well as the theoretical framework underpinning this research, before exploring my own beliefs and understandings of the world, and how these influence my research. Next I explore in more detail the research methods and tools which provide the foundations of this mixed methods study, as well as the sampling approach used to collect data from my specific target population. I then provide an account of my data collection process which took place in two distinct phases, across two countries, including my key considerations for working with women with disabilities in the Global South. I then further explain the ethical considerations which underpin this research, as well as the methods of analysis I employed, before finally considering the challenges and limitations of this study and reflecting on this research as a whole.

## 5.2 Research Objectives and Questions

This research aims to understand the lived experiences of women with physical disabilities in Cambodia and Rwanda, especially as they relate to livelihood opportunities. In particular, it focuses on education and employment opportunities for women with physical disabilities in suburban areas of Siem Reap and Kigali. This research further explores how women with disabilities can be better supported to participate in society, and to improve their livelihood opportunities in the Global South context.

The main objectives of this research are to:

- demonstrate through empirical evidence, the relationship between gender and disability, as experienced by women with physical disabilities in the Global South.
- understand the factors which may influence how, and to what extent, women with physical disabilities participate in education and the labour market.

- explore the socio-cultural understandings of women with disabilities in Cambodia and Rwanda.

To address these objectives, the following research questions will be answered:

1. What is the relationship between gender and disability in Cambodia and Rwanda? And how do societal perceptions of these identities shape the experiences of women with disabilities in both countries?
2. What opportunities for education and employment are pursued by women with physical disabilities in Cambodia and Rwanda?
3. Do women with physical disabilities receive support in pursuing livelihood opportunities? And if so, where does this support come from?

### 5.3 Theoretical Framework

When thinking about the theoretical framework on which to base this research, it was important to me as a researcher to consider a number of factors. Firstly, I wanted to highlight the lived experiences of women with disabilities by using empirical evidence in a way that is both participatory and empowering. Secondly, I aimed to avoid essentialising women with disabilities, and reducing their identities only to their impairments, through considering the multiple, intersecting identities held by each of us. Finally, I considered the importance of symbolic interactionism, and how women with disabilities perceive themselves based on the favourability of attitudes of those around them towards disability. With these three considerations in mind, I felt that one singular theory on its own - such as feminist disability studies or critical disability theory - would not provide enough nuance to this study, and would force me to rely more heavily on one identity factor - such as gender or disability - over the other. It is for this reason that I have chosen to base this study on the concepts of both intersectional feminism and critical disability theory in tandem.

As discussed during the review of theories and research, gender and disability are often considered defining characteristics in a person's identity, but the fields of both feminism and disability studies rarely consider the overlap between the two. This study therefore highlights the need for an intersectional viewpoint when considering

disabled identities, so that multiple factors of a person can be considered at one time, rather than focusing solely on disability or gender in isolation. The concept of intersectionality has been criticised by many scholars as merely a new 'buzz word', bringing 'methodological murkiness' with its use (McCall, 2005). Nash (2008) notes the lack of a clearly defined intersectional methodology, as well as the ambiguity inherent in the complex definition of the term. Weigman (2012) also points out the Western-centric theories of power which underpin the concept as a whole, suggesting that it may not be applicable in all contexts. Despite these valid concerns about the applicability of the intersectional approach, it remains a useful tool for understanding the complex realities of living with a disability in societies which are inherently gendered, racialised, and ableist.

In the early years of feminist disability studies, Abu Habib (1995, p. 49) wrote that one consultant's report presented to Oxfam at the time, stated vehemently that one cannot 'do women and disability' at the same time, adding that one should 'do disability first, then think of women'. She believes that the grounds for this conclusion are that gendered analysis would probably overwhelm or confuse an analysis of people's experience and circumstances based on disability. This has been a widely held assumption about the disability movement for many years, and highlights how disability has often been left out of other types of analysis because it is considered to be too technical, specialised, or not relevant to other aspects of a person's life.

Even today, women with disabilities often have difficulty having their points of view acknowledged both in the women's movement, and in the disability movement. This is due in part to the view of women with disabilities as 'childlike, helpless, and victimised', who can be seen as detracting from the efforts to advance 'more powerful, competent and appealing female icons in feminist arenas' (Fine & Asch, 2009, p. 4-5). Palmer and Woodcroft-Lee (1990) agree that there has been a reluctance on the part of the disability rights movement to address gender issues, as well as vice versa. Academics from both fields have historically disagreed on a number of important considerations (e.g. Sumskiene et al (2016), citing the feminist movement calling for women's right to abortion while the disability movement fights forced sterilisation), and it is only in recent years that disability has been recognised as an important component of identity studies, and has begun to be explored under a

feminist lens (e.g. Meekosha, 2004; Wayack-Pambé & Seni, 2022; Wickenden, 2023). In an effort to add to this growing body of literature, this research takes an intersectional approach to feminism and disability studies, exploring them both as interrelated and compounding theories, which heavily impact the lives of women with disabilities.

As explored briefly in earlier chapters, it can be argued that women with disabilities suffer from multiple, interrelated oppressions due to their experiences as women, and people with disabilities. In some cultures, this means that women with disabilities are denied equal enjoyment of their human rights based on the lesser status ascribed to them because of their social positioning (Yuval Davis, 2006). Authors such as Garland-Thomson (2005) argue that this approach shifts attention away from the socio-cultural problems at hand, and risks painting women with disabilities as mere victims of oppression. However, Yuval Davis (2006) comments that there is really no such thing as suffering oppression only as 'a Black person' or a woman, or a working-class person, and that these social divisions are always experienced together and so are indivisible from each other. I tend to agree more with this standpoint, especially in the context of research which takes place in the Global South, where multiple intersecting identities are more prominent due to cultural and environmental factors.

With this history of marginalisation of disability as a feminist issue in mind, I have chosen to explore feminist disability studies and critical disability theory together, as interrelated oppressions. Through combining these two frameworks, I am able to focus more clearly on the lived experiences of women with disabilities themselves, giving equal weight to their identities as both women and people with disabilities. Using both of these concepts together to form my theoretical framework should allow me to maintain a balanced feminist/disability perspective, which is grounded in reality and empirical evidence. These ideas aim to show that the social forces and processes that construct and give shape to both gender and disability are closely linked, and have a profound impact on the lives of women with disabilities (based on Thomas, 2006). As I explore later in my findings chapter, women with disabilities in Cambodia and Rwanda are primarily concerned with those practical issues which

have the greatest impact on their daily lives, and therefore I am also choosing a pragmatic approach to analysis, which also considers symbolic interactionism.

Firstly, I have chosen to use intersectional feminism, as it centres the voices of those experiencing overlapping, concurrent forms of oppression in order to understand the depths of the inequalities and the relationships among them in any given context (UN Women, 2020). It can be used to show the way that people's social identities can overlap, creating compounding experiences of discrimination. Using an intersectional lens also means recognizing the historical contexts surrounding issues. Long histories of violence and systematic discrimination have created deep inequities that disadvantage certain members of society from the outset. These inequalities intersect with each other, for example, poverty, ability, racism and sexism, often denying people their rights and equal opportunities (UN Women, 2020). While issues including sexism, extreme poverty, and discrimination based on disability may seem separate at first, intersectional feminism illuminates the connections between these fights for justice. In this way it serves as a framework for addressing overlapping forms of discrimination simultaneously.

I have chosen to use this theory to inform this research for two reasons. Firstly, and most immediately, as a framework to help me to understand the intersecting identities that come with being a woman with a disability in low-income contexts, and how these factors can create disadvantage. Secondly, as a lens through which to listen to different kinds of feminists, from different cultures and with different life experiences. I aim to make this research as inclusive as possible, and intersectional feminism will allow me to understand the viewpoints of many different women from different social divisions.

In conjunction with this, critical disability theory (or critical disability studies), at its core, is an area of study populated by people who advocate for building upon the foundational perspectives of disability studies, whilst integrating transformative agendas associated with postcolonial, queer and feminist theories (among others) (Goodley, 2016). This concept forefronts lived experiences, and allows disability to be understood from the perspective of the person who experiences it, as much as possible. Critical disability studies views disability as both a lived reality in which the

experiences of people with disabilities are central to interpreting their place in the world, and as a social and political definition based on societal power relations (Reaume, 2014). In this way, critical disability studies is similar to intersectional feminism, as it considers disability to be just one of a number of social factors that influence the life of an individual. The difference here is that critical disability studies places disability at the foreground of theoretical debates while, at the same time, highlighting disability's relationship with the politics of race, ethnicity, gender, sexuality, class, age, etc.

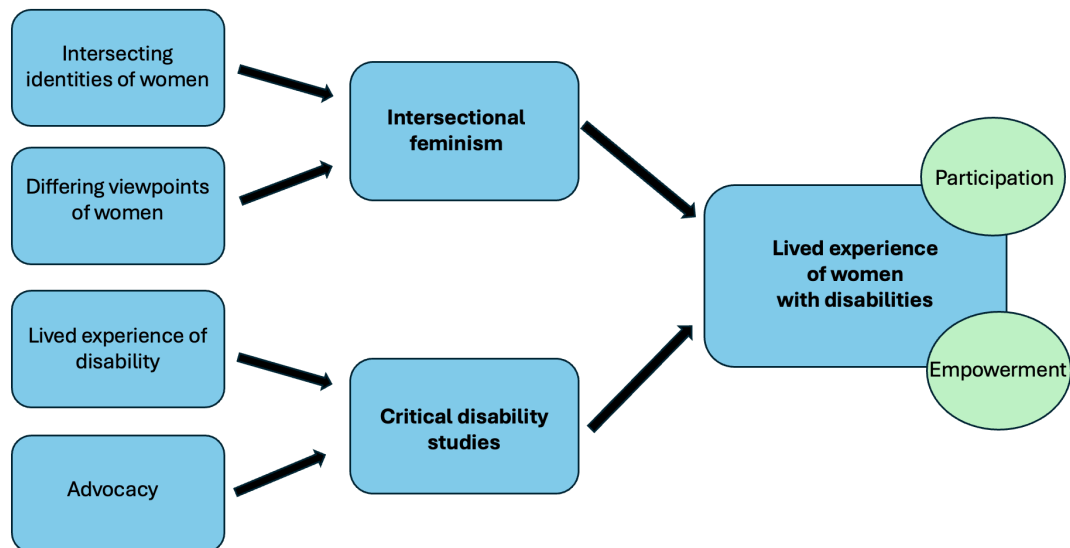
A central facet of this concept is that academics and activists who employ critical disability studies also advocate for progressive societal change, so that the theory can be used as an emancipatory discourse. Goodley et al (2019) argue that critical disability studies is not inclusive enough of scholars from the Global South, and I would be inclined to agree. Much of the literature is written from the perspective of authors from the Global North (myself included), and does not adequately address the concerns of scholars from the Global South. With this in mind, I aim for my research to be participatory in nature as far as possible, working with local disabled people's organisations, and local researchers in order to allow this research to reflect some of the concerns of women with disabilities in Cambodia and Rwanda on an international platform.

I am therefore using critical disability theory in this research to help me to understand the lived experiences of women with disabilities, as they themselves see them. This approach will help me to analyse disability as a socio-political phenomenon, as well as to explore power dynamics within communities. This research will also have broader applicability beyond academia, and I hope to use the findings to stimulate discussions about disability inclusion within mainstream NGOs, thus utilising the emancipatory nature of critical disability studies.

As illustrated by figure 1, below, taking both of these concepts together allows me to form a broad and novel theoretical framework for my research. While this approach recognises many of the merits of feminist disability studies, it aims to be more practical and more inclusive of local disability movements. Through focusing on the lived experiences of women with disabilities in both Cambodia and Rwanda, I aim to

combine feminist disability studies and critical disability theory to encourage more participatory and emancipatory research, and to generate unique empirical evidence.

Figure 1: Illustration of my theoretical framework



## 5.4 Research Philosophy, Strategy & Design

A research philosophy is what the researcher perceives to be truth, reality, and knowledge. It outlines the beliefs and values that guide the design of, and the collection and analysis of data in a research study (Ryan, 2018). When thinking about my overall research philosophy for this study, I firstly explored ontology, which is concerned with the existence of one singular 'truth' which can be studied, and how humans experience the world around them. Ontology is used by researchers to gauge how certain they can be about the nature and existence of objects they are researching (Moon & Blackman, 2017). In the case of this research, I have based my assumptions on relativist ontology, meaning that reality is constructed in the human mind, so that reality is relative according to how individuals perceive it at any given time. Because this research is both intersectional and comparative in nature, I have further chosen to work from the position of bounded relativism, which explains that one shared reality often exists within one 'bounded' group, but across groups, different realities exist (Moon & Blackman, 2014). This philosophical understanding

is especially important when researching the experiences of marginalised groups, who may experience stigma or discrimination based on intersecting identities. This position also theorises that realities and 'truths' can change as new information becomes available, thus 'truth' is not fixed and cultures and attitudes shift as time moves on and groups change.

With this philosophy in mind, I then chose an epistemology which would frame both my research questions and the methods I use to collect data. Epistemology is described by Lincoln (2008, p. 9) as asking:

how do I know the world? What is the relationship between the inquirer and the known? Every epistemology...implies an ethical-moral stance towards the world and the self of the researcher.

I have chosen to take a constructionist approach to this research, which rejects the positivist idea that an objective reality exists independently of the mind, which is discoverable through hypothesis and experimental testing (Ryan, 2018). Instead I believe that meaning arises out of our engagement with the realities in our world, and that people create their own 'truth' as they reflect upon their own realities. Constructionism argues that truth and knowledge are subjective, as well as culturally and historically situated, based on people's experiences, and their understandings of them (Ryan, 2018). This approach is again useful for my research, as it accounts for the context in which people live, and the experiences they have encountered along the way. While disability studies produced in and applicable to the Global North can produce knowledge that is valuable within its own distinctive political contexts, when applied to the Global South, it often reproduces a new form of 'epistemic injustice' that fails to recognize epistemological and contextual dynamics in the Global South (Nguyen & Stienstra, 2021). This politics of exclusion, as further argued by Nguyen & Stienstra (2021, p. 2036), 'reflects the continued dominance of Western knowledge, practices and institutions, the unfettered control over what counts as knowledge, and how it is produced, by whom, and how it should be disseminated'

I also chose to distinguish my standpoint from that of constructivism. While the two approaches are relatively similar, constructivist scholars focus on individual cognitive processes, and the making of meaning in this way, while constructionist scholars are

more interested in socially constructed knowledge, which emphasises the importance of social processes and interactions in creating the world around us (Zajda, 2020). Constructionism emphasises the characteristics of social participation, relationships, the setting of activities and how these change over time, and sees people as building up the world around them as they interact with each other in certain social settings. Again this approach focuses on historically- and culturally-bound narratives of people's lives, and how they perceive themselves and each other, and emphasises the co-existence of any number of situation-dependent ways of life.

With this post-positivist view in mind, I also recognise that I am not an independent observer of the world around me (Clark et al., 2021) - especially in the context of this research where I interacted with women with disabilities, and learned about their lives. I believe that my ideas and identities shape what I observe and the data I collect, and therefore bias my study to some degree. Thus I aim to keep some level of objectivity as an ideal model, and to distinguish and remove sources of bias where possible, but I also accept that a certain level of bias is necessary to understand the lived experiences of the women who participate in this research, especially as interviews of this nature involve a process of mutual trust and sharing between the researcher and participant.

Thus, reflexivity is central to this research in many ways, as my position as a researcher, and as a woman, affected how I related to participants, as well as how open they chose to be with me in interviews. Dodgson (2019), explains that if a researcher clearly articulates the intersecting relationship between themselves and the participants (including race, socio-economic status, age, cultural background, etc.), it increases credibility of the findings and deepens reader's understanding of the work. This is therefore how I have chosen to engage with participants, in order to get the most out of interviews.

I am also very taken with Dryden-Peterson's (2020) account of the malleability of researcher positionality over time, and how reflexivity should be a constant process of 'checking in' throughout the research. She argues that, rather than being a static snapshot of a moment in time, researcher positionality is about a process of identity

development, as knowledge, comparative frames, and positions of expertise and vulnerability continuously shift and influence the ways in which we, as researchers, collect data and conduct analysis. I felt that this was particularly relevant to my research because of the nature of the phenomenon being studied, which allowed me to get close to the life stories of participants, build relationships with them, and further advocate for social change in this area based on the findings of this research. This type of advocacy-based research often has a profound impact on the researcher, and I am interested to reflect on my shifting identity as a researcher, an advocate, a student, and a foreigner during this research.

Additionally I note a shifting identity in myself throughout the course of this research, in line with Dryden-Peterson's approach. I generally identify myself as a young, white, Irish, woman from the Global North, with a huge amount of privilege in this research setting. Whether or not I consider myself to have a disability is part of this shifting identity narrative - as well as the importance of vulnerability - that Dryden-Peterson talks about, and has changed throughout the course of this research. At the very beginning of this research, I did not consider myself disabled in any way, but for a period of time I became very ill with a neurological condition that heavily impacted my daily life, and restricted my ability to function for many months. During this time I did consider myself to be somewhat disabled, as I lost my ability to function at full capacity. My condition has not gone away, but has been controlled with medication for now, so that I can once again function almost as before. But this leaves me with the question of identity, where do I fit on the spectrum of disability? Am I an insider or an outsider to participants of this study? And which part of my identity makes me such? During my research trip to Cambodia in late 2022, my illness was generally well controlled and did not come up during discussions with participants, other than as passing interest in why I was studying disability. While in Rwanda in mid-2023 however, I was struggling with a side effect of my condition, which sometimes made it difficult for me to use my hands, and it was interesting to see how participants reacted to this. Towards the end of one in-depth interview in a rural area, a participant with a complex disability asked about my condition, and when I explained, she offered her condolences and said that we are all the same even if we look different. I found this to be so interesting as there were clearly many power imbalances between us, but at that time, all that mattered was the shared experience

of disability as a woman. So I came to view myself as both an insider and outsider to study participants, with many differences, but also certain important commonalities.

I also feel further compelled to acknowledge my position of power and privilege in this area. As a funded scholar from the Global North, I recognise the privilege this gives me, and how this, as well as my identities as a white, mostly able-bodied, European woman, change the power dynamics between the participants and myself. Power differentials are always inherent within the researcher/participant relationship, especially as the researcher is the one who will be determining the results of the study, while the participant is asked to share something of themselves often without any control over the outcome (Dodgson, 2019). It remains of great concern to me that this research be inclusive, empowering, and participatory, so as to minimise these power differences and to avoid any chance of my ideas as the researcher overshadowing those of the participants and local activists. Participants have been asked to feed into all parts of this study, and findings and recommendations are taken directly from data captured on the ground, so as to share knowledge as accurately and completely as possible.

Having understood the ontology and epistemology that I wish to use to underpin this research, I finally settled upon the more concrete philosophical perspectives that guide this project as a whole. These are intended to set out the assumptions that I made about my research, leading to choices that are applied to the purpose, design, and methodology of the research, as well as to data analysis and interpretation (Clark et al, 2021). In this regard I aim for my research to be both emancipatory and participatory, so that the women who participate feel some ownership over their stories, as well as feeling empowered by my research. Emancipatory research is generally described as a process of producing knowledge which will be of benefit to marginalised people. For this reason it has been common among feminist and disability scholars for many years, although it is not without critique.

Buettgen et al (2012) describe participatory research as consisting of the maximum participation of stakeholders, those whose lives are affected by the problem under study, in the systematic collection and analysis of information for the purpose of taking action and making change. This type of research, in a cross disciplinary

project such as mine, entails the establishment of a workable dialogue between the research community and participants in order to facilitate empowerment, and is rooted in the values of supportive relationships, social change, and learning as an ongoing process (Barnes, 1992; Scheyvens, 2014). This research, then, is participatory almost by default, as women and the disabled community were engaged at all levels to ensure that their experiences were accurately captured. While I recognise that this does not resolve the difference in power dynamics between the researcher and the participant, it is important that the latter feels some ownership over their stories, and can feed into the research process. These philosophical perspectives allow me as a researcher to view this study as a collaborative inquiry process with research goals that go beyond knowledge generation and into real-world impact, including conclusions and recommendations which can be used to create social change.

While it is beyond the scope of this study to claim co-creation or co-authorship with the women who participated in this study, participation and empowerment are central to this methodology. Through listening to participants, sharing direct quotes, and checking findings with communities, I have aimed for this study to be as participatory as possible. With this in mind, it is also important to acknowledge that this thesis could only partially give 'voice' to the participants, as it was written and compiled by me alone.

## 5.5 Research Methods & Tools:

As referenced in the theoretical framework, the field of disability studies has often been dominated by research which uses individualistic and biomedical approaches to data collection, which focus on specific lines of inquiry around the individual and their impairment. These studies most often use controlled experimental methods as the main means of investigation, and tend to exclude the type of intersectional analysis which allow women with disabilities to share their experiences and views.

This research instead utilised a mixed methods approach to data collection, recognising the value of both qualitative and quantitative data. Mixed methods

research is generally defined as 'research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study.' (Tashakkori & Creswell, 2007, p. 4; Fetters, 2020). Its emergence came about in response to the limitations of the sole use of quantitative or qualitative methods, and is now considered by many as a legitimate alternative to these two traditions. Mixed methods research is not restricted by the use of traditional approaches to data collection in the same way as these original methods, but instead it is guided by a foundation of inquiry based on the research area (Creswell, 1994; Clark et al, 2021). In this way, mixed methods researchers are often guided by pragmatism, which allows them to determine which methods and approaches will be best suited to answering the research questions. This pragmatic approach to research is informed by the belief that the practicalities of research are such that it cannot be driven by theory or data exclusively, and a process of abduction is recommended, which enables the researcher to move back and forth between induction and deduction in a process of inquiry (Morgan, 2007). While this pragmatism is seen as a weakness of mixed methods by some, I find it to be very appropriate for my study, as I aimed to explore different types of research questions, which could not be addressed using a singular method. To understand the lived experiences of women with physical disabilities in Cambodia and Rwanda, I needed to employ qualitative methods, in order to collect rich, descriptive data. On the other hand, outcomes relating to education and employment were best explored quantitatively, using closed-questions and statistics to illustrate the reality for many women in both countries. Thus I feel my research benefited from the opportunity to use a dynamic approach to address a complex and multi-faceted research problem.

Mixed methods research has been advocated for by authors based in both feminist and disability studies, suggesting that this method strengthens the external validity of the findings (Tracy & Sorsoli, 2004), adds weight to arguments, and gives voice to those who have been marginalised (Barnes & Sheldon, 2007; Scheyvens, 2014). The main benefits of mixing methods in the context of this research are triangulation, which allows for greater validity by seeking corroboration between quantitative and qualitative data; and completeness, whereby using a combination of research approaches provides a more complete and comprehensive picture of the study phenomenon, and provides a comprehensive answer to the research questions

(Doyle et al, 2009). This methodology is not without limitations, however, and these include needing functional knowledge of multiple methods, time-consuming research design and data collection, and sometimes complex data analysis. In my view however, these do not outweigh the capacity to answer complex, real-life research questions.

As mentioned above, a mixed methods strategy requires knowledge of both qualitative and quantitative methodologies, and so I detail my understanding of these below.

The primary method of data collection for this study was qualitative. I have chosen to collect data in this way because I am interested in understanding the lived experiences of women with physical disabilities in these two countries. According to Buettgen (2012), qualitative methods provide an opportunity for disabled people to articulate the issue under study and describe problems and experiences in their own words. These social worlds of women with disabilities are therefore best explored through qualitative means, which allow for the generation of rich data, and allow participants to speak freely about their own experiences, and the issues that they see as important (Clark et al, 2021). As well as this, qualitative research can be highly creative and participatory, allowing for a rebalancing of power between researcher and participants by conducting studies 'with' rather than 'on' participants (Clark et al, 2021).

For this research, data was mainly collected through semi-structured interviews and focus group discussions, and all of the data was recorded and stored on KoboToolbox (a well-known data collection software in the humanitarian sector) because responses can be saved offline, and the software works across both computers and phones. Semi-structured interviews included both women with disabilities (referred to as in-depth interviews) and key informants as part of this study. These methods are widely used in qualitative research, and allow the researcher to enquire openly about the situational meanings or motives for an action or statement, as well as allowing for deeper discursive understanding through the participants' direct interpretations of his or her own experiences (Hopf, 2004).

In the early stages of this research, I considered using phenomenology as a qualitative research tool. This method seeks to explain the nature of things through the way that people experience them, and to gain insight into the experiences and feelings of a specific audience in relation to the phenomenon being studied (Clarke et al, 2021). While this is a useful tool, and aligns with many of the objectives of this research, I ultimately decided not to utilise it, due to limitations in time and access. In my opinion, for this study to truly utilise phenomenology, I would have had to spend a great deal more time observing and interacting with participants, and to gain access to more of their personal views. It is for these reasons that I chose to focus on interviews and discussions.

As a feminist researcher, it was important to me that the participants involved in this research felt ownership over their own narratives, and were able to speak freely about their experiences. I felt that semi-structured interviews provided the best avenue for this, while still allowing for focused, productive discussions, which were used to inform recommendations later in this study. The bulk of these interviews comprised in-depth interviews with women with disabilities themselves, but also included semi-structured interviews with key informants in both countries. These strategically important individuals informed much of my cultural awareness during research trips, and provided me with an insight into the NGO and disability sectors in each country. I also acknowledge that there are some weaknesses to these types of interviews, including that the categories of enquiry chosen by the researcher may not reflect local understandings, interviews can be very time consuming, and can place a burden on interviewees (Mazmanian et al, 2013).

Focus group discussions were also utilised during this study, to supplement the data gathered in individual interviews. The interactive, fluid nature of focus group discussions, which do not follow the predictable question-answer pattern of interviews, often allows researchers to gain a more nuanced understanding of topics than they would through other methods (Clark et al, 2021). I have chosen focus groups to inform this research, as I was interested in creating an environment where participants were able to express their beliefs and perspectives about gender and disability, which may have been considered taboo in other settings. Focus groups are also useful for promoting dialogue, where participants are able to transform

social knowledge into action when they share ideas, and these discussions thus informed the recommendations of this research. Focus groups also provided space for participants to meet and come together to learn from each other, as well as to share their thoughts and ideas about the topic. As such, both focus group participants and the researcher gained knowledge and social resources by having an opportunity to meet and hear from other disabled people who wanted to work together for action and change (Partington, 2005).

On the other hand, focus groups rely heavily on assisted dialogue to produce results, and therefore the quality of the data depends on the skill of the moderator. There are also issues of dominant voices talking over the rest of the group, and the difficulty with getting honest opinions on sensitive topics in these group settings. In all cases, the moderator is key, so I as the researcher had to become skilled in facilitating these groups (Smithson, 2000).

In order to generate a full and contextualised understanding of disability in Cambodia and Rwanda, quantitative methods of data gathering were used mainly to build up a background on disability in both countries, as well as to support qualitative findings. Census data on disability in both countries, as well as data gathered during my research on rates of employment, income, years of education, and other quantifiable variables were used to complement the qualitative data above, and provided a deeper understanding of the lives of women with disabilities in both countries and the discrimination they face. Quantitative methods tend to ensure that data is reliable and verifiable, as well as more objective than qualitative methods. This 'hard data' was easily compared across countries, showing differences in the lives of women on easy-to-read graphs and tables. I recognise that quantitative research is generally not the norm in either feminist or disability studies, where qualitative methods which emphasise the reflexive, subjective nature of human experience are often favoured (Tracy & Sorsoli, 2004). However, increasingly, authors in both spheres are calling for creativity on behalf of researchers, and neither discipline should shy away from quantitative research, as 'it is not the use of a particular method or methods which characterises a research project as feminist, but the way in which the methods are used' (Letherby, 2003, p. 81).

The specific quantitative methods I have chosen for this research are analysis of secondary data and structured interviews. In order to conduct an analysis of secondary data, I employed content analysis to examine census data collected in Cambodia and Rwanda, as well as lists of registered NGOs working in both. Through census data I also explored the types of data being collected on disability, the way this data is collected, and the findings from both surveys. I have also chosen to work through the lists of NGOs in both countries to understand how many of them work with people with disabilities, the types of programmes they run, and what their overall engagement with the inclusion agenda looks like. A summary of the findings from my content analysis is available in Annex 12. This methodology gave me a broad overview of the disability landscape in both countries, providing a background both in terms of prevalence and types of disability in Cambodia and Rwanda, but also in the political will that exists in both countries to collect data on people with disabilities and to assess their needs. I have therefore chosen this method because it can be used to generate a nuanced understanding of my research area in context. Additionally, by examining some of the main statistical work on disability at a national level, I was able to better understand the figures which underlie the attitudes and beliefs that surround disability. Some authors would argue that content analysis is not sufficiently quantitative in nature, or that it is too simplistic and does not lend itself to detailed statistical analysis (Morgan, 1993; Krippendorff, 2018). I found it to be appropriate for this research as I am not aiming to conduct detailed statistical analysis, but to use quantitative data as a backdrop against which to view my qualitative findings. I also found content analysis to be useful for disability research due to its content-sensitive nature, which allows for in-depth exploration of specific topics, making it useful for a comparative study (Creswell & Clark, 2017).

I also made use of structured interviews as part of this study, which enabled the interviewer to ask each respondent the same questions in the same way. Questions in this style of interview are planned in advance, and are often closed-ended - asking the respondent to choose from a list of answers. Despite being similar in methodology, I have chosen this method of interviewing over questionnaires because an in-person interview is generally more accessible for women with physical disabilities - who may often be illiterate - than a written questionnaire, and I feel it is important that there is some trust built up between the researcher and the participant

before the interviews, which simply cannot happen in the same way with questionnaires. The structured interviews were not separate from the semi-structured (in-depth) interviews with women with disabilities described in the qualitative methods, but instead formed two halves of the same interview, thus giving me a well-rounded picture of the experiences of each participant. Structured interviews are useful in quantitative research as they tend to be very precise and reliable, and usually promote standardisation of both the asking of questions and the recording of answers. This standardisation in approach means that any variation researchers find in the answers of interviewees is a true variation, and not an error due to the way a question was asked or coded (Clark et al, 2021). Structured interviews offer a rich and comprehensive view of an issue, while still being comparable and easy to repeat, making this process useful for comparative research. At the same time, I recognise that there are disadvantages to this type of interviewing, including that the respondent is limited in the responses they can give, the likelihood of acquiescence, and that the researcher needs to be skilled in the facilitation of these interviews (Clark et al, 2021). These are all valid critiques, and form part of my reasoning for choosing a mixed-methods study.

## 5.6 Target Population & Sampling Approach

This research aims to understand the lived experiences of women with physical disabilities in Cambodia and Rwanda, especially as they relate to livelihood opportunities. My approach to research therefore was not to export knowledge from the Global North to the Global South or vice versa, but instead to listen to indigenous knowledge, and to share this with a wider global audience, thus avoiding the types of epistemic injustice described by Tremain (2017). My goal was to learn about culturally appropriate, collaborative approaches to disability inclusion that could lead to better outcomes for women with disabilities in Cambodia, Rwanda, and beyond.

In order to gather empirical evidence in collaboration with women with disabilities themselves, my study drew from a relatively narrow target population of women with physical disabilities, who are of working age, and live in urban and suburban areas of Siem Reap, Cambodia and Kigali, Rwanda. Other participants also included 'gatekeepers' and advocates in the disability space, such as NGO and DPO staff,

religious leaders, community chiefs, local researchers, and government officials. I have chosen to sample from this population because there are very few studies on gender and disability which actually take into account the views of this population, especially in the context of the Global South, and I believe that these women know their needs best, and have valuable knowledge to share. Additionally, adding advocates, NGO workers, and others involved in the disability sector into my sample gave me a broad understanding of the context of disability and international development in both countries, and was useful for planning recommendations. This sample does not aim to be representative of the views of all women with disabilities, but rather to explore the issues as they appear in these particular contexts. Criteria used for the inclusion of participants in this research were: identify as female, consider themselves to have a physical disability (for interviews specifically), between the ages of 18 and 65, living and/or working in suburban areas of Siem Reap/Kigali and involved with a DPO, able to give informed consent. This excluded women with psychosocial or developmental disabilities, and those who could not give informed consent on their own behalf from my research, due to concerns around safeguarding.

Initially, through contact with local NGOs and DPOs as 'gatekeepers', I used purposive sampling to select women to participate in this research based on the kind of information they were able to provide in each country. This sampling approach allowed for members of the sample to differ from each other in terms of key characteristics including age, nationality, impairment, and job type, while still sharing key life experiences relevant to this research (Clark et al, 2021). Following this, once sufficient differences between initial participants had been established, I then used snowball sampling, as participants and organisations referred others through word of mouth, and the sample grew from there.

The purpose of both the qualitative and quantitative data in this study is to gain a deeper understanding of the lived experiences of women with disabilities in both countries, and to highlight any commonalities or differences in their lives, therefore the sample is not representative, and is not statistically significant. Focus groups - drawn from the community surrounding women with disabilities including DPO representatives, NGO workers, advocates, scholars, community members etc. -

comprised 2 groups of up to 10 participants each, in both countries, for a total of 20 participants. These focus groups were intended to provide me with a broad overview of the context of working in disability and development in each country, as well as getting those involved in the disability sphere thinking creatively about the problems they currently face, and how to solve them. These were supplemented with 12 semi-structured key informant interviews in each country as mentioned above, with participants ranging from religious leaders and NGO staff, to government officials and community members. While in each country, I also conducted 16 individual interviews in Cambodia, and 20 individual interviews in Rwanda. The reasons for this discrepancy in numbers are described in more detail in the limitations section, but relate mostly to difficulties with accessing participants in Cambodia. While answers to certain questions began to repeat at this point, with over 35 interviews conducted, I was and continue to be more interested in the diversity of women's stories and life experiences, rather than data saturation. The purpose of these in-depth interviews was to gain insight into the lives of women with physical disabilities, and to give them a platform to speak about issues that they see as important.

According to French (1992), collecting data on people with disabilities can distort the meaning of disability, as well as oppressing the very people the research is trying to help, if the research is not carefully planned and designed. As exemplified by the census data from Cambodia and Rwanda in Chapter 4, the criteria and definition used to define disability dictate the prevalence of disability found in any given study. Considering earlier statements about this research utilising a process of moving back and forth between induction and deduction, I therefore based my study on the CRPD definition of disability, while also recognising that there are regional differences in interpretations of the concept of disability. French (1992) also points out that the way questions are posed by the researcher have an impact on the types of data that is recorded, citing the example of questions asked in terms of 'what people cannot do' rather than how society can adapt. This serves as an important reminder of the use of the social model in formulating questions for interviews and focus groups, as well as the importance of working with local DPOs and advocates to ensure that questions are culturally appropriate and useful (Scheyvens, 2014). For this reason I have chosen to engage with local DPOs in both countries at all levels of planning, field work, and analysis of this research.

As well as this, examining the similarities and differences between empirical evidence collected in two countries in this way allowed me to draw conclusions and make recommendations about the importance of cultural context in the disability movement and how best to support women with disabilities. Cambodia and Rwanda were selected as focus countries because they both have comparable rates of disability among populations, as well as having governments which show strong political will towards women and people with disabilities through commitments made in laws and policies. Further to this, both countries have well developed networks of NGOs working both locally and internationally, and are relatively similar in terms of broad economic development. Finally, both countries suffered recent national tragedies, which have influenced the culture and attitudes of the populations, as well as contributing to a rise in the proportion of each population living with a disability.

## 5.7 Research in Action: Access, Recruitment & Data Collection

In order to properly compare the intersectional relationship between gender and disability in Cambodia and Rwanda, the same research procedure was followed during research trips in both countries. Gender and disability are sensitive topics in both cultures, and the nature of power dynamics between a researcher from the Global North and participants from the Global South meant that it was important for me at all times to be respectful, and sensitive in nature, regardless of whether I agree with the patriarchal norms and standards of these societies or not.

Trust and understanding are extremely important in both Cambodian and Rwandan societies, so prior to research trips, and in the first few days in both countries, I devoted significant time to meeting informally with NGO and DPO representatives, local advocates, and key informants, who acted as gatekeepers in helping me to access populations of women with disabilities. These informal meetings were invaluable in building up trust and rapport with organisations, which both contributed to the findings of the research, as well as provided me with access to other participants. In order to facilitate open sharing, I regularly met with these organisations, as well as maintaining communications about the research through

email, whatsapp, and calls. These relationships and open lines of communication proved to be key to accessing participants, as well as holding me accountable for correctly interpreting their stories. Women with disabilities who volunteered to be interviewed were in all cases introduced by these gatekeepers, and in many cases, interviews took place on the premises of DPOs themselves, facilitated by local staff. While I made an effort to learn both Khmer and Kinyarwanda in order to be able to communicate respectfully with participants, I also relied on local translators in both countries, so that participants could communicate clearly, in their own language. In Rwanda, where two deaf women volunteered to participate, my translator was also able to act as a sign language interpreter. Ideally, translators would have been female in both countries, but due to issues with availability and quality, this was not possible in Cambodia. At the beginning of each interview and focus group, participants were given an information sheet, which was also clearly explained by me via the translators. Each participant also signed a consent form, or recorded verbal consent, and agreed to be voice recorded for the purposes of data processing. To make participants more comfortable, I started the interviews with an informal chat, and an introduction to me and the research. Participants were given time to ask any questions they might have, and were reminded that they are free to withdraw at any time.

The first research trip to Cambodia took place between the 13th September and the 12th December 2022, and the second research trip to Rwanda took place between 29th May and 3rd July 2023. Research in Rwanda was shortened following lessons learned in Cambodia, and due to research permit restrictions, which are discussed in more detail in the limitations section. In total I conducted 36 in depth interviews with women with disabilities, 2 focus groups totalling 20 participants, and 24 key informant interviews.

This research was conducted in two distinct phases; the first taking place in Ireland, and encompassing all of the background work needed when undertaking fieldwork abroad, and the second involving travelling to both countries to carry out this field work in person. As mentioned above, fieldwork in Cambodia took place more than 6 months before fieldwork in Rwanda, however, during phase 1, I decided to undertake all of the preparation and planning at the same time (except for the language classes

and visa applications), as if the trips were happening concurrently, so as to standardise the process as much as possible, and so that I could accurately draw comparisons during content analysis. The long break between fieldwork was also necessary for me as a researcher, due to the reverse culture shock I experienced upon returning from Cambodia. This is explored in more detail in the reflections section.

## Phase 1 – Preparation

During the first phase of research, before leaving Ireland, I first sought ethical approval for this study from the committee at the University of Galway. Once this was granted, I then began the process of creating sample interview and focus group guides, in order to standardise procedures across both countries. I uploaded the final drafts of interview guides to Kobotoolbox while still in Ireland, so that the questions would be accessible offline, and on different platforms including my laptop, and phone. This was an extremely useful way of gathering data, and allowed me to keep all my findings in one secure place during my travels. During this time I also created and translated materials including consent forms, information sheets, and protocols, as well as planning logistics for both trips, and taking formal classes in both Khmer and Kinyarwanda respectively before each trip. I spent many months making initial contacts in NGOs and DPOs in both countries, and building up an initial rapport with gatekeepers by email and video call during this phase, which helped enormously in facilitating the second stage of my research.

Practically, it was very important for me to secure the correct type of visas/permits to allow me to conduct this research properly and legally, so much of this preparatory period was spent obtaining the necessary documentation for these. For Cambodia, this was relatively straightforward and involved obtaining a category E visa once I arrived in the country, to allow me to work and study there for a period of 3-months. It was, however, not easy to access this information, and I made many phone calls to the Cambodian Embassy in London, as well as requesting help from local contacts. The process was even more difficult in Rwanda, and at one point I considered abandoning this portion of fieldwork entirely, due to bureaucratic issues. Over a period of around 2 months, I applied for and received letters of introduction from 3

different INGOs, ethical clearance from the National Ethics Committee in Rwanda, and finally a Research Permit allowing me to stay for up to 2 months. Difficulties with this permit are explained in more detail in the limitations section, but these logistical issues formed a considerable piece of work during the preparatory phase of fieldwork.

At this stage I also started my content analysis of census data and NGO coverage in both countries, in order to understand the context and background in which I would be working. During this desk review, I explored in depth the types of data collected by both governments on disability, as well as the numbers of NGOs working with people with disabilities, or actively promoting inclusion. Understanding this data before undertaking fieldwork provided me with a clearer picture of the disability landscape in each country before leaving Ireland, and also helped me to understand the culture surrounding how people with disabilities are treated in Cambodia and Rwanda. Finally, as a last step before undertaking fieldwork, I worked with key contacts from DPOs in both Cambodia and Rwanda to revise interview and focus group guides, to ensure the questions I was asking were appropriate, and that there were no issues with accessibility.

## Phase 2 – Fieldwork

While the same fieldwork procedure was followed in both countries, practical and cultural differences meant that each trip differed slightly in layout.

### *Cambodia*

On arrival in Cambodia I immediately made appointments with key informants from strategic local and international NGOs, to understand more about the NGO framework in Cambodia, and to explore the possibilities for inclusion in different sectors. Using connections made during Phase 1 of the research, I was quickly able to meet with key actors from these international NGOs, local DPOs, and advocates. These included initial meetings with organisations such as SeeBeyond Borders, Landmine Relief Fund, PEPY, AGILE, and the Women's Resource Centre, among others. As well as teaching me about the culture and attitudes towards disability in Cambodia, these actors also served to refer me on to other organisations,

individuals, and groups who were interested in participating in my research, and in this way the sample continued to grow and widen.

This phase of data collection was difficult for me, as making connections was not always easy in the Cambodian context. Informants were always warm and welcoming of me, but the pace of work is slow, emails often go unanswered, and culturally it is very difficult to get a solid answer out of people. This led to many miscommunications and frustrations, and was quite difficult to navigate as a solo researcher. I describe this more in detail in the limitations section, but research progress stalled for a number of weeks between first arriving in Cambodia and making significant progress in interviews, due to these logistical challenges, and continued in this stop-start fashion throughout my field work.

Following the first key informant interviews, I was introduced to some local women with disabilities who were interested in sharing their stories with me. These types of interviews took place over the full course of my time in Cambodia, and generally lasted between 30 and 45 minutes in length. Originally I had scheduled for the interviews to be longer, but because most of the women who participated in interviews had work and family commitments, and interviews normally took place during the week, the shorter interruption to their work day was appreciated. I also chose to omit some questions which I had included in the test questionnaires, for the sake of brevity, but also because in reality, some of the questions did not feel completely relevant or insightful given the circumstances. I also chose to remove more theoretical questions about things like aspirations and role models, because these did not translate well into Khmer, and were not properly understood by participants. I have attached the final interview guide in Annex 2, and used the same questions in both Cambodia and Rwanda. Interview participants generally fell into the category of physically disabled, but some identified as having multiple or complex impairments, and others were unsure if their impairment was 'severe enough' to be included in my study. This spectrum of disability added complexity and weight to my study, as women with diverse experiences shared their views with me. Interviews took place wherever participants felt most comfortable, for example in their homes, workplaces, community centres, or the home of a friend or relative. I always travelled with my translator, and introductions were usually made by a key

informant who knew the participant well. Some participants felt more comfortable having a friend, family member, or key informant sit in on the interview, and in this case the other party was asked not to intervene in the interview, except to clarify translations. At the end of each interview participants had time to ask any questions they had about the research, and many took the time to simply enquire about me and my life, leading to informal conversations often ending interviews. Before leaving, I thanked participants for their time, ensured they knew how to contact me in case they had any questions or problems with participation, and provided each woman with a small token of appreciation which I had brought with me from Ireland. These interviewees and key informants then referred me to other women with disabilities and organisations working with people with disabilities, and in this way the sample continued to grow.

Once relationships had been established with a number of local and international organisations, I organised a focus group discussion with 10 participants from diverse civil society organisations in Siem Reap. These included DPOs, advocates, INGOs, and people with disabilities themselves, as well as a translator. Discussions were moderated and followed the interview guides as closely as possible to prevent conversations from going off topic, but participants were invited to speak freely about whatever they felt was relevant. These discussions were very productive, and provided a wealth of information about attitudes towards women with disabilities in Cambodia, as well as the culture of the NGO sector itself. Participants also reported finding these discussions useful for the sharing of new ideas, and as an opportunity to network between organisations. I had hoped to host at least one more focus group during my time in Cambodia, to capture the views of a wider array of organisations, but as mentioned earlier, the logistics of contacting organisations and having them honour commitments proved too challenging.

In the final stages of this field trip, I conducted the rest of the interviews with both women with disabilities, and key informants, to gain a more complete understanding of how gender and disability intersect to create disadvantage in Cambodia. These final key informant interviews included DPOs like KILT and Grace House, a senior monk from a local pagoda, local disability advocates, and INGOs including APOPO and Oxfam. Through these contacts and those made previously, I carried out the

remaining interviews with women with disabilities in the same manner as those conducted previously. While I had hoped to reach 20 in-depth interviews in Cambodia, this was not possible due to limited access to participants, and difficulties with contacting organisations. Before leaving the field, I scheduled debriefing sessions with key organisations to inform them on the next steps of my research, as well as to create a kind of exit strategy, so that participants could be kept up to date with the research progress, and feel as though they had ownership over the narratives they had shared with me.

### *Rwanda*

While the same research process was applied in Rwanda, some logistical changes needed to be made to the existing framework, to facilitate the more organised and centralised civil society sector in Rwanda. Since this fieldwork trip was my first time in Rwanda, I thought it was important for me to first visit some of the country's genocide memorials and museums, to help me to understand the history which informs much of modern-day Rwanda. Following these visits, I once again met with strategic key informants from local DPOs and INGOs in order to better understand the functions of the sector, and to develop a broad understanding of disability in the Rwandan context. Partner organisations like Trocaire, NUDOR, and UNABU were invaluable in helping me to settle into the country, and in introducing me to the attitudes and beliefs which surround disability in Rwanda. These organisations were extremely knowledgeable and happy to share information. Thanks to the government-led inclusive agenda, civil society is very well organised here, so I found it relatively easy to schedule meetings and calls, and organisations were happy to refer me on to others, as well as to facilitate in-depth interviews. Because of this, fieldwork moved quickly, and early in my trip I had most of my interviews scheduled for the following weeks.

As described in earlier chapters, trust is extremely important in Rwandan society, and the preparatory work carried out before these fieldwork trips was invaluable in establishing relationships with gatekeepers, and subsequently gaining access to women with disabilities themselves. In this context, even more so than in Cambodia, it was important for me to take the time to informally meet with key informants and

gatekeepers, in order to establish trust and mutually beneficial relationships. Once these trusting relationships had been established, I was granted easy access to a wide range of participants for interviews.

Under the guidance of NUDOR, UNABU, and Talking Through Art, I organised interviews with 20 women with diverse impairments throughout my time in Rwanda. All of these interviews were assisted by a female local translator who travelled with me to interviews, and also acted as a sign language interpreter. Interviews followed the same format as those in Cambodia, and I used the same finalised interview guides, making sure to omit the same questions as I had chosen to remove in Cambodia. Again women were mostly living with physical disabilities, but here I found more women to have complex impairments as well as to have multiple disabilities, which sometimes included both mental and physical impairments. Here again, the process of establishing trust was more pertinent than in Cambodia, and during interviews I took more time to explain my own background and the intended outcomes of my research to participants, as some women were slower to open up to me, and were sceptical of my motives for conducting research. It was also more difficult to provide privacy for interviewees in Rwanda, because of the density of population in urban and suburban areas. As a work around to this, interviews took place at the offices of DPOs and local government, in community gardens, at the workplaces of participants, and even in my car. In contrast to Cambodia, here participants preferred to conduct interviews on their own, and did not request to have anyone else accompanying them. Participants were often shy and quiet in the initial stages of interviews, as Rwandan culture dictates that women should be demure and retiring, so I often asked my translator to informally chat with them before commencing interviews, to calm their nerves and reassure them that this was a safe space. Even after this, some women barely spoke above a whisper and never made eye contact with me or my translator. Despite this quiet demeanour, the women with disabilities I spoke to were extremely keen to share their stories, and when asked for their opinions, were happy to share their thoughts and feelings with me. Many expressed thanks for allowing them the chance to talk, and felt happy that their voices were being heard. At the end of interviews, participants had time to ask questions and share feedback with me, and each participant was given an envelope containing FRw 10,000 (around €7) to cover their transport fees.

Around halfway through my fieldwork in Rwanda, I organised a focus group discussion with 12 participants from diverse civil society organisations including Trocaire, VSO, Concern, UNABU, NUDOR and Human Rights First Rwanda. Discussions were guided using the same format as in Cambodia, but I felt that organisations were more engaged and more active in their participation here. Similarly to Cambodia, the organisations involved here taught me valuable lessons about attitudes towards disability in the Rwandan context, as well as the significance of the government in this sphere. Organisations also reported getting value out of the session in terms of both learning and networking. I chose not to run a second focus group in Rwanda, as to do so would have muddied the comparability of my data with Cambodia, and I also felt that the diversity of voices in this group yielded significant data in itself.

Instead, I sought more meetings with key informants to round out my understanding of gender and disability in the Rwandan context, while at the same time finishing my interviews with women with disabilities. These final meetings with key actors like NUDOR, Humanity and Inclusion, Human Rights First Rwanda, and Disability Rights Fund, as well as those in the wider community like local government officials, religious leaders, and advocates, provided me with a more complete understanding of the intersection between gender and disability here, as well as the wider cultural context. Due to the responsiveness and wide-reaching connections of the organisations I engaged with while in Rwanda, I actually had more participants for interviews than I was able to accommodate, again to try to keep the sample comparable with Cambodia. Where women with disabilities wanted to participate but were not able to, I asked organisations to share the initial findings of my research with them, so that they still had a chance to share their views with me, and to feed into the findings of this research. Before I left Rwanda, I provided a debrief to organisations, and outlined plans for the future of this research, letting them know where to reach me if they had any further queries or comments.

The final step of fieldwork came after the findings chapter was drafted and re-written at home in Ireland. At this point I drafted short versions of findings from both Cambodia and Rwanda which were sent back to those key organisations I worked

with in both countries, to allow them and the women I interviewed, to review what I have written, and to provide me with any feedback and comments they may have. These were then taken into account in the final write up of the findings chapter. As well as this, I have been sharing the initial findings from my research, as well as some of my methodology, with a wider audience through publishing in academic journals, presenting at conferences and workshops, and giving lectures in Irish Universities.

## 5.8 Analysis

While choosing to carry out a mixed methods study meant that I had both qualitative and quantitative data to analyse, my quantitative data represented a smaller and more manageable dataset, so I chose to work through this first, to get a feel for my analysis, and to frame the context of the study. I entered data from the structured parts of interviews into an excel sheet for statistical analysis, and measured basic frequencies to describe the sample, as well as measuring self-reported indicators of poverty like income, education, and exploring participants' experiences of support through disability. I then compared these basic descriptions of my sample with census data from both countries, to gain a wider perspective on disability in both countries. Through content analysis, I also explored the civil society space in both countries to understand the size and relative inclusiveness of these sectors, with a view to understanding how they can better support women with disabilities.

During the initial phase of sorting, cleaning, and transcribing both qualitative and quantitative data, I kept a hard-copy notebook to write out initial codes as they appeared, which allowed me to familiarise myself with my data, and ease me into the process of coding. This initial method involved keeping notes alongside data, which were eventually refined into codes. I then reviewed my codes in relation to my transcripts and notes, to condense my ideas and solidify connections between codes. In this way themes emerged naturally from both qualitative and quantitative data, and also allowed me the freedom to continuously reflect on and refine broad concepts and ideas as referenced by participants themselves. With this strategy in mind, I then worked to integrate more general theories and concepts into my codes,

so that I could give meaning to the data that I had generated, and then sort these into coherent and consistent themes and sub-themes which could eventually be compared between countries.

Once I became very familiar with my data, I was able to reflect on those general categories of themes and sub-themes, and work through a framework approach to thematic analysis with my qualitative data. This allowed me to identify patterns and connections between categories, and to delve deeper into the material. Taking my in-depth interviews at first, I constructed an index of recurring themes, which I displayed in an excel spreadsheet, separated into Cambodia and Rwanda. I then analysed each interview with reference to this spreadsheet, manually copying brief excerpts from the data into the corresponding cell, while also making sure to keep the language of participants as much as possible. During my initial and subsequent coding of these interviews, I was particularly looking out for repetitions of ideas or references, descriptions of lived experiences, and similarities and differences both within and between countries. By considering these narrative aspects, alongside my research questions, I was able to populate the framework with relevant qualitative data. I chose the overarching themes of attitudes towards disability, opportunities, identity, and supports, as these were the categories of ideas that were most referenced in interviews, but also the things that participants felt most strongly about in their daily lives. As well as this, these broad themes allowed for a wide-ranging comparative analysis across both countries, as participants expressed diverse views about each idea. With this framework in place, I continued to analyse and re-code interviews until I came to a satisfactory level of analysis. I then applied the same method to the notes I had taken from focus group discussions and key informant interviews, to add excerpts of these into the framework, finally leaving me with manageable data from both countries which I was able to compare and contrast under themes and sub-themes.

Barbour et al (2023) propose that flexibility in data analysis is a central aspect of inclusive research, and serves as a way to resist ingrained ableist structures and traditional methods which sometimes do a disservice to people with disability. For my analysis, I felt that my research was very personal to the women who shared their stories with me, and therefore my analysis carried a lot of weight. It was for these

reasons that I chose not to use software such as NVivo, although this was available to me. After testing out this software, I chose to manually code hard-copy transcripts and notes in different colours instead, as I felt that I could get a better sense of the context of the data when taken in hard copy, and I also had more freedom to make notes on my own transcripts, especially when coding excerpts for more than one theme. In this way I was able to consider the text as a whole when deciding on how to code each excerpt, rather than just focusing on one code at a time, which may risk losing some of the wider context. I also found it useful to be able to look at each interview transcript and note from meetings and interviews, and immediately see which themes and sub-themes were the most frequently referenced, and where the ripest data for comparison was likely to be. While this approach was undoubtedly more time-consuming and labour-intensive, I found it to give me a deeper contextual understanding of my data, and helped me to 'humanise' this phase of analysis so that I could remember each of the women who told me their stories.

I would not consider this research to be fully co-designed with participants, due to the fact that I as a researcher made most of the important decisions about research from the outset, including locations for research, methods to be used, and sample sizes, co-design certainly played a role in the analysis phase. The principles underpinning co-design are based on the idea of setting research agendas in collaboration with people with disability, strengthening research quality, and ensuring the outcomes remain central to people's priorities and interests (Barbour, 2023). It is this final piece, about ensuring that outcomes are relevant to participant's priorities, that most struck me. Therefore, as a final step in analysing my research, I drafted short versions of the findings from both Cambodia and Rwanda, and sent these documents back to all of the organisations that I worked with in both countries for review. I felt that this was an important step in continuing the participatory process of my research, and therefore asked each organisation if my interpretations of participants' stories were correct, and complete, and if they felt I was missing anything. Some, of course did not reply, but many organisations did, and gave some suggestions on clarifications and other points to include. I was heartened to read that many felt that what I had written was an accurate reflection of the situation of women with disabilities in their countries, and that they felt that my research was useful and authentic.

## 5.9 Research Ethics

Ethical considerations are particularly important to this research, as women with disabilities are often considered to be a vulnerable population. Therefore, it was my responsibility as a researcher to ensure the safety and well-being of participants throughout the study. Ethical approval was granted by the University of Galway research ethics committee as a first step to this research, and subsequently also obtained from the National Council for Science and Technology in Rwanda. This ethical clearance at country level was not needed in Cambodia, as no such body exists in the country.

The ethical guidelines used for this research explain that vulnerable research participants should receive special attention as they experience heightened stigmatisation, limited power, lower education, increased poverty, limited resources, and may be at risk of being exploited or harmed during research (WHO, 2016). Given their marginalisation and vulnerability in Cambodia and Rwanda, researching livelihood opportunities for women with physical disabilities challenged me to account for extra ethical considerations, as well as those that I would normally use. As with most research projects, informed consent, confidentiality, and conflict of interest were central to this research.

Informed consent, in the context of research, is described as a 'voluntary choice ... based on sufficient information and adequate understanding of both the proposed research and the implications of participating in it' (Xu et al, 2020, p. 2) This kind of informed consent is an ongoing process between researcher and participant, where a rapport is formed and information is continually passed back and forth as trust is formed. As previously described, this process of building trust was fundamental to the data collection phase of my research, and took up a significant portion of my time. In order to make this research inclusive and accessible to women with physical disabilities, informed consent was gathered in the local language (either Khmer or Kinyarwanda) through the use of a local translator, and printed consent forms, and information sheets in these languages and in large print were provided to all

participants. Through the recruitment process and the use of DPOs as gatekeepers, participants were informed about the research in advance, and had access to the researcher and supporting organisations, to facilitate any questions or concerns. Before the interviews took place, the structure and purpose were explained again, and participants were asked to sign a consent form. As some of the women participating in this study were deaf/blind and/or illiterate, my translator and I also provided the option of having materials and consent forms read out, where recorded verbal consent was obtained instead of written consent. Interviews were recorded, in order to facilitate transcription, and consent was obtained from participants prior to starting audio recordings of all interviews, where participants were free to decline.

Participants were also free to withdraw from the study at any time - without giving a reason, and without consequence - or to speak off the record should they so choose. Participants were provided with links to support in their community, such as counselling services and local women's refuge centres through key contacts in the DPOs who facilitated interviews. Because this research was centred around these DPOs in both countries, they formed vital links between the researcher and participants, and performed the role of gatekeepers, intermediaries, and facilitators in these interviews. These DPOs were also involved in seeking consent from local community chiefs/elders to carry out this research, so that women felt safe in their involvement, and so that the research could have longer lasting effects on communities.

Confidentiality and anonymity in research are closely linked with privacy, and involve whether or not individuals are identifiable in research, either explicitly or through deductive disclosure. Given that qualitative studies often contain rich descriptions of study participants, qualitative researchers often face a conflict between conveying detailed, accurate accounts of the data they collect, and protecting the identities of the individuals who participated in their research (Kaiser, 2009). Anonymity and confidentiality were maintained in this study by giving each participant a study number, through which their data was anonymised. Pseudonyms were used where necessary, and any identifying characteristics which were not relevant to the research were changed during data processing. Participants were also asked to feed into the data analysis and write up stages of research, to ensure that they were

satisfied with the level of confidentiality given to them. This research also took place in Siem Reap in Cambodia, and Kigali in Rwanda. These are large urban and suburban areas in both countries, and therefore allowed for greater anonymity of participants. Translators used in both countries were asked to sign a non-disclosure agreement before working on this study, in order to maintain confidentiality within the research team.

Anonymised data is stored securely and encrypted in the University of Galway microsoft cloud storage, as well as on an encrypted hard drive, and originals were destroyed, so that they cannot be traced back to individuals. Recordings of interviews were dated and named according to study numbers, before being cleaned to remove identifying characteristics through editing software. These were then stored and encrypted in the microsoft cloud system, as well as on the encrypted hard drive, and the originals were destroyed. Some of the data generated may be of interest to other researchers, and as such will be made available through the university's publication repository, as well as in open access journals. Paper files are kept in a locked filing cabinet in the researcher's home office, and only the researcher holds the key. These will be destroyed after 7 years in accordance with GDPR requirements.

Conflicts of interest occur in research projects when researchers have coexisting personal, financial, political, and academic interests and the potential exists for one interest to be favoured over another that has equal or even greater legitimacy in a way that might make other people feel misled or deceived (Given, 2008). Qualitative researchers often use the term to describe a conflict of role where their relationships with research participants involves multiple roles as researchers as well as teachers, clinicians, activists, colleagues, or friends. This can occur whenever researchers are embedded in research sites, especially in action research. In managing conflicts of interest in this research, I maintained open and ongoing discussions with all stakeholders about my role and my intentions for this research. This included frequent contact with my institution, supervisor, funding body, mentors, participants, and host organisations in each country.

As well as these ethical concerns that underpin every research project, I was also guided by The Global Code of Conduct for Research in Resource-Poor Settings (The Code) (TRUST, 2018), and Ethical Guidance for Research with People with Disabilities (Ethical Guidance) (NDA, 2009). The Code aims to foster research partnerships between higher-income and lower-income settings in fair and mutually beneficial ways. It highlights the considerable imbalances of power, resources, and knowledge that often accompany research in the Global South, and aims to rectify these through a framework based on fairness, respect, care and honesty. This research was guided by many of the articles contained in this Code, but especially those related to the participation of local communities, respect for cultural sensitivities and community assent, and honesty throughout the research process. As well as the good practice principles set out in the Ethical Guidance, my research was further guided by the core values set out in this document. These included promoting the wellbeing of those participating, involved in or affected by the research process; and respecting the dignity, autonomy, equality and diversity of all those involved in the research process. On a practical level this meant making reasonable accommodations for participants wherever possible, including scheduling interviews at a time and place most suitable to them, allowing for sign language interpretation or on-line interviews, preparing large print materials, and providing water and tissues to make participants comfortable.

As mentioned above, I needed to hire others to assist me during my research in both countries. These included a driver, a translator, and a sign language interpreter. These local assistants were recommended to me by contacts in NGOs and DPOs, and took part in a sensitisation meeting with me prior to commencing work, to understand the nature of my research. Translators/sign language interpreters were also asked to sign a non-disclosure agreement prior to starting work, and were briefed on the importance of maintaining confidentiality. These research assistants served a dual purpose of practically assisting my research, but also keeping me safe, as an individual researcher in a foreign country. My safety was further guaranteed by regular contact with a network of NGOs that I have built up in both countries, who I met with regularly both formally and socially, and who offered me space to host interviews and meetings. I relied heavily on these contacts during my time in each country, and checked in with them daily in most instances. I also had at

least bi-weekly debriefs with my supervisor in Ireland, to look out for my own health and well-being.

Those locally-based partner organisations, including both DPOs, women's organisations, and NGOs, were consulted and utilised at all stages of the research project, to ensure that all participants fully understood the process, as well as to provide greater accountability. All women who were invited to participate in interviews were recruited through these organisations, in order to prevent them feeling pressure from the researcher to participate, and also to provide an extra level of support, in cases of distress. These organisations formed a vital link between the researcher and participants, and greatly aided in all ethical considerations, as organisations working on the ground who know the context best. Community assent was also important to this research, so that research was not 'forced' on communities who do not need it, and so that women felt safe in participating in this research. Open conversations have been maintained with communities throughout the course of this research, and local DPOs have assisted me in reaching out to leaders in local communities, so that I could get local approval to carry out my research, and so that communities can continuously feed into this study. Participants were also actively engaged in all aspects of this research, with disability organisations and women with disabilities involved in developing interview and focus group guides at the initial stages of research, as well as being asked to review findings and discussions to ensure that any conclusions I have drawn are accurate and representative. Participants also had the chance to develop recommendations for NGOs working in this area, so that there is some sort of benefit to their participation.

## 5.10 Limitations

While I made every effort to ensure this study was conducted in the most rigorous and efficient way possible, working in two countries in the Global South presented some difficulties and limitations. Firstly with regard to the sample size and significance of the study, I did not aim for, nor did I achieve, statistical significance with this research, therefore the findings are not intended to be read as

generalisations about all women with disabilities. Instead, this study is limited in scope to include a small number of women with physical disabilities and their advocates, living in urban and suburban areas of Siem Reap and Kigali, with the intention of gathering empirical evidence. This small sample size allowed me to build better relationships with organisations and gatekeepers, leading to more in-depth interviews, and in my view, richer data.

During the course of this study, I encountered many issues with the logistics of working in two different countries in the Global South. Initially in Cambodia, research was limited by difficulties with communication with gatekeepers, and therefore with access to participants. As mentioned earlier, I often found it very difficult to establish and maintain contact and relationships with INGOs and DPOs in Cambodia, as the style of communication and work culture there is more laid back and sporadic than I am used to. It was not unusual for organisations to not respond to emails at all, or for gaps in communication to span multiple weeks. The indirect style of communication in Cambodia - which was also expected of me as a young woman needing to respect those in a higher position in society than me - also made it difficult to make exact plans for meetings, with key informants often giving vague promises and then pulling out at the last minute. This led to many miscommunications and difficulties in planning meetings and interviews, and contributed to the reduced number of focus groups and interviews than I had initially planned. In order to get around these issues, I strengthened my Khmer language skills as much as possible, and found many alternative ways to contact organisations, including through Facebook, Whatsapp, phone calls, mutual contacts, and cold calling to offices.

Related to this, I sometimes found it difficult to gain the trust of participants in both countries, especially at the level of gatekeepers. In both Cambodia and Rwanda I felt that there was (justifiably) some level of wariness towards a Western researcher coming to study women with disabilities, and it took me quite some time to build up relationships and trust with many organisations. There was also a need for my research to be credible, and it was very important in many cases that I had ethical clearance from both the University of Galway as well as the NCST in Rwanda. Trust with participants in interviews was also important, and was built through referrals from local organisations, and taking time to properly introduce myself and my

research. I believe this was rooted in the 'closed' cultures of both countries, where people tend to be very private and don't usually talk about their problems with others, or discuss taboo topics openly. The number of organisations and participants that I could speak to was eventually limited by how much trust I could gain in each community, as in both countries I found that some organisations were unwilling or unable to engage with my research. Some were not interested in participating in my research and did not want to share their knowledge, and others were openly critical of my work. It was often difficult to get 'buy-in' from large mainstream INGOs, who oftentimes were not interested in disability research.

A further logistical limitation I experienced while in Rwanda was in relation to my research permit and the duration of stay this allowed. As mentioned above, during the preparatory phase of research, I struggled immensely with the bureaucracy around getting this permit, as I had to submit and resubmit a myriad of documents over and over again. I was asked to provide letters of support for my research from multiple local organisations - some of whom are no longer active and therefore could not support me - and to present my case as to why I should be granted a research permit, in person in Rwanda, before actually being given the visa to enter the country. Around 2 months before my field trip was scheduled to take place, I genuinely did not think this permit would be granted at all, and therefore started looking into other countries that I could conduct my research in instead. Eventually the permit was approved, but only after I had to pay over \$800 in fees to the NCST. Additionally, when this permit was granted, I was only allowed to stay in Rwanda for a maximum of 60 days, thus limiting my research period. In an effort to make this trip as comparable as possible with Cambodia despite the condensed timeline, I did most of the initial logistical work including finding a driver and translator, setting meetings, and sourcing accommodation before I left Ireland. As well as this, I organised as many meetings and interviews as possible in the first few weeks of the trip, to ensure I would not run out of time.

Another limitation I experienced in both Cambodia and Rwanda was the difficulty I encountered with organising focus groups. As previously explained, in Cambodia I struggled with establishing and maintaining contact with organisations, and when it came to organising focus groups it was extremely challenging to get a clear

commitment to attend from some representatives. This resulted in miscommunications and logistical difficulties with planning focus group discussions, and eventually led me to abandon plans for a second focus group in Cambodia due to a lack of confirmed participants. In Rwanda I was less set on having a second focus group discussion, so that I could accurately compare my sample size with Cambodia, but even here in organising my first focus group I experienced some miscommunications and delays. In both cases I found that there were only a certain number of organisations who were actually interested in my research, and willing to share their learnings with me, which limited the scope of these focus group discussions.

## 5.11 Reflections

Considering the importance of reflexivity in my methodology, I feel that it is important to include some general reflections on the overall research, from a more personal point of view. I knew from the beginning that this study would be emotionally demanding, and having previously worked in numerous countries in the Global South, I thought I was relatively well prepared for the realities of conducting this research as a lone researcher in two countries. While my preparation and previous experience did serve me well, this research was undoubtedly one of the most challenging things I have ever done, and I believe that it has changed me as a person.

In the initial years that I spent leading up to my fieldwork, I worked hard to ensure that this study was sound, and that my methods would be both participatory and empowering, led by women making a difference in their own communities. I was very proud then, on entering the field as a woman on my own, to be able to lead my own project, to get women with disabilities involved, to hear their stories, and to successfully gather data across two countries. The success and triumph of gathering quality data in both Cambodia and Rwanda despite the challenges I faced, is something I am immensely proud of, and has shown me just how much I am capable of. The communities of women that I engaged with and learned from during this process have also shown me the strength and capacity of DPOs, NGOs and

women's organisations at local levels, and have inspired me in their openness and kindness, and it is with their help that I continue to work in inclusion and disability.

Despite all this good, this research took more of an emotional toll on me than I could ever have anticipated. Working in the field as a woman on my own was difficult in itself, but I was surprised by the effect that the stories told by many of the women had on me. As I became closer to communities and gained the trust of participants, I was told some very difficult and traumatic stories, and sometimes it was difficult to separate my feelings as a human from my job as a researcher. I felt so much sympathy and compassion for many of the women I spoke to, that it often made me upset in the privacy of my own space. I knew this research would be emotionally demanding to some degree, but for many participants this was the first time they felt listened to and heard, and some of what they expressed to me was extremely difficult to take on. I often felt at a loss for what to do and say, and felt guilty and ashamed for my position of power over these women. There were days after interviews when I felt drained and exhausted, and like I had reached my emotional limits. Towards the end of my time in both countries I felt that I could not facilitate any more interviews or meetings because I had simply run out of my own capacity. It was difficult taking on all of this on my own, and I often struggled with both homesickness and burnout.

Upon returning home I felt both immense relief to be back in my own safe environment, as well as huge guilt and discomfort for what I had left behind in both countries. This reverse culture shock was worse after my fieldwork in Cambodia, likely because I spent more time there, and became closer to the community.

Once I started to transcribe all of the interviews, meetings and focus groups from both countries, I continued to feel extremely guilty and upset over what I had left behind, which slowed my progress in the beginning of my analysis. It was only through debriefing sessions, reaching out to others, and finding meaningful outlets for this research that I was able to move past this. This eventually led me to take action on my research, so that there could be some small concrete outcome for the women with disabilities who were kind enough to tell me their stories. I decided to set up a small sewing cooperative in Cambodia for 20 of the women with disabilities who

were part of my research, to help them to improve their incomes and to bring them into a community structure. This is an ongoing project which is still in the early stages of development, but in February of 2024, after fundraising within my own community, I travelled back to Siem Reap to meet with these women again, and to deliver the machines to their homes. For me this was a big step in realising the participation and empowerment aims of this research, as these women were able to see that I had listened to their concerns, and was starting the process of working with them in the longer term. The women and community leaders I met during this return visit repeatedly expressed to me how happy and grateful they were for this project, and for the material support they received, and I have most recently heard from one community leader that the women are earning on average \$7 per week in extra income from the sewing machines, bringing the average weekly income for women engaged in this project to almost \$70. The project is not finished, and these sewing machines alone are not going to facilitate the type of change I am looking for in the lives of women with disabilities, but it really helped me to deal with some of my own guilt and sadness, to be able to provide some assistance out of this research. Depending on the outcomes in Cambodia over the coming months, I would hope to roll out a similar tailored initiative in Rwanda in years to come.

Finally, after receiving feedback from many of the organisations and women that I worked with, I feel proud to have conducted my research in a way that was truly participatory and emancipatory to the best of my ability. I have aimed at all times to amplify the voices of women with disabilities themselves, and to highlight their capabilities and inherent knowledge. In remaining accountable to those who took part in this research, I feel that I have contributed in some small way to the discourse around the inclusion of women with disabilities in society, while also highlighting that participatory research between the Global North and the Global South is feasible.

## 5.12 Conclusion

In summary, my research aims to highlight the experiences of women with physical disabilities in their own words, focusing especially on their opportunities for education and employment. Throughout this thesis, I have used both intersectional feminism

and critical disability theory as a theoretical framework through which to view my findings. Using these approaches has allowed me to account for all of the different identity factors that influence the experiences of women with disabilities, and to focus on the practical applications of this research in the real world. Using this framework, I conducted 36 in-depth interviews, 24 key informant interviews, and 2 focus groups in Cambodia and Rwanda, exploring the opportunities available to women with disabilities in both countries, as well as the discrimination and ostracisation they often face. It was of great importance to me that this research was and continues to be empowering and participatory for women with disabilities in both countries, and this was reflected in community feedback during the analysis phase of research, as well as in the extra considerations accounted for during the ethics process. All of these factors have contributed to the findings of this research, which are presented in the next chapter.

# Chapter 6: Findings & Discussion

## 6.1: Introduction

In this chapter, I aim to address the research questions presented in Chapter 5: Methodology. In particular, I will use data gathered from the field to address the real and perceived relationships between different identity factors for women with disabilities, as well as exploring the opportunities and supports offered to them. Through answering these research questions, data will be presented with the aim of providing a deeper socio-cultural understanding of women with disabilities in both countries, from their own perspectives and in their own words.

Guided by the theoretical framework described in Chapter 5, this chapter presents both quantitative and qualitative data collected from content analysis of census and NGO data in both countries, as well as from in-depth interviews with 36 women with disabilities. These key insights shared by the women themselves are supplemented by 20 key informant interviews and 2 focus group discussions in order to provide a broader perspective on economic and social empowerment for women with disabilities.

As the basis of this study is comparative, the chapter opens with an overview of the overall contexts in which this research took place, including similarities and differences between countries, and what this means for women with disabilities. In addition to this, an overview of the data collected through content analysis of the censuses and NGO databases of both countries explains the background against which the interviews and focus groups took place. Following this, I briefly introduce the key characteristics of interview participants, to highlight key attributes of the sample, and frame further discussions. With this framing in mind, I then explore in detail the 4 main themes which emerged in interviews, and form the basis for the findings of this study. These themes, and the sub-themes contained within, describe the different lenses through which disability is understood in Cambodia and Rwanda,

and explain the high-level barriers these women encounter to their participation in society.

## 6.2: Trends in Disability Inclusion in Cambodia and Rwanda

Current initiatives in both Cambodia and Rwanda have taken the first steps towards the full inclusion of women with disabilities in mainstream society. This is evidenced by the inclusion of disability-based questions in the census of both countries, as well as mainstream NGOs beginning to include people with disabilities in their programmes. To demonstrate this, I present an analysis of both census and NGO data obtained in both countries. This data, taken together, helps to explain why it is that people with disabilities more generally tend to live in poverty in both countries, as they are shown to be poorer than their non-disabled peers in the census, as well as less well supported by NGO programmes across the board.

As mentioned above, the prevalence of disability in Rwanda is slightly lower for women than it is for men, but women with disabilities tend to face more disadvantages in terms of access to services and supports. Girls with disabilities tend to receive fewer years of schooling than boys with disabilities, and 50% of women with disabilities in Rwanda have no education at all (NISR, 2012). Labour force participation is also significantly lower for women with disabilities, no matter the type of disability experienced. The census also reports that women with disabilities work in agricultural occupations more than their male counterparts, suggesting that men with disabilities face lower barriers in accessing non-agricultural industries. In terms of marriage, slightly more men with disabilities have never married, although rates of divorce or being widowed are much higher among women with disabilities.

In Cambodia on the other hand, disability prevalence was found to be higher for women than for men in all types of disability. Apart from this anomaly, the rest of the data reported by the census follows the same patterns of those in Rwanda, with much lower literacy rates for women with disabilities than their male counterparts. Data collected on education for people with disabilities in the census is not disaggregated by sex, but based on overall literacy rates, as well as anecdotal

evidence from other reports, it can be assumed that the rate of educational attainment for women with disabilities is lower than for men with disabilities. Following on from this, significantly more men with disabilities (62.7%) are in employment in Cambodia than women (45.9%), although it is unlikely that this census accounted for the informal work or caring roles that are often performed by women with disabilities. Similar to Rwanda, more men with disabilities have never married in Cambodia, but significantly more women with disabilities are widowed or divorced.

It is clear from this data that women with disabilities have fewer opportunities for education, employment, and social development in both countries. In general, the trends in both countries are similar, with low educational attainment and workforce participation being the most prominent. The categories and types of data collected, however, are not standardised, and are therefore difficult to compare across countries. Each variable, apart from disability prevalence, is measured differently, and points of interest in both surveys vary widely. Despite this, many of the issues faced by women with disabilities are almost universal, as patriarchal standards and negative attitudes towards disability combine to create discrimination.

With this discrimination in mind, I further examined NGO databases in both countries, to better understand the level of support provided to women with disabilities. Again, there is no standardised way of collecting this type of data, thus limiting my analysis. Regardless, I found it interesting to explore whether the differing governmental approaches to inclusion described above translated into programmes on the ground.

Despite (or maybe because of) the strong governmental control of the NGO sector in Rwanda, it is very hard to find a full list of NGOs working here, as the Rwanda Governance Board (RGB) does not make this information accessible to the public. The information below has been mostly sourced from 'NGO Explorer', which only includes NGOs that are active in the UK, as well as 2023 lists provided by RGB, and therefore provides an incomplete picture of the INGO sector in Rwanda. Nonetheless, this data can be used to generate an overall picture of the types of work being carried out by NGOs in Rwanda, and what their main priorities are.

Using the 'NGO Explorer' database, and filtering out limited companies providing finance to other organisations, there are currently 483 UK-linked NGOs working in Rwanda. This is a huge number for a relatively small country, and does not include local Rwandan NGOs. Arguably all of the biggest global charities currently working in Rwanda are included in this list, including WWF, CARE International, Actionaid, Rotary International etc, and many of these have huge budgets of around or over €10 million (NGO Explorer, 2024).

An overwhelming majority of these NGOs focus on education, with almost 75% of NGOs working in this area, with the aim of improving access to education, building schools, or training teachers. 'Sponsor a child' organisations are also very popular in Rwanda, with many of the largest NGOs using this model. Health is the 3rd most common area of intervention, with many organisations providing services and advice, undertaking research, and providing finance (NGO Explorer, 2024). Over 100 of these organisations are connected to religion or missionary work, and some exist solely to fund the existence of churches in East Africa. This is unsurprising given the proliferation of mega-churches in Rwanda, and the devotion of much of the population to their chosen religion. These are mostly Christian or Jewish organisations, and the impact that these organisations have on the everyday lives of many Rwandans is clear (NGO Explorer, 2024). Despite these areas being highly relevant to disability, many of the mainstream INGOs do not work with people with disabilities, and inclusion is not popular among this network.

While it is reported on this database that 120 INGOs (27% of the total in this database) work with people with disabilities in Rwanda, this is a huge overestimate, as it takes any organisation that mentions working with the elderly, vulnerable, or marginalised people to mean working in an inclusive way. If the criteria is narrowed to just those organisations who work with people with disabilities specifically, only 22 INGOs - or 4.5% of the total in this database - work with people with disabilities (NGO Explorer, 2024). Of these, 16 work in healthcare, for example in the reparation of cleft palates, restoring sight, or providing mental health services. The other 98 organisations here claim to be inclusive in some way of the 'most vulnerable in society', but do not commit fully to inclusion, or describe what this means. 66% of

these inclusive organisations work in advocacy or the provision of information, followed closely by those that provide services directly. Many of these organisations also have a specific focus on children and young people. 26% of these inclusive organisations are religious, with a strong emphasis from the Christian community on helping the marginalised, in line with the charity model of disability (NGO Explorer, 2024).

In terms of local organisations and NGOs in Rwanda, it is even more difficult to find data on this, as again, this information is not public. A small amount of information is available on the Rwanda Governance Board website, and so this has been used to generate a broad understanding of the priorities of local organisations in Rwanda, without providing specifics.

This local NGO space, like the INGO sector, is highly centralised and controlled by the government, meaning that even small organisations tend to be well managed and supported. Over half of these locally-led projects are concentrated in rural areas, and most see this decentralisation of power as a crucial part of their role in the national strategy of the country, despite the fact that less than 15% of them receive direct funding from the government of Rwanda (RGB, 2023). For local NGOs, the most common area of intervention by far is social protection, presumably providing support in place of government programmes, which do not cover welfare. Beyond this, programmes tend to focus on education and health, much like the INGO sector (RGB, 2023). It is unclear what proportion of these national NGOs and CSOs work with people with disabilities as this is not reported.

There is far more information available on the NGO sector in Cambodia than in Rwanda, but it is not quite as well maintained. Currently there are 385 officially registered NGOs operating in Cambodia, according to the Cambodian NGO database for 2021/22, maintained by the Council for the Development of Cambodia (CDCB, 2024). Of these, 65.7% are foreign NGOs, accounting for 253 organisations, implementing 736 projects across the country. The remainder of the NGO space is made up of 132 local organisations, responsible for 323 projects throughout Cambodia. Some of these records are poorly kept, incomplete, or inaccurately translated, and as such there are some discrepancies in records and reporting. It is

also important to note that there are many other NGOs working in Cambodia, especially at the local and community level, who are not registered in the government system. This is often due to complex registration requirements and poor monitoring and evaluation.

International organisations mainly focus on education in Cambodia, and this is by far the largest sector of intervention. Following this, health and orphanages are the most popular areas of intervention, although it is unclear what kind of programmes these are, as the records only provide top-line information. Of the 253 foreign organisations currently working in Cambodia, 33 run programmes that involve people with disabilities in some way. These inclusive organisations make up just 13% of the foreign NGO sector (CDCB, 2024). The most popular areas of inclusive interventions are exactly the same as those working more generally, focusing on education, health and orphanages. These clearly indicate the areas where there is a lack of public services in Cambodia, so INGOs have stepped in to fill this gap. This focus on orphanages is also interesting as there has been a trend away from this model of charity in the last number of years, but the practice has remained strong in Cambodia, despite the country's continued issues with human trafficking. It is also useful to note the prevalence of Japanese and Korean investment in Cambodia, which is much higher than European, American, or Australian investment, and may indicate a more localised approach to development financing.

In terms of local NGOs, of 132 Cambodian NGOs currently working in the country, 25 work with people with disabilities. This accounts for 18.9% of Cambodian organisations currently registered with the government (CDCB, 2024). In this sector the focus is mainly on participation in political processes and governance, indicating vastly different priorities from the INGO sector. The only area of overlap is in education, once again pointing to the lack of resources in public education in Cambodia.

Since information is more accessible in Cambodia, it is easier to make comparisons about how inclusive programmes are in both national and international NGOs. In total it was found that 58 organisations in the CDCB database - or around 15% - work with people with disabilities in some capacity. Of these, 27 cater specifically to

the needs of people with disabilities, 30 are mainstream development organisations who include people with disabilities in their programmes, and 1 takes a twin track approach to inclusion - meaning that they mainstream inclusion while also offering specific provisions for people with disabilities (CDCB, 2024). Of these inclusive organisations, the majority of international organisations work on health, especially in HIV and eye health, and most of these are religious organisations. Local inclusive organisations work mainly in advocacy, landmine/uxo clearance, and health. While there are some differing priorities for inclusive programmes, the greatest focus both locally and internationally is on health, which suggests that NGOs are still needed to fill the gap in healthcare provided by the state, and is also in line with the medical model of disability - as per the local definition of disability.

Again there are issues with the standardisation of data collection here, as organisations are not obligated to report on whether or not they include people with disabilities in their programmes. What is clear, however, is that local organisations in both countries are far more likely to include people with disabilities in programmes, and are more likely to work in rural areas, where populations of people with disabilities are higher. These local organisations also have vastly different priorities from international NGOs in both countries, focusing on issues which may be more relevant to local populations (key informant, 2022). Most interestingly, neither country provides evidence of any programmes targeted specifically towards women with disabilities, thus effectively dismissing the intersecting identities which influence their lives.

All of this highlights that support does exist for women with disabilities in both Cambodia and Rwanda, but that this can be hard to access or even find information about. It also shows that a majority of NGOs working in both countries do not include people with disabilities in their programmes, despite varying degrees of commitments from governments. I would argue that - in international organisations at least - this is because disability is not yet seen as a priority by many, and is often considered to be a specialised area, requiring significant investments of both time and money. This has led to the exclusion of women with disabilities from many initiatives which could benefit them.

## 6.3: Profile

In order to contextualise interviews, and frame them against the intersectionality discourse that is so central to this study, I also include a general profile of the basic characteristics of the 36 participants in interviews. Table 1 below shows that the majority of women interviewed live in urban areas and are between the ages of 36 and 45 (8 participants in each of these age categories). While 73% of participants are currently employed, the sectors they work in vary greatly, with the majority in Cambodia working in the textile industry, and most women in Rwanda working as artisans. This study accounted for both formal and informal work, and while it can be difficult to differentiate between these sectors, a majority of women interviewed reported working under informal conditions. Literacy is high among participants - although higher in Rwanda than in Cambodia - with 78% of all participants reporting full literacy despite low educational attainment. All participants from both countries reported having engaged with vocational training of some sort.

Table 1: Participant profiles

Interview Number	Country	Area	Age	Literacy	Years of education	Vocational training?	Employed?	Self-employed?	Sector	Average monthly pay (USD)	Age at onset of disability
1	Cambodia	Urban	36 - 40	Yes	16	Yes	Yes	No	INGO	500	Birth
2	Cambodia	Urban	36 - 40	Yes	12	Yes	Yes	Yes	Market	400	1
3	Cambodia	Urban	36 - 40	Yes	5	Yes	Yes	Yes	Market	300	5
4	Cambodia	Urban	41 - 45	Yes	7	Yes	Yes	Yes	INGO	100	Birth
5	Cambodia	Rural	46 - 50	No	6	Yes	No	No	N/A	0	40
6	Cambodia	Rural	56 - 60	Yes	4	Yes	No	No	N/A	0	26
7	Cambodia	Urban	41 - 45	Yes	12	Yes	Yes	Yes	Textile	180	31
8	Cambodia	Rural	41 - 45	Read only	0	Yes	No	No	N/A	0	1
9	Cambodia	Rural	41 - 45	No	0	Yes	Yes	Yes	Market	70	12
10	Cambodia	Rural	41 - 45	No	0	Yes	Yes	Yes	Textile	150	Birth
11	Cambodia	Rural	31 - 35	Yes	10	Yes	Yes	Yes	Textile	150	16
12	Cambodia	Urban	56 - 60	Yes	0	Yes	Yes	Yes	Textile	100	8
13	Cambodia	Rural	41 - 45	Read only	0	Yes	No	No	N/A	0	Birth
14	Cambodia	Urban	36 - 40	Yes	11	Yes	No	No	N/A	0	Birth
15	Cambodia	Urban	41 - 45	Yes	5	Yes	No	No	N/A	0	5
16	Cambodia	Urban	46 - 50	Yes	0	Yes	Yes	Yes	Massage	400	2
1	Rwanda	Rural	46 - 50	Yes	8	Yes	Yes	No	Artisan	40	32
2	Rwanda	Urban	36 - 40	Yes	12	Yes	Yes	No	Artisan	45	Birth
3	Rwanda	Rural	36 - 40	Yes	10	Yes	Yes	No	Artisan	90	Birth
4	Rwanda	Urban	18 - 25	No	4	Yes	Yes	No	Artisan	10	11
5	Rwanda	Urban	36 - 40	Yes	6	Yes	Yes	No	Textile	20	13
6	Rwanda	Rural	31 - 35	Yes	11	Yes	Yes	No	Artisan	20	20
7	Rwanda	Urban	56 - 60	Yes	3	Yes	Yes	No	Artisan	20	6
8	Rwanda	Urban	31 - 35	Yes	16	Yes	No	No	N/A	0	8
9	Rwanda	Rural	31 - 35	Yes	16	Yes	No	No	N/A	0	Birth
10	Rwanda	Rural	26 - 30	Yes	12	Yes	Yes	Yes	Beauty	40	Birth
11	Rwanda	Rural	31 - 35	Yes	16	Yes	Yes	No	Financial	120	9
12	Rwanda	Urban	18 - 25	Yes	16	Yes	No	No	N/A	0	Birth
13	Rwanda	Urban	18 - 25	No	16	Yes	Yes	No	Media	250	Birth
14	Rwanda	Urban	31 - 35	Yes	2	Yes	Yes	No	Textile	20	Birth
15	Rwanda	Urban	46 - 50	Yes	9	Yes	Yes	No	Artisan	10	Birth
16	Rwanda	Urban	36 - 40	Read only	6	Yes	Yes	No	Textile	20	Birth
17	Rwanda	Urban	41 - 45	Yes	5	Yes	Yes	No	Textile	20	28
18	Rwanda	Rural	26 - 30	Yes	6	Yes	Yes	No	Textile	45	27
19	Rwanda	Urban	18 - 25	Yes	7	Yes	Yes	No	Artisan	20	19
20	Rwanda	Urban	31 - 35	Yes	10	Yes	Yes	No	Artisan	20	24

## 6.4: Attitudes Towards Disability

Having explored the broad background to this research, and understood more about my target population, I now explore some of the main findings from my data collection, focusing on the stories told by women with disabilities about their own lives, and supported by the cultural discourse provided by key informants and focus group participants.

When exploring the empirical evidence surrounding the intersection between gender and disability in Cambodia and Rwanda, participants routinely asserted the importance of the perception of others in their understandings of disability. In other words, the attitudes of families and communities were found to have a huge impact on the identities of women with disabilities, and the opportunities they felt able to pursue. This is very evident in over half of interviews when women with disabilities express the lack of support and belief they feel from their families and communities (Interview 1, Cambodia; Interview 4, Rwanda). Goffman (1963) argues that most people understand themselves and their self-worth through the eyes of other people, and further explains that individuals tend to determine how they act based on their perceptions of themselves or others. This, he argues, often leads to people with disabilities being seen as 'not quite human' by those around them, and often being 'discounted' by society for their differences. The discrimination that many of the women in this study reportedly face may therefore be amplified by the attitudes of those around them, and may therefore have a profound impact on their own sense of self-worth.

According to research in Sub-Saharan Africa, the intersectionality of gender and disability is particularly apparent in low-income settings, where disability based discrimination combines with patriarchal attitudes towards women, to produce new and more complex experiences of marginalisation (Pal et al, 2015). In Rwanda, previous research found that social ostracism and dehumanising attitudes relating to patriarchal values and misunderstandings of disability were significant in the experiences of women with disabilities, where disabled women were more likely to experience stress related to social isolation than their male counterparts (Joyjee et

al, 2015). Similarly in Cambodia, women with disabilities experience significant exclusion due to the complex Khmer belief system, including direct discrimination and social isolation, as well as exclusion from political processes and development (Thomas, 2005).

When considering how attitudes towards disability impact their daily lives, participants spoke about their experiences under four main themes of discrimination and stereotypes; functional capacity; gendered experience of disability; and culture. These themes, and how they relate to and shape perceptions of disability in Cambodia and Rwanda, are explored in the following sections, as told by women with disabilities themselves.

#### 6.4.1: Discrimination

In both Cambodia and Rwanda, many of the general stereotypes around disability are compounded by cultural narratives surrounding the family, patriarchy, and religion, and this has led to significant experiences of discrimination for women with disabilities. As referenced in the literature, the structural violence faced by women and girls with disabilities, coupled with the attitudinal and environmental barriers they face, tend to lead to lower economic and social status, as well as wider ostracisation from communities. Women and girls with disabilities tend to feel this most acutely, as they are often socially ostracised by those around them, as well as structurally discriminated against in terms of access to services, education, and employment (UN, 2018).

All participants in this study reported experiencing significant discrimination at some point in their lives, especially in terms of attitudes of those around them. Many women describe feeling “discriminated against and looked down on”, and feeling like people without disabilities “don't want to have a good relationship together” (Interview 6, Cambodia). Many women with disabilities experience these different types of discrimination on a daily basis, due to their intersecting identities as both women and people with disabilities, and therefore tend to be excluded from accessing society's resources due to their multiple disadvantage, as described by

Tefera et al (2017). This is discussed further in a later section, but was described by most participants as very significant in their experiences.

In rural areas, this problem tends to be exacerbated, with one participant explaining a more general feeling among rural women: “in the area where I live, people treat me like a strange person and always wondered why I look like this” (Interview 9, Rwanda). During focus group discussions in Rwanda, participants explained that it will likely take a long time in rural areas to achieve the inclusion that women with disabilities in the cities have achieved. This is because rural women usually have lower access to education, and are surrounded by negative attitudes of families and communities (key informant, 2023). This marginalisation was described by all participants as difficult to deal with, “Sometimes it can touch your heart, and we don't know how to deal with that.” So women with disabilities need to develop resilience and “learn not to care”. (Interview 2, Cambodia)

80% of participants in this study described regularly experiencing negative attitudes surrounding disability from those around them. This discrimination often starts in the family, with most women describing how their parents were not interested in sending them to school because their disability meant that they would not be able to work in later life. In Rwanda, a participant described how, according to her parents, “even if you study you cannot find a job, no one will give it to you.” (Interview 7, Rwanda) Another participant in Cambodia echoed this sentiment, stating that “my parents gave up on me because I have a disability.” (Interview 1, Cambodia) This is consistent with findings from Tefera et al (2017), who also found that parents of children with disabilities tended to have negative mindsets about the education and employment prospects of their children, and as such did not invest the required time and money to give them a quality education. This links back to the wider devaluation of the knowledge and experiences of people with disabilities, due to widely held assumptions of their capabilities (Green et al, 2005). In many cases, these assumptions are based on traditional beliefs, religion, and stereotypes, and present all people with disabilities as a homogenous group, all of whom lack the capacity to engage with the world in a way that is ‘normal’. Devoka et al (2019) also found that in many low-income areas, myths, folklore and misconceptions about disability paint

people with impairments as 'tragic figures' worthy of pity and charity, and unable to lead independent lives.

This is true in both Cambodia and Rwanda, and was highlighted across the board in both interviews and focus group discussions. Focus group participants in Rwanda explained that children with disabilities are often not encouraged to go to school because there is a societal expectation that someone will always have to provide for them and look after them, they are never expected to be independent (Focus group discussion, 2023). Under the patriarchal systems of Rwanda in particular, it is expected that girls with disabilities will be reliant on the family, and are therefore expected to stay home, as explained by one interviewee whose parents thought "you have a disability, you are useless, you are supposed to be at home. We are going to work, but you are not able to do anything. You stay here." (Interview 12, Rwanda) This culture of assuming that people with disabilities are dependent on others was very clear in interviews in both Cambodia and Rwanda, and is indicative of a broader cultural mistrust of women with disabilities and their own abilities (Fremlin, 2023).

Education is only one example of the complex discrimination many people with disabilities face in the home, and some participants spoke of people with disabilities being 'hidden' in their houses. This concept comes up often in the literature (see for example Kuyini & Desai, 2007) and explores the tendency to 'hide' people with disabilities away in societies where services are poorly developed and superstitious beliefs about disability predominate - especially in Africa. This is much less common in Cambodia, as a very communal and family-oriented society, but was raised in two interviews in Rwanda. According to these participants, women with disabilities "are just hidden in their homes, no one wants to show them, no one wants to bring them on board. We have many deaf women who are hidden in their families and they are just being discriminated and doing nothing." (Interview 6, Rwanda) As explained by a key informant, this is especially true in rural areas, where negative mindsets are more pervasive due to lower education. Another participant described how in these areas women with disabilities struggled "with the community stigmatising them... Some of them were hidden because of their disability... But now, having joined together in groups, they are stronger" (Interview 13, Rwanda).

Furthermore, it is important to consider the family model of disability here, where disability may affect the whole family in low-income settings. In these cases, when poor families in the global South do not provide opportunities for their disabled family members, it is often not because they are hidden away out of shame and embarrassment as is suggested by some authors (see for example Stone-Macdonald & Butera, 2012), but usually because they are not able to support all of their children equally, or that they do not have the required information to help them (Sarmaa, 2023).

As explored in Chapter 3, this idea of hiding people with disabilities, especially in Africa, is quite pervasive in writings around disability, but from empirical evidence gathered during key informant interviews, this issue is misunderstood by the literature. In reality, where women with disabilities are kept in their homes, it is usually for their own protection and safety, as gender-based violence and rape is such a common occurrence. According to key informants (2023) in Rwanda, this is often the only way to protect them from harm, especially in rural areas. Karangwa et al. (2010) also emphasised that literature from the Global North fails to recognise the complexity of discrimination faced by women with disabilities, and to account for the love and care that families provide for their members with disabilities. These misunderstandings of the discrimination faced by women with disabilities may mean that they are excluded from accessing services, and that NGO programmes aimed to help them are not properly targeted.

#### 6.4.2: Stereotypes

In terms of the wider community, all participants reported in similar ways that “disabled women are not considered enough in society” across the board (Interview 1, Cambodia). Stereotypes and misconceptions about disability abound in both countries, and culminate in the large-scale ostracisation of women with disabilities from mainstream society. According to a DFID report from 2005, negative attitudes towards people with disabilities are pervasive in Rwandan society, where the abilities of people with disabilities are often underestimated, and they are often seen as unable to care for themselves independently (DFID, 2005). Pal et al (2015) also found that attitudes of avoidance of people with disabilities in social and professional

settings are still common. What compounds this is a lack of institutional means or mass media to create greater awareness about disabilities, thus perpetuating misinformation. The consequent lack of visibility in the mainstream, is said to create a frozen 'visibility' of disability which assumes people with disabilities cannot manage independent living.

Focus group participants explained that these generalisations are still largely believed, and that the general expectation is that if a woman has a disability, she has to rest, or sleep, or sit everywhere she is. She is expected to rely heavily on others, and her mind is delayed. She is essentially seen as useless. Similarly, in Cambodia, superstitions and misinformation about disability have led to misunderstandings about the capabilities of people with disabilities, often leading to their exclusion from communities (Connelly, 2009). Focus group participants also explained that it is very difficult for women with disabilities to move around independently because footpaths, roads, and modes of transport are not usually accessible to people with disabilities. Women with disabilities often need assistance in navigating footpaths and roads, and there is a very small number of adaptive tuk tuks and motorbikes. This further reinforces the idea that women with disabilities cannot live independently, and - in the words of key informants - cannot be trusted in their abilities to work, raise a family, or be successful in life (key informant interview, 2022). This reflects the views of Fine & Asch (2009), as described in my theoretical framework. Through this intersectional feminist and critical disability studies lens, these societies still view women with disabilities as 'childlike, helpless, and victimised', who cannot function independently of others.

Further to this, in interviews, 4 women with disabilities in Cambodia described how others are hesitant to interact with them if they know they have a disability, saying things like "people won't talk directly to people with disabilities, they prefer to ask someone with ability. They are scared of contagious blindness or what?" (Interview 6, Cambodia), and "people don't dare to ask or talk to them. Tuk tuk drivers don't want to transport them. They are afraid they will infect them." (Interview 14, Cambodia) As explained in the literature, as well as by key informants, these misconceptions around disability are more common in rural areas, where education is lower, and where people may be less exposed to technology (Connelly, 2009).

Stigmatisation and ostracisation is reportedly even more pronounced in Rwanda, where 6 participants described feeling less than human:

*Even if I touched a cup of tea or something on a plate, no one else would want to use it again. Like I wasn't a human being (Interview 16, Rwanda).*

*People in my neighbourhood use me as a [location] marker 'you come and when you reach where there is a woman with one eye, you just call me (Interview 15, Rwanda).*

*When I became disabled everyone rejected me. My friends, they couldn't come and talk to me, as they used to, and those are my friends, you can imagine with the family. I was rejected (Interview 20, Rwanda).*

Often, this stigmatisation is due to lack of education and understanding around disability “people don't understand, or don't want to understand” (Interview 6, Cambodia), especially around complex or hidden impairments. One blind participant in Cambodia spoke about how people misunderstand her impairment:

*People think 'oh you are blind, you cannot go anywhere... why do you want to go to Angkor Wat [temple] if you cannot see it? I say 'even though I cannot see, I can touch! My other senses are right!' People don't understand how blindness is (Interview 6, Cambodia).*

These misconceptions and stereotypes around disability tend to keep people with disabilities on the margins of society, and further their experiences of discrimination and 'otherness'. This can lead to people with disabilities 'opting out' of a society that does not accept them, thus furthering marginalisation (Cobley, 2018). Especially for women with disabilities, the compounding of cultural understandings of disability and gender can lead to isolation, loneliness, and a feeling of not being accepted (key informant, 2023).

Other factors that cause people to misunderstand disability include cultural beliefs, religion, and social norms that exist in both societies. Where religious influence is

particularly strong - as it is in Cambodia and Rwanda, perceptions of disability tend to be shaped by both biomedical and traditional understandings of impairments (Morgan & Tan, 2011). A combination of these factors often leads to a society which holds negative or discriminatory attitudes towards women with disabilities. According to an interview participant, in order for a society to become more welcoming towards people with disabilities “the attitude is the most important actually”, and people must be better educated on disability so that they can be more accepting and inclusive of women with disabilities in order for accessibility to be successful (Interview 1, Cambodia). This is especially true at local government levels, where key informants explained that there is an opportunity for national level policy to be implemented in meaningful ways. This was also discussed during focus groups, where participants explained that oftentimes, local officials at community, village, and district level do not have a good understanding about disability, and therefore tend to perpetuate myths and stereotypes, even at relatively high levels. This is especially true in rural areas, where education around disability is virtually non-existent in both countries, as described above (Focus group, 2022).

Discrimination and stereotypes are also common in the workplace no matter the country. In general, employers are reported by key informants to have negative mindsets towards women with disabilities, and are thought to be slow to hire them (key informant, 2022). This is further reflected in the literature, where a UK survey found that 60% of employers surveyed reported having concerns that people with disabilities would not be able to do the advertised job (Ability Focus, 2020). Louvet et al. (2009) also showed that, globally, employers tend to evaluate workers with a disability as being less competent professionally than people without disability. This again relates to earlier discussions of the assumptions a society makes around the capabilities of people with disabilities, often seeing them as less able to engage in productive work than people without disabilities.

Most interview participants reflected this in their own experiences of discrimination in the workplace, stating that “some companies, they don't want to employ the people with disabilities, because they think that they work slowly.” (Interview 3, Cambodia) and “[Employers] can't trust the perfection of work done by women with disabilities. They think ‘how can a woman with one arm do such a thing?’ They can't believe that”

(Interview 1, Rwanda). Key informants in Rwanda also pointed out that many employers still hold out-of-date beliefs about people with disabilities, considering that in order to hire someone with a disability, “you must have failed to get a proper employee.” (key Informant, 2023). These beliefs again link back to the cultural misconception that women with disabilities are dependent on others for survival and cannot be independent.

According to focus group participants in Rwanda, employers also tend to stereotype women with disabilities as weak, assuming that all of their capabilities are limited by their impairment, as captured by a participant from Rwanda:

*They think if a person has a physical disability automatically the brain does not work, which is not true, because even if I have some limitations, my brain works well* (Interview 11, Rwanda).

This highlights the intersection between gender and disability in the workplace, where women with disabilities often experience unequal hiring and promotion standards, unequal pay for equal work, and occupational segregation due to stereotypes about their capabilities both as women and as people with disabilities (O’Reilly, 2007). This inequality was mentioned by over half of the participants in this study as manifesting in multiple ways, across different types of disability. One participant in Rwanda explained that she has a hidden disability which she has not disclosed to her employer. “Even though [she has] disability, [she] can’t even reveal that secret here. Because when they realise that [she has] disability, they can dismiss [her]. [She has] to cover [herself]” (Interview 11, Rwanda). It is this complex intersection between stereotypical attitudes towards women, as well as stereotypical attitudes towards people with disabilities that combine to exclude women with disabilities from the job market, based on assumptions about their capabilities.

Often the availability of jobs for women with disabilities also depends on attitudes of employers, and this is one of the most important factors in terms of physical and attitudinal barriers to the inclusion of women with disabilities in the labour market. Often employers will tell women with disabilities that they will be “useless to our work” because women with disabilities “are seen to be weak, to have weakness” in

the minds of many employers (Interview 2, Rwanda). With so much weight given to the attitudes of individual employers, and no guidelines or policies being enforced for the protection of women with disabilities in the labour market, participants in this study report significant difficulties in finding employment.

### 6.4.3 Functional Capacity

In emerging economies such as Cambodia and Rwanda, a person's ability to be productive and earn money for themselves and their family is often a primary factor in how other people perceive them, as well as how they perceive themselves.

Therefore, as described in the literature review, a person's functional capacity can have a huge bearing on their inclusion in society, depending on the context in which they live, and how people view disability. Most of the women in this study brought up functional capacity in one way or another, suggesting that a primary focus of their identity as a woman with a disability is on what they can and cannot do, and on their "labour worth" (Interview 1, Cambodia). In Rwanda, Karangwa et al (2010) found that disabilities are perceived in relation to the influence they have on the functional life and activities of a person with a disability. This level of functioning designates his or her place within the family and the general community.

During interviews, it was clear that participants also felt that this is how they are perceived, recognising that higher their functional capacity, the more respect they earned in society. My research also found there to be no correlation between severity of disability and income or employment status, suggesting that functional capacity is more important than actual impairment in these contexts. This does not necessarily correlate with findings from the literature (such as Clausen et al., 2004), but this study only includes women with physical disabilities, and does not include more complex impairments and psychosocial disabilities.

While the women that I spoke to during these interviews recognise that they cannot work in all types of jobs "like construction or agriculture", they also acknowledge that there are plenty of jobs that fit within their own functional capacities such as "jobs which require us to sit down, we are fine. Because even if we have disabilities, we are smart. We can work" (Interview 19, Rwanda). This awareness of their own strengths is very important for both empowerment and employment, and is led by the

women themselves - “with time and awareness we are now aware that we can do different things” (Interview 5, Rwanda). This awareness is reportedly an outcome of improved self-confidence and self-belief, which is described later in this chapter, and is considered a cornerstone of identity for women with disabilities.

Within the identity of ‘disabled’, and with this awareness of their own strengths in mind, the women I interviewed considered there to be a sort of scale of functional capacity, where people with different conditions and abilities could do different jobs, and “have different ambitions with disability” (Interview 4, Cambodia). Focus group participants in Cambodia also explained that if a person can do their job well, and function properly in society, they are not “fully” considered disabled, and society may look at them differently (focus group, 2022). As reported in the literature by Saunders & Nedelec (2013), as well as by interview participants in Rwanda, this correlation between ‘disability’ and ‘ability to work’ has a huge impact on how women with disabilities are treated in society “depending on what jobs they can and cannot do.” (Interview 9, Rwanda) Women with impairments are seen as having to “prove that [they are] able to perform and provide” in order to be accepted into society (Interview 5, Rwanda). Key informants in Cambodia also explained that this creates a divide between people with and without disabilities, as women with disabilities feel that they are constantly having to prove themselves and their abilities, and often means women with disabilities have to “work twice as hard” just to be considered level with their non-disabled peers (Interview 6, Cambodia).

In terms of work and their ability to find a job, most women in both countries consider functional capacity the most important indicator of ability to find employment, explaining that work “depends on their condition, because they have different conditions, and can do different things, and also what they want is different.” (Interview 5, Cambodia). These jobs are also context dependent, as oftentimes manual labour is more in demand in low-income countries. One participant in Rwanda highlighted the limitations to her functional capacity due to her impairment, stating “I can’t dig, I can’t run, I cannot carry anything on my head.” (Interview 5, Rwanda), however, most participants believe that any job that requires mental abilities is well suited to women with all types of impairments. Especially in Rwanda, participants expressed that “any job that uses mental capacity, I think they are

capable to do that.” (Interview 9, Rwanda), and “we have capacity to do any job, because we have many skills, we have many capabilities, and we can interact with anyone.” (Interview 14, Rwanda),

Another important point that many participants raised in Cambodia was the importance of allowing women with disabilities to choose the skills that they want in a participatory way, rather than prescriptively (Interview 5, Cambodia). In line with Sen’s capabilities approach (1999), as outlined in the literature review, allowing women with disabilities to actively participate in decision-making around their own skills not only increases their self-confidence and earns them respect from others in their communities, but also improves their opportunities to achieve those valuable livelihood outcomes described by Sen. This approach allows women with disabilities to develop skills that are well suited to their own functional capacities, rather than pushing them into skills which may not be suitable.

Finally, when considering functional capacity, opinions on the importance of gender as an identity marker differ by country. While the intersection between gender and functional capacity is not well explored in the literature, it was discussed by some participants in interviews, who considered whether society's perceptions of them were complicated more by their ability to function with a disability, or their identities as women with disabilities. In Cambodia, there is some consensus that functional capacity is a more important identity marker than gender in the eyes of the wider society, and that “women and men [with disabilities] have similar opportunities, if you are talking about disabled people of the same condition” (Interview 16, Cambodia), but it is important to highlight the mention of ‘people of the same condition’. The focus here is on the impairment and the functional capacity of the person, rather than on the job that might be considered suitable for a man or a woman. In Rwanda however, there is much more focus on the gendered dimension of a person’s identity, where “men are stronger, and can do more physical work” (Interview 1, Rwanda), and where “Only certain jobs [are] suitable for women” (Interview 2, Rwanda). This is a mark of a more patriarchal society in Rwanda, where attitudes towards women intersect with attitudes towards people with disabilities to blur the boundaries of functional capacity and suitable employment.

#### 6.4.4 Gendered experience of disability

As mentioned above, both Cambodia and Rwanda are still considered to be patriarchal and hierarchical societies by key informants and interviewees. While both countries have made considerable strides in gender equality over the past number of years, women with disabilities have generally lagged behind in terms of both empowerment and employment.

The Asian Development Bank's 2012 assessment of gender equality in Cambodia explains that Cambodia is still a hierarchical society 'with strong ideas about power and status'. Women are considered to be of lower status than men, and are generally expected to act mainly as household managers (Asian Development Bank, 2012, p.9).

The situation is similar in Rwanda, where it is described that traditional norms are still popular, and 'men are seen as responsible for ensuring the good behaviour of wives and daughters – wives are expected to be upright, daughters to be virgins and widows to be virtuous'. Women are also expected to do the bulk of the household labour, but have little control over resources (Abbot & Malunda, 2016, p. 578 - 579). This is echoed by focus group participants, who state that cultural norms dictate that women should depend on their husband, father, or brother for everything. In Rwanda, key informants describe that women are always expected to rely on a male figure in their lives, and cannot speak on behalf of the family.

Many of the women that I interviewed for this research brought up the importance of functional capacity in understanding the opportunities that are available to women with disabilities, but even more participants emphasised the importance of this idea of gender inequality and patriarchal norms, which compound the lack of opportunities they already face. It was reiterated over and over again that "men definitely have more opportunities" (Interview 9, Cambodia), "everyone faces issues, but women have more issues because it's much more difficult for women to get jobs, but for men with disabilities it's not that hard." (Interview 6, Rwanda), and "men have more opportunities because of the work they can do and the level of understanding of people." (Interview 1, Rwanda). This is where the intersection of gender and

disability becomes tangible, as discrimination on the grounds of both identity factors seems to combine to exclude women from society, and effectively prevent them from accumulating the types of social and physical capital that they need to be successful in their lives and careers.

A significant finding of this research was that the unpaid household labour that is expected of women with disabilities in both countries hampers their opportunities outside of the home. Throughout interviews, women repeatedly asserted that their responsibilities held them back from overcoming marginalisation, saying “for men it’s not so hard because women have more challenges. If they are single that is ok, but if they have children they have a lot of responsibility” (Interview 14, Cambodia), and the fact that for women with disabilities “it’s hard to get married” (Interview 18, Rwanda). Focus group participants also agreed with this across both countries, explaining that men and boys find it easier to access information about jobs and opportunities because they have more free time which is not devoted to household labour, and oftentimes this is used to learn from peer groups and access new technologies. While these traditional roles in the lives of women with disabilities have not been well studied in previous literature, Kynaston (1996) theorised that this patriarchal division of labour, and the ‘overburdening’ of women, is rooted in gender inequality, and is legitimised by the dominant ideology of naturalism in many societies. This asserts that existing male and female roles are natural and complementary expressions of underlying sexual differences, whereby men are strong and intelligent and thus do the hard work, and women weak and docile and are to be kept primarily at home in reproductive roles. These ideals systematically disadvantage the lives of women whilst at the same time enhancing those of men and are very pervasive in patriarchal societies. According to key informants in this research, as well as research by Wallace et al (2018), these patriarchal ideals are often intensified for women with disabilities, who try to render themselves normal in society through their gendered performances.

As well as this, the opportunities that are afforded to women with disabilities are often based on the attitudes towards women held by society in general. For example, “There are many jobs that people think are only for boys... and when opportunities are given to people with disabilities, they are always given to men with disabilities

first. They have more opportunities than women.” (Interview 8, Rwanda). This is important in patriarchal societies such as Cambodia and Rwanda, where physical differences between men and women tend to be given more weight due to traditional societal structures and cultural domination, as well as histories of foreign domination and decolonisation (Jayachandran, 2015). Consequentially, when it comes to disability, gender was found to be an important determinant of opportunities because men are assumed to be more able - or less ‘dis-abled’ than women with disabilities who are already seen to be weak. These gendered differences were also raised in focus groups, where it was explained that it is easier for men with disabilities to get jobs, as there is a cultural belief that men are stronger than women. “If there are jobs to be given to people with disabilities, 100% sure they will give it to a man with disabilities” (Focus Group, 2023). This can further be seen in how easy it is for men to pursue opportunities in patriarchal societies, where women are expected to be demure and quiet. In societies like these, opportunities “depend on a person's experience, but for men it is easier to be confident and go knock on different doors. But for women we are shy and it is hard for us to knock on different doors which makes men have more opportunities than women” (Interview 17, Rwanda).

Another symptom of patriarchal norms which limits access to employment for women with disabilities is the cultural expectation that women will fill traditional gender roles within the household. Especially in Cambodia, it is a widely held belief among participants that women with disabilities “have more opportunities than men because women usually have skills in traditional roles” (Interview 4, Cambodia), and that the skills that are ‘appropriate’ for women with disabilities include sewing, handicrafts, growing crops, selling at the market etc. Whereas for men - regardless of ability - “they fix motorbikes, repair computers or phones, and farm” (Interview 5, Cambodia). According to key informants, many of these skills that are considered ‘easy’ for women with disabilities are traditionally feminine roles in the first place, and do not extend far beyond the household, providing some sense of freedom while simultaneously limiting their independence. This is true of many countries in the Global South, where women are primarily responsible for caring and reproductive roles, and tend to defer to men for those responsibilities which take place in the outside world, and have the power to make significant income. This clear division of

labour tends to subtly limit the independence and opportunities of women (Qiu, 2023).

This study found that women with disabilities tend to take on these traditional roles both inside and outside the home, firstly as they are easily accessible, but also because of what is expected of them in patriarchal societies, showing that women with disabilities are often more limited by these roles that they are expected to fulfil as women, than by their impairments. Participants also feel that if they can do a good enough job in the roles that are traditionally prescribed to them, then they will be considered 'normal' in society.

With these traditional roles in mind, jobs which are generally considered suitable for women with disabilities are similar in both Cambodia and Rwanda. These roles - which will be explored in more detail in the following section - tend to limit women with disabilities to the domestic sphere, in jobs which do not necessarily pay well, thus again causing them to rely on those around them, and limiting their independence. Traditionally feminine jobs also mirror the cultural norms of the patriarchal societies of Cambodia and Rwanda, and reflect the argument in the literature that women with disabilities have to be 'extra feminine' and heighten their performance of their gender identities to be considered good housewives or partners (Wallace et al, 2019).

Many of these issues highlighted by women with disabilities in interviews stem from wider socio-cultural issues around women's rights in these patriarchal societies. In Cambodia, as described by the ADB (2012), men are seen to be leaders, and women are taught to think that men are leaders of the family, so it is only natural for them to take the better jobs, and the higher ranking positions. One participant, when speaking about having the views of women with disabilities recognised at ministerial and government level, commented that "sometimes you can't even say your thoughts because there is so much overload [of] men around you!" (Interview 1, Cambodia), highlighting the invisibility felt by many women with disabilities not only because of their impairments, but also because of their gender.

### 6.4.5 Culture

As explored through the patriarchal understandings of gender and disability above, definitions of disability are often shaped by the culture and context of different countries. Meekosha (2004) proposes that gender stereotypes interact with disability stereotypes to constitute a deeply complex experience of disability in every culture, developed within specific historical contexts, and changing over time. She summarises that disabled men are expected to behave and express their being differently to disabled women in all cultures, though the manner of these expressions is culturally specific. This was reiterated by participants in interviews and focus groups, who emphasised how differently their distinct cultures defined disability.

In Rwanda, as explored in Chapter 4: Context, the culture is generally quite reserved and private. People tend to be quiet and slow to open up, and even in interviews, some of the women I spoke to barely spoke above a whisper. Families usually deal with their problems on their own, and there is a great deal of importance placed on being discreet and on others not knowing your business. There is a strong shame culture, and saving face in public is extremely important (key informant, 2023).

In this context, and against the background of the recent genocide against the Tutsis, trust is extremely important and not freely given. People are very slow to trust others, and even during research, it took me a long time to build relationships with organisations and with others, and to be granted access to participants. Even when this trust was granted, I could tell some interviewees were unsure about sharing their stories, and some organisations declined to speak with me. This is understandable given the trauma of the past, which is still felt by many in Rwanda.

History was found to play an important part in the lives of women with disabilities in both countries, as many of their lives are still impacted by the trauma of the past. In Rwanda, 5 participants spoke about their experiences during the genocide, and the impacts of this on their lives thereafter, highlighting the growth of the disability movement in the aftermath of genocide. Two are recipients of the genocide survivors fund, and spoke openly about this. Genocide memorials are also very prevalent in Rwanda, and are used to keep the memory of those who were lost during this time alive. Many participants spoke about the importance of these as a place to honour

their loved ones and to process their trauma. At one of these memorials which I visited during my time in Kigali, there is also a section about the Khmer Rouge genocide in Cambodia, explaining the similarities and differences between both countries. These memorials, and the events of the genocide as a whole, have an influence on Rwandan society and how people perceive each other in everyday life, especially in terms of trust and community engagement (key Informant, 2023). All of these contextual factors need to be considered when analysing attitudes towards women with disabilities here.

In the Cambodian context, the culture is similarly reserved and quiet. Respect and manners are central to Cambodian culture, and again discretion and saving face are pivotal. The main difference here is that people are more open and trusting generally in Cambodia, as the family unit lies at the core of Cambodian society. This unit both supports and relies on all of its members, and is uniquely strong in its bonds (key informant, 2022). During research I found people to be extremely warm, welcoming, and willing to share their stories with me. This openness made the link between history and disability very apparent during interviews, where two women spoke of acquiring disabilities during the Khmer Rouge war, and many others spoke of losing family members during this time, and still dealing with trauma in the aftermath. Memorials are again important in this context, and people spoke often of memories of this time and the civil war that followed. Despite this war having occurred almost 50 years ago, memories are still very fresh, and participants and informants of this research spoke of the fear they still feel that the regime could re-emerge, as the country is still led by the same political parties from that time.

Alongside history, religion also plays a huge role in the lives of everyday people in both Cambodia and Rwanda, and these factors combined illuminate some of the origins of the patriarchal and cultural norms which influence perceptions of disability in both countries.

In Cambodia, the belief in Theravada Buddhism and karma has led to cultural discrimination against people with disabilities (Morgan & Tan, 2011). Under this karmic rule, people with disabilities are believed to have committed sins in a past life, and therefore are being 'punished' with disabilities in this life. One participant

explained a widely held Khmer belief, that “because of Karma, they think we are not good people from a previous life. They think the family has bad luck to have a child with disability.” (Interview 1, Cambodia) This karmic belief, combined with strong ideals about ‘the perfect woman’ - as described in a later section - creates patterns of systemic disadvantage and discrimination against women with disabilities in Cambodia.

During key informant interviews, a senior monk at a local pagoda explained further that in the Cambodian belief system, disability can be caused by past or current karma. If you are born with a disability, it is a manifestation of your actions from a previous life, but if you develop an impairment later in life, it is as a result of your current karma. Disability therefore is seen as something the person themselves does not have any control over, it is based on karmic destiny or the interference of spirits (key informant, 2022). As such, people with disabilities are often discriminated against, and shown little sympathy by other people in society. Communities may sometimes be suspicious of people who are born with disabilities, “because they are wondering what did you do in your past life that made you have this problem?” (Focus Group Discussion, 2022) Because of this, women with disabilities are often marginalised or discriminated against, and family or community members may take pity on them and assume they cannot care for themselves.

During our meeting, the monk also explained that women with disabilities still need to help themselves, and they can be “equally valued for their skills if they work hard. If they just wait around for handouts then the mind gets bad and they create more suffering” (key informant, 2022). This was very much echoed by participants in interviews, who believed women with disabilities shouldn’t “wait around until people give you help, you have to help yourself first too” (Interview 1, 2022). As well as this attitude helping women with disabilities to be able to acquire more opportunities in society, when related to the karmic belief system, it also reveals that “if you live well and do good in this life, you might not have a disability in your next life.” (Focus Group Discussion, 2022) This attitude is very pervasive in Cambodia, where the culture of saving face places emphasis on relying on oneself and having the strength to overcome challenges. When considered in the context of a Buddhist society, the case may be that women with disabilities feel pressured to do good by their families

and employers in these traditional patriarchal roles, in order to improve their future karma and that of those around them.

Meanwhile in Rwanda, the literature suggests that much of the culture surrounding disability in Rwanda is still based in traditional East African beliefs including proverbs, folk tales and traditional healers (MacDonald & Butera, 2012). While this is true to some extent, especially in rural areas, currently the belief system in Rwanda is around 80% Christian, and faith plays an important role in the everyday lives of much of the population. Many of the women I interviewed here spoke very openly about how their faith helped them to deal with adversity and to accept their disabilities. One participant told me “What I can say is that God is almighty, God is always helpful no matter what. God is always there for us.” (Interview 11, Rwanda), and others spoke about “Thanking God”, and “God willing” (Interview 5 & 14, Rwanda). Key informants also explained that 70% of schools in Rwanda teach a Christian ethos, promoting this reliance on religion in all aspects of life, and teaching children from a young age that their problems can only be solved by God. In many cases, key informants described how this upbringing has led to a perpetuation of discriminatory norms against people with disabilities, where they are believed to be in need of charity and pity, and unable to look after themselves.

While in Rwanda, I was invited to attend a Christian church service, which helped me to better understand how Christianity influences the lives of everyday people. During this service, attendees were encouraged to repent and offer their problems up to God, and the pastor spoke about the importance of healing, deliverance, and living one’s faith. This faith appears to be central to the lives of many people in Rwanda, and during these services it is clear that ancient beliefs mix with Christianity, to influence people’s beliefs about disability, as well as about the world around them. In a closed society like Rwanda, where issues are dealt with in private, and saving face is important, this church service was the first forum where I had seen people show emotion so freely and emphatically - clearly showing their trust in God to relieve them of their problems. This translates into how disability is perceived too, as some families of strong faith, and especially in rural areas, may prefer to seek religious intervention and healing for children with disabilities, in place of or alongside modern medicine (key informant, 2023). In many cases, key informants explained, disability

is seen as something that can only be controlled by God, which may lead to what has been described in the literature as “hiding” disabled family members, or a reliance on religion to “heal” the person.

While these two religions may not appear to have many similarities on paper, in reality, the way they perceive disability is quite comparable. Both place a heavy emphasis on the individual as the bearer of the weight of their impairment, and also promote an acceptance of one’s circumstances - in Buddhism you cannot change your past karma, and in Christianity this is God’s plan. There is also a similar belief that only acts of devotion will cure or save a person. In Cambodia this looks like people with disabilities trying to do good and improve their karma for their next lives, and in Rwanda people routinely attend church services to be delivered from their problems. This demonstrates another significant finding of this research, that societal perceptions and understandings of disability are deeply rooted in the cultural and religious norms of a country, and that they are very context specific, differing from place to place.

#### 6.4.6 Summary

In this section I have presented some of the unique forms of discrimination experienced by women with disabilities in Cambodia and Rwanda, highlighting gender as a main determinant of opportunities and marginalisation, due to the patriarchal expectations of women in both countries. In this chapter I also emphasise that disability and gender are tied to the cultural context of each country, and that discrimination may be more pronounced in countries with stronger patriarchal values. The outcomes of this discrimination based on both gender and disability, will be explored in more detail in the next section.

### 6.5 Opportunities

During interviews and focus groups, almost all participants spoke about the lack of opportunities that often comes with living with a disability, and how this impacted their lives. This is best summed up by Kiani (2009) who explains that women with

disabilities felt blocked from realising their full potential. They believed they had the capacity to contribute richly to their communities, yet obstacles of various types prevented them from fully engaging.

Recent studies show that women with disabilities - and especially rural women with disabilities - are poorly included in many areas of community life, and continue to be the most marginalised from international, national and local disability-inclusive development initiatives and innovation, policy and practice (Gartell & Soldatic, 2016). This often manifests in their exclusion from opportunities to develop human capital, such as education and training, as well as relationships with peers and community members. Tefera et al (2018) further report that exclusion from education is one of the key factors which may cause the marginalisation of women with disabilities in later life, as the potential that women with disabilities demonstrate in their education and employment can be proof of their capability to fulfil other social responsibilities, such as married life and motherhood.

This inequality of opportunities is especially apparent when women with disabilities enter the labour market, and can be seen in the challenges women with disabilities experience in securing the support – both financial and practical – that they need to access employment, health and other services (Pal, et al., 2015). The types of deprivation and marginalisation experienced by women with disabilities also vary across countries, and may change over time, for example lack of education in Cambodia, and difficulties with finding employment in Rwanda. While there are others, below I have outlined the 5 main areas where participants described experiencing a tangible lack of opportunities due to disability.

### 6.5.1. Education

Across the world, educational outcomes for people with disabilities are far lower than for those without disabilities, and this is even more true when considering women with disabilities. Participation rates in education are far lower for children with disabilities, they are found to spend significantly less time in school than children without disabilities across all age groups, and they are significantly less likely to complete primary education. As well as this, disabled girls are reported to be at a particular disadvantage in terms of schooling (Cobley, 2018). Across the board during this study, women with disabilities expressed that they were not happy with their level of education, and would like to have studied more if they had the opportunity. In both countries it is “hard for women with disabilities to go to school” (Interview 1, Rwanda) for a variety of reasons.

As presented in figure 2, data from interviews shows that educational attainment for women with disabilities is far better in Rwanda than in Cambodia. Here all participants have at least basic education, and average years of education reach 9.5, or somewhere around lower secondary school. In Cambodia however, 37% of participants received no formal schooling, and of those that did, the average years spent in school was 5.5. This is likely due to the Rwandan government’s focus on education, and the political will that exists to make education more inclusive (key informant, 2023). Rwanda also has a number of schools specifically for children with disabilities, and disability mainstreaming has been made a priority in schools across the country to promote the inclusion of children with disabilities (Wallace et al, 2018). This is possibly a positive side effect of the predominantly Christian school system, reinforced by a strong governmental commitment to education, which has built a robust and extensive network of schools across the country (key informant, 2023). Cambodia, on the other hand, has a

Figure 2: Participant's years in education

Cambodia	Rwanda
16	8
12	12
5	10
7	4
6	6
4	11
12	3
0	16
0	16
0	12
10	16
0	16
0	16
11	2
5	9
0	6
	5
	6
	7
	10
Average = 5.5 years	Average = 9.5 years

relatively unregulated education system, so education among the general population is still low, and schools tend to be scattered and less standardised.

In Cambodia, most participants in interviews had not completed primary school, and only 1 participant had gone to university. Of the Cambodian participants who did continue on into secondary education, 68% of women with disabilities surveyed here did not complete secondary school. Participants explained that it was “hard to access education due to disability”, and that poverty and needs of the family were major barriers to their education (Interview 1, Cambodia). A study by UNICEF (2019) also identified poverty as a significant barrier to inclusive education in Cambodia, and expands on this by explaining that many children with disabilities from poor households are unable to attend school due to the costs of uniforms, school supplies, and transportation. Further, teacher training is also identified as a significant challenge in promoting inclusive education in Cambodia, as teachers may have negative mindsets, and do not know how to treat children with disabilities in their classrooms (UNICEF, 2019).

These negative attitudes are one of the most significant barriers to education for women with disabilities according to interview participants, who explain that even at home, “[my] parents did not encourage [me] to study because of disability.” (Interview 5, Cambodia) and that “my parents didn’t think girls could continue at school so I don’t have any possibility to continue my schooling.” (Interview 20, Rwanda) Often girls with disabilities are denied education because family members view them as not worth the investment of time and money, since they are unlikely to succeed in education, get married, and have a job in later life. As explained above, this is often because a woman’s main role in most patriarchal communities is still to be a wife, mother, and homemaker, while the man is the main decision-maker and income-earner. Since education and vocational training are seen as investments for higher-value employment, a woman with disabilities is less likely to have the opportunity to receive them (Kiani, 2009). This is another facet of the types of discrimination faced by women with disabilities due to assumptions about their abilities based on both their gender as well as their disability. A major finding of this research is that women with disabilities are systematically denied opportunities to

engage with education and the labour market due to these societal perceptions of them.

In Rwanda, educational attainment among women with disabilities is higher, with the majority having attended lower-secondary school, and 5 participants completing a university degree. Here all interviewees received at least basic education, with no reports of informal education, likely because primary school education is free for all children in Rwanda. Despite this, access to appropriate education is still a problem for women with disabilities in Rwanda, and the literature highlights that children with disabilities face similar problems to those in Cambodia, and are often unable to attend school due to costs of uniforms and books, as well as distance from institutions (Karangwa et al, 2010).

These issues with school fees and distance are some of the major barriers to inclusive education in Rwanda, and were discussed frequently in interviews. Many of the participants from both rural and urban areas in Rwanda spoke about the difficulties their families had with paying fees in secondary school, and the worries they had about paying school fees for their own children. In interviews, women explained that they are “not happy with [their] education but could not go into secondary school because they could not pay the school fees.” (Interview 2, Rwanda) In another case, a participant “went to a school for people with disabilities and did well in class because she had confidence. But she had to stop in secondary school because she could no longer pay the fees.” (Interview 12, Rwanda) As described above, in both countries, exclusion from education is often due to poverty and lack of resources, combined with traditional views on the role of women, with women reporting that they could not attend school “because of the living conditions” and “needing to look after the household to survive” (Interview 2 & 3, Cambodia).

In addition, discriminatory attitudes among students and staff, communication barriers for those who are deaf and blind, lack of support for teachers, and inaccessible school infrastructure make school attendance difficult for children with disabilities (Karangwa et al, 2010; Trani et al, 2011). One interviewee stated that she “started school at more than 10 years old because [she was] discriminated because of [her] disability. The parents left [her] at home” (Interview 12, Rwanda), and

another told a similar story: “After primary school [she] went 5 years without going to secondary school because of disability, then [she] got a scholarship to go to university” (Interview 13, Rwanda). Other participants reported going to school, but being unable to complete their education:

*There was a school for PWDs in Southern Province that I joined but could not complete even 1 year because of the sickness that I had (Interview 4, Rwanda).*

*I wanted to continue my studies but it wasn't easy...I could leave for school, come home, find nothing to put in my stomach, and then it wasn't easy for me to continue school. I dropped out (Interview 16, Rwanda).*

Participants also noted that while enrolment and attendance at school are important for girls with disabilities, their inclusion, empowerment, and participation are arguably more important in later life. This retention and participation is important because higher levels of education tend to lead to improved self-belief and self-confidence in later life (Joshi & Srivastava, 2009), which are valuable assets to women with disabilities as they navigate this web of discrimination and marginalisation in later life.

Further to this, in both Cambodia and Rwanda, literacy is a big concern for women with disabilities. In Cambodia, where education is lower, 31% of women surveyed reported not being fully literate in Khmer, with some participants explaining that they “went to primary school but cannot read or write” (Interview 7, Cambodia). Others described being able “to read and write a little. [She] went to primary school, but had to leave to work.” (Interview 8, Cambodia), or not receiving formal education “but [her] father taught [her] to read and write” (Interview 12, Cambodia). While in Rwanda only 15% of the women interviewed reported difficulties with literacy, the issues are the same. Most of these participants described not returning to education after acquiring disabilities, so their level of education is low. “Writing is not easy for me, but I do read. I cannot cry with what I couldn't get” (Interview 7, Rwanda). Others have a functional level of literacy, but still report difficulty. “I can read and write in Kinyarwanda, I'm not that good, but I try” (Interview 5, Rwanda). This is a tangible

outcome of the discrimination faced by women with disabilities on a daily basis, as they are systematically denied opportunities to engage fully in society, and further shows that it is not just access to education alone that will improve opportunities for women with disabilities, but rather the quality of the education that they receive (UNICEF, 2019).

Interestingly in Cambodia, each of these women that expressed being illiterate or a difficulty with literacy, also expressed a wish to learn more. For example, two women who have never been to school expressed that they “now want to learn English” (Interview 12, Cambodia), and the other “wants to learn more but cannot because she has to support her family.” (Interview 14, Cambodia) Clearly there is a wish for better education here, but because of discrimination and inaccessibility, as well as a lack of self-belief, many women are “afraid [they] cannot learn more” (Interview 7, Cambodia).

In both countries, women with disabilities also believe that education and literacy are key to better opportunities for both women and young people with disabilities. This is also supported by a recent report from the Inclusive Education Initiative (IEI) (2023), which proposes that girls with disabilities who access quality education tend to report greater confidence and self-esteem, improved social interactions, financial independence, and more positive aspirations for their own futures. For some women who took part in interviews for this study, they had aspirations of being a teacher, doctor, or driver, which they couldn't fulfil due to lack of education, and now advocate for children with disabilities “to get higher education so that they can choose the skills they want” (Interview 5, Cambodia). Others emphasised the importance of continuing education for women with disabilities at all stages of their lives so that they can improve their futures, saying: “If I could continue my schooling, I couldn't be like this, I could be having a very good career, and even if I got a disability I think I would be in a better position than the one I'm in” (Interview 20, Rwanda). This once again highlights education as a main determinant of opportunities for women with disabilities in later life.

Discussions in focus groups further emphasised that education is the key that leads to employment. This is because there is huge competition for jobs in emerging

economies, and if women with disabilities don't have excellent education and qualifications they cannot compete with their non-disabled peers (focus group discussion, 2022). As populations in general are gaining more skills and experience, the labour market is such that people with disabilities get left behind because they do not have the same opportunities for learning and growth in the first place. As this implies, the educational programmes with the best outcomes for girls with disabilities are likely to be those that incorporate hands-on training, and present participants with a clear sense of how to build a secure and meaningful future for themselves (IEI, 2023). This is where vocational training and skills programmes can be useful to give women with disabilities experience and skills that are practical and useful when entering the labour market.

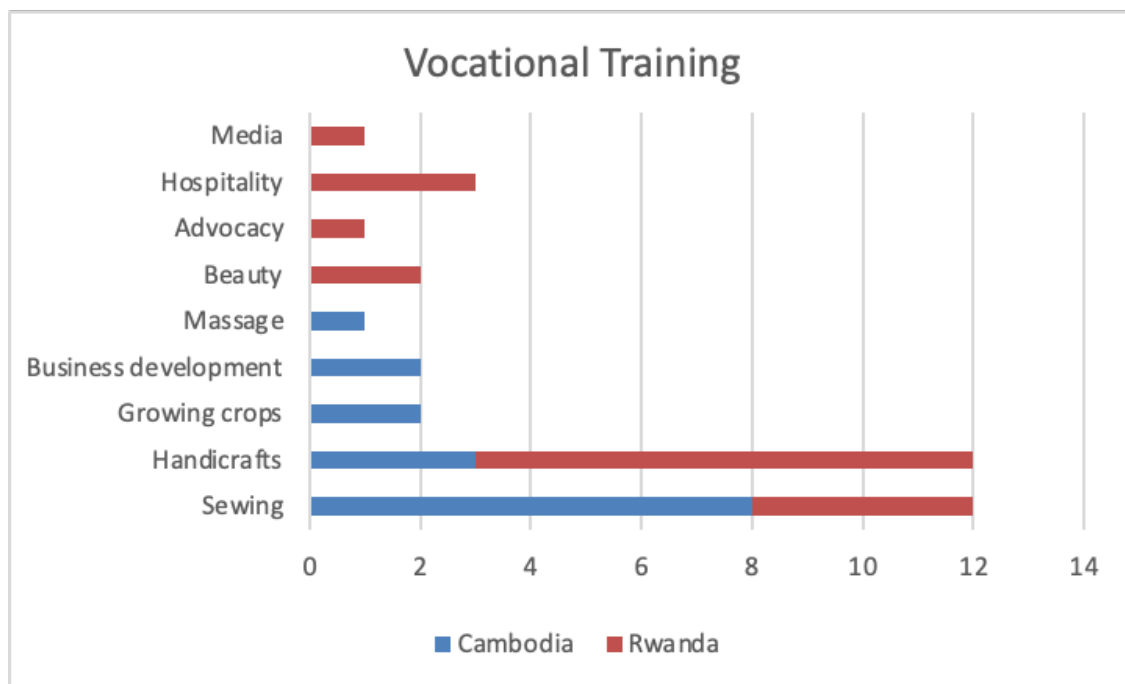
### 6.5.2 Vocational Training

According to all but one interviewee, vocational training is one of the most important opportunities afforded to women with disabilities, and all interview participants in this research had received vocational training of some sort. A 1999 report prepared by the ILO emphasised the need for vocational training for women with disabilities because it provides them with legitimate entry points into employment, by equipping them with specific skills for jobs in the labour market. Vocational training also furthers the education disabled women have received from school, and can even compensate for the earlier lack of opportunities for an adequate education (ILO, 2017). Vocational training also provides vital opportunities for women with disabilities to engage with their peers, identify as part of a community, and reduce isolation (Bartram & Cavanagh, 2019). In these cases where women have little to no education, vocational training represents an opportunity to “gain skills for them to earn an income and support [their] families” (Interview 1, Cambodia). As further reported by the ILO (2017), vocational programmes tend to be most successful when they incorporate training which presents women with disabilities with a clear sense of how to build a secure and meaningful future for themselves. Often, this allows students to contribute to household income, and build aspirations for their futures.

As described by figure 3 below, in both Cambodia and Rwanda, sewing and handicrafts were the most popular sectors for vocational training, and most women

believed that “after they get training from an organisation, they can have any opportunity to get a job” (Interview 2, Cambodia). While most women trained in traditionally feminine roles as outlined above, some chose less traditional paths, like agronomy and hotel management (Interview 13, Rwanda), English and financial literacy (Interview 10, Rwanda), and massage (Interview 6, Cambodia). The soft skills taught by vocational training and utilised in everyday life were also extremely important to women with disabilities in the research. For deaf women, or those with hearing impairments, it is most important that they be taught sign language because “without communication you can do nothing. That will change their lives” (Interview 6, Rwanda).

Figure 3: Sectors of vocational training among participants



The skills learned in vocational training were described as transformational for women in this study, as multiple women were able to conduct interviews fully in English, and others have previously been invited to share their stories and leadership capabilities on international platforms. Focus group participants agree that oftentimes skills are the most important qualification for people with disabilities, especially in terms of English and computers, and that, if they have these, then they are in a better position (focus group discussion, 2023). Many of these women agreed that these trainings were vital in helping them to secure a job, but also pointed out

that “trainings can be very expensive and should be subsidised” (Interview 6, Cambodia).

On the other hand, vocational training may not always be the ideal solution, as some women reported that they had completed vocational training, “but I can’t say that they were enough or that they were relevant. Sometimes people give you training... but for sure you have nothing else, not enough knowledge to work” (Interview 4, Rwanda). This was echoed in Cambodia, where participants described “not having enough [knowledge] to get any job from vocational training” (Interview 3, Cambodia). Another common issue across countries is a lack of long-term planning for after vocational training. Despite 12 women having vocational training in sewing, 8 expressed that they “couldn’t get a machine to sew, so couldn’t continue what [they] learned.” (Interview 16, Rwanda) This also meant that they were unable to get a job in sewing afterwards, as making a profit in this kind of work usually requires that tailors have their own machines (Interview 5, Cambodia). Another issue that was raised mainly in Rwanda was once again around money. Women explained that for many skills it is “hard for us to get vocational training because school fees for those trainings is not easy.” (Interview 18, Rwanda) This poverty is clearly stopping women with disabilities from being able to access opportunities, as another participant explained “where they were giving training, they are charging money that I don’t have.” (Interview 15, Rwanda). This is where the vicious cycle of disability and poverty as described by Copley (2018) has tangible impacts, as women with disabilities are unable to pay for vocational training which could lead to salaried employment, and are also unable to access salaried employment without vocational training.

Another aspect of vocational training to consider, is the informal training that takes place within communities, often alongside training from organisations. This does not appear in the literature, but was emphasised by participants as important to their development. For example in Cambodia, one participant got training in running a small business from AGILE [a national NGO], while also learning to sew from her brother-in-law (Interview 12, Cambodia). Where organisations can’t or don’t provide assistance, communities often step in to fill the gaps in opportunities. This was explained by another participant in Cambodia who considered herself to have no

formal vocational training, but learned to make bags and purses from the community and her parents, to sell at the local market (Interview 7, Cambodia). These local trainings, in conjunction with formal vocational training, may in many cases, fill the gaps in education experienced by many women with disabilities, and allow them to enter the labour market in non-traditional ways. This is also emblematic of the informal community support received by many women with disabilities, which is discussed later in this chapter.

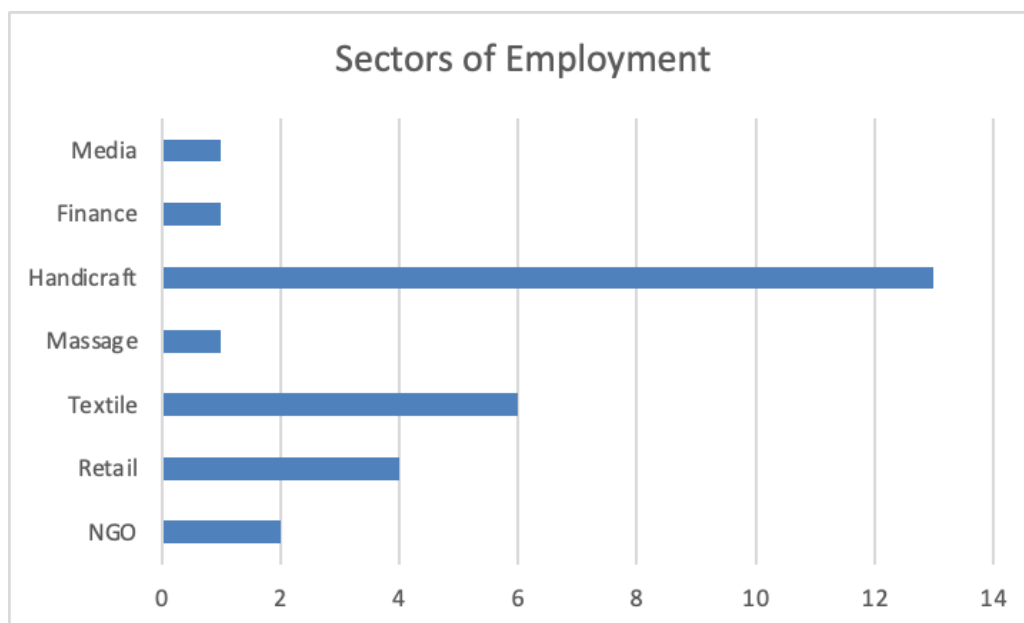
### 6.5.3 Jobs

As referenced in the literature review, in the Global North, it is well established that people with disabilities have worse outcomes in terms of economic indicators than people without disabilities, including lower employment rates, wages and earnings. This is mirrored or even amplified in many settings in the Global South, where many people with disabilities experience compounded livelihood challenges related to general economic disadvantage as well as disability. Overall, the evidence from Hanass-Hancock & Mitra (2016), supported by CBM (2018) & Plan (2013), suggests that there is a disability gap in employment rates globally, and that, in the Global South, policies promoting access to employment may be particularly important for the economic well-being of people with disabilities and their families.

This disadvantage was certainly emphasised by interview participants in both countries. In Cambodia, women described having “difficulties finding a job due to disability”, but “if they [make] a big effort, the jobs will be coming to them.” (Interview 3 & 6, Cambodia) One participant also pointed out the intersection of education and disability as described earlier in this section, which can lead to a denial of opportunities: “it wasn't easy for me to get a job because I'm not educated and as you see, I'm disabled.” (Interview 19, Rwanda). This is an example of how previous ostracisation from education leads to fewer opportunities for employment in later life. This can be further complicated by a lack of functional capacity and self-confidence. For example, women with disabilities need to have knowledge and self-belief to be able to apply for a job in the first place, and often this knowledge is not accessible to them due to a lack of accessible technology and infrastructure (Interview 10, Rwanda).

For women with complex impairments, these challenges are multiplied. One participant described how women with visual impairments find it especially difficult to find jobs “because all people around you they think 'how can you use a machine without seeing the screen? How can you do our work without having normal eyes?’” (Interview 8, Rwanda). Equally for deaf women there are obstacles, “Being a deaf tailor with hearing customers is especially hard. If I get another job, how am I going to communicate with my colleagues?” (Interview 6, Rwanda) This highlights the inaccessibility of most traditional workplaces in both countries, and may explain why most women in this study have chosen self-employment or informal employment. This also emphasises that women with disabilities are disadvantaged by the attitudes of those around them, which are frequently discriminatory and disparaging. As previously described, this is another example of how women with disabilities are underestimated in the workplace, both because of their impairments, as well as their gender in patriarchal societies.

Figure 4: Sectors where participants work



As described in figure 4, sewing /textiles and handicrafts are the most popular jobs for women with disabilities in both countries, but participants in interviews work in diverse sectors, despite difficulties in finding employment. Other sectors include textiles, retail, NGOs, massage, media and finance. In Cambodia and Rwanda, almost all participants in interviews considered having a job to be fundamental to both their livelihoods and to their identities, saying “if you are working and you have

something in your pocket, they cannot abuse you.” (Interview 12, Rwanda) Economic participation can therefore play an important role in lifting people out of poverty, as well as boosting self-esteem, and contributing to household income (Cobley, 2018).

Across many countries there is growing recognition that one of the opportunities for increased participation of women with disabilities in the work-force is self-employment and entrepreneurship. It is argued in the literature that self-employment, alongside benefits to livelihoods and living conditions, may also lead to breaking down some of the barriers faced by people with disabilities in society, and provide them with access to opportunities that are traditionally viewed as not possible or unattainable given their impairments (Martiz & Laferriere, 2016). During interviews, 10 participants reported being self-employed, working in areas like massage, market stalls, sewing, and beauty. In Rwanda, one participant explained that “She feels like she is not supposed to work for other companies but to create her own job” as the opportunities for growth are better (Interview 12, Rwanda), and another in Cambodia, when asked about the hours she works, commented that “my business is always happy, nothing about long hours!” (Interview 3, Cambodia). Self-employment can be an attractive option for women with disabilities for these reasons, as well as others, including increased independence and the ability to accommodate an individual’s lifestyle needs, as well as flexibility in work arrangements, and overall job satisfaction (Martiz & Laferriere, 2016).

Many of these women take pride in owning their own businesses, and in some cases managing a team of staff. In most cases they are also finding success, even if they “started small, now the business is growing” (Interview 12, Rwanda). This is another significant finding of my research, showing that when women with disabilities receive the right training and education, they can be confident in themselves to make significant business ventures, and to engage in the world of work in a meaningful way. Thus the livelihood opportunities available to women with disabilities are not limited to traditional salaried employment, but also include entrepreneurship and management.

Despite considering the types of jobs which are appropriate for women with disabilities to be ‘easy’, interviewees report working hard in both countries. Women

work slightly longer days on average in Cambodia, at 8 hours, than in Rwanda, at 7 hours, although this varies greatly based on sector and on functional capacity, and does not account for the unpaid labour most engage in after work. As reported by participants in this study, pay is also significantly higher in Cambodia, averaging \$250 per month, compared with just \$48 per month in Rwanda. This is surprising when considering that levels of basic education are much higher in Rwanda, but is likely due to a higher demand for products in Cambodia. It could also be argued that in Cambodia, where the economy is growing rapidly, vocational trainings are more relevant to expanding markets like the garment and tourism sectors, meaning that women with disabilities who graduate from these programmes are employable in sectors where their skills are in demand. This is not as prominent in Rwanda, where the economy in general is smaller, and the skills considered suitable for women with disabilities simply aren't in as high demand.

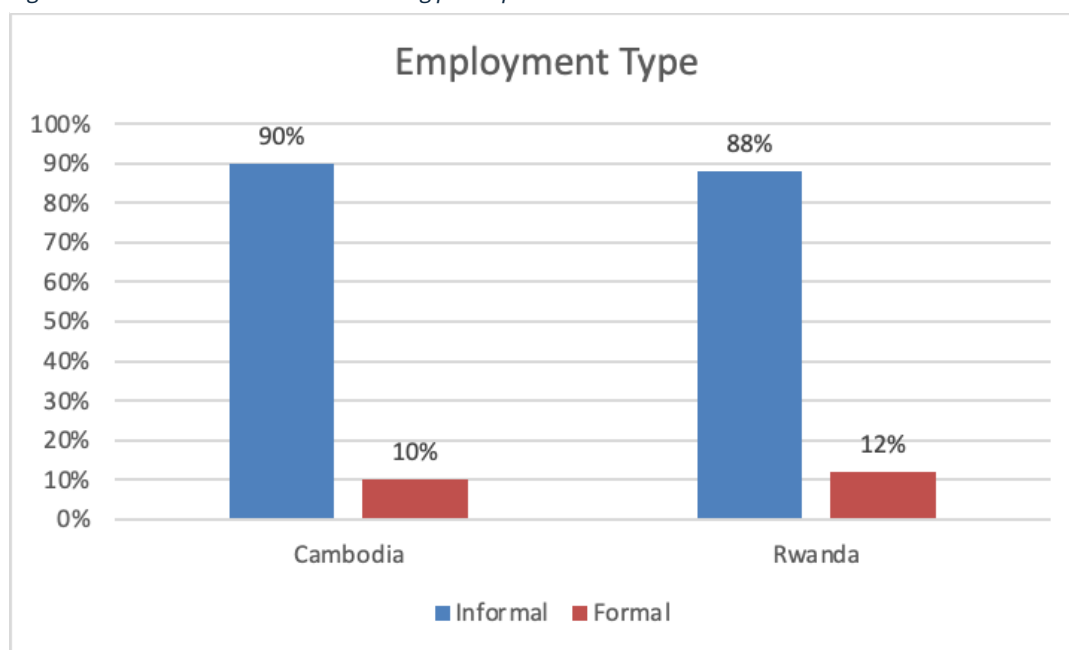
One of the most popular livelihood opportunities for women with disabilities in both countries is sewing, as it is seen as women's work, and it is appropriate for women with disabilities to "just sit down and do the easy job" (interview 1, Cambodia). It is also "easy for them to work at home" so women can still take care of their household tasks (Interview 5, Cambodia). These quotes again demonstrate how patriarchal ideals and traditional household roles limit the opportunities available to women with disabilities, assigning them to specific roles based on what is culturally expected of both a woman and a person with a disability. Once again, women with disabilities may choose to play further into these stereotypically feminine roles, in an attempt to be seen as closer to a 'normal' woman in society (see Wallace et al, 2018).

As reported by Maritz & Laferriere (2016), women with disabilities are often marginalised from the formal labour market due to a lack of business knowledge, experience, and skills. This lack of work experience, in conjunction with a low level of education, often relegates women with disabilities to low-skilled, manual jobs in the informal sector. This was highlighted by participants in Rwanda, who explained that they started sewing and handicrafts "because there is no other thing that I can do" (Interview 5, Rwanda). Interviewees further explained that it can be difficult to find a job "if you have no knowledge or experience", so for many women with disabilities learning skills in sewing "can help to improve profit" (Interview 1 & 4, Cambodia).

There are also practical benefits to working in sewing, as a lack of disposable income means that clothing and household items need to be mended often, and this most often falls under the typical household tasks of women.

Focusing on the gendered identities of women with disabilities, this finding also uncovers a more general cultural devaluation of skills which are primarily considered to be feminine - meaning that traditionally female occupations and tasks are assumed to be less valuable than male tasks. Further, this widespread devaluation of women's work tends to decrease wages in female-dominated occupations such as sewing and handicraft work (Magnusson, 2009). This means that even with relevant skills in sewing, opportunities for employment are usually only in the informal economy, where pay is low and often irregular for women with disabilities, and they may take on other jobs in similar sectors to supplement this (Interview 4, Cambodia). In other cases, women may work as part of a cooperative to increase profit and improve the stability of income (Interview 6, Rwanda).

Figure 5: Formal vs. informal work among participants



While it is difficult to fully gauge whether employment is formal or informal due to the nature of the sector, based on frequency of employment and pay, around 90% of interview participants in Cambodia and 88% of interview participants in Rwanda are part of the informal economy, as presented in figure 5 above. As explored in the literature review, the informal sector has usually been regarded as preferential for

people with disabilities, since it has lower barriers to entry and enables them to earn a basic income. Conversely, accurately capturing the true economic well-being of individuals working in the informal sector can be difficult, and the dominance of non-cash remunerated work, irregular flows of income, and complex community-based resource sharing arrangements often make informal work complex to navigate for people with disabilities. As a result of this, people with disabilities have been indirectly obliged to work in conditions with no social security, no insurance, and sometimes negative work environments, to secure their basic needs (Boutros & Fakih, 2023). As well as this, as highlighted by the ILO (2018b) above, women are often responsible for unpaid childcare and household work in families, meaning that they may have no choice but to take on low-quality, flexible jobs that allow them to attend to these responsibilities outside of work hours.

It is difficult to find information on the informal economy in Rwanda, but employment in this sector is likely lower here because of government regulations and policies, as well as better access to education and support programmes for women with disabilities. In the garment industry in Cambodia, this informal work is often referred to as 'piece work', and is a popular way for companies to hire women with disabilities to work from home while paying them less than factory staff (key informant, 2022). These jobs are often unstable and women who work in this way explain that "if business is not good, we don't have any jobs to do." (Interview 12, Cambodia) This can also involve working long hours with irregular pay, which can increase if a tailor can learn to make more current styles of clothes (Interview 13, Cambodia). Key informants also mention that while working conditions may be better in smaller-scale enterprises, larger factories generally have better salaries and are therefore more attractive.

This type of work is also extremely common in Rwanda, although more participants did piece work for the handicraft industry here. Regardless, conditions are the same, "They pay us with the work we do so if I start weaving a basket, when it's complete is the time I get payment." (Interview 1, Rwanda) Again women are not receiving a monthly salary or any of the benefits of formal employment, and are often working irregular hours, as explained by another interviewee: "[the hours I work] all depends because this work is the only thing which gives me money. So I can over work, or if

I'm not feeling well, I just do a few things and then I come home." (Interview 3, Rwanda) This work is not considered ideal or a perfect solution for participants, but many feel that they have no other option but to work this way due to low education and functional capacity, as well as high barriers to entry into other sectors.

Another issue participants raised - mostly in Rwanda - is the disparity of opportunities between rural and urban areas. This is further explored by Kiani (2009), where women with disabilities reported significant differences in quality of life between rural and urban areas. Here women in rural areas described having less access to healthcare and rehabilitation-related services, as well as being confined to the boundaries of the home more, usually due to financial limitations and lack of information. It is for these reasons, as well as others, that many interview participants in Rwanda moved to Kigali to find work, and explained that "In Kigali, it is easy for them to get a job and access different things." (Interview 3, Rwanda). Especially for women with complex needs or blind women "there are many more opportunities in cities than in the rural areas" (Interview 8, Rwanda). This phenomenon has not been well studied in the literature, and would be interesting for further study.

#### 6.5.4 Unemployment & Poverty

As highlighted in previous sections, there is a significant disparity between disabled and non-disabled individuals in educational opportunities and training, which in turn impedes their ability to secure employment. Unemployment is an important factor in this research, as women with disabilities are impacted not only by the financial implications of being out of work, but also with the identity constraints that this places on them. This is because work is an important aspect of identity for many people, and even for those who are out of work, it's value to their identities does not decline.

A core finding of this study is that the discrimination and ostracisation experienced by women with disabilities throughout their life cycles often results in poverty and exclusion from the labour market. This unemployment also has wider implications for women with disabilities, as limited participation in the labour force results in reduced power and influence in decision-making, both at home and in the community (Tefera

et al, 2018). This is reflected in many countries in the Global South, where the unemployment rate for disabled people remains at 5.3% (Boutros & Fakih, 2023). When considering jobs and unemployment, poverty and money were often raised in interviews, and despite major differences in earnings across countries, the issues and concerns raised are the same.

Considering figures 6 & 7 here, unemployment among women with disabilities in this study is higher in Cambodia than in Rwanda, with 38% of participants in Cambodia reporting being out of work, compared with 20% of participants in Rwanda. Even in this small-scale study, this number is likely to be undercounted, as many of the questions in this study do not account for all the material and social costs of living with a disability (see Parish et al, 2008).

Figure 6: Employment rates among participants in Cambodia

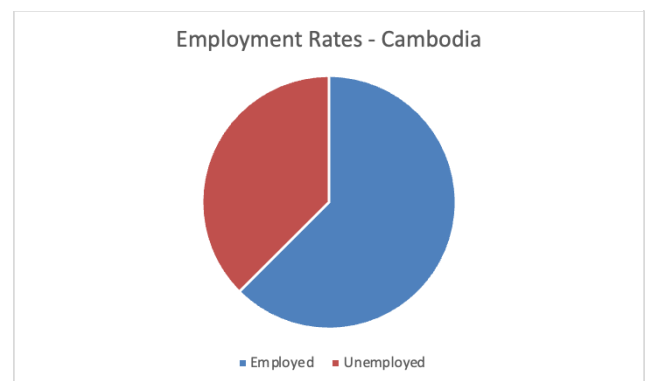
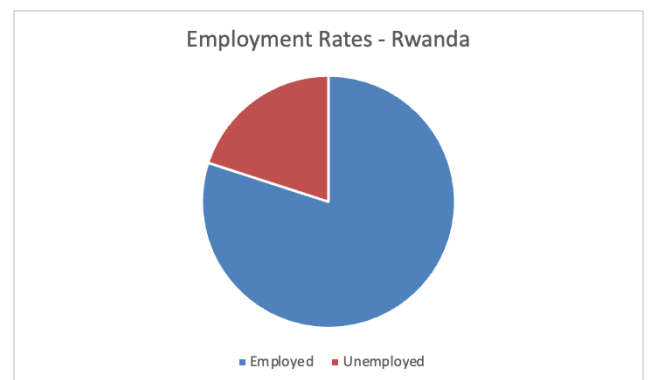


Figure 7: Employment rates among participants in Rwanda



Despite this, the reasons for unemployment are similar in both countries, and some women believe that they cannot get a job because they have a disability (Interview 7 & 8, Cambodia). Here it is clear that women with disabilities may internalise the perceptions and attitudes held by those around them relating to disability, gender and capacities. If women with disabilities are constantly fed messages by those around them that they will not be successful and will have to rely on others for their entire lives, then it is no wonder that they themselves lack belief in their own abilities.

Economic factors of course also play a role in overall unemployment figures, and in Cambodia, the effects of Covid-19 were particularly pronounced during interviews in late 2022, due to the country's reliance on tourism. Participants who worked in retail or hospitality reported having their incomes cut in half since the start of the pandemic

(Interview 6 & 12, Cambodia), and others described being unemployed now that markets and shops have closed down in the aftermath (Interview 7, Cambodia). This again demonstrates the precariousness of reliance on informal employment, which can leave women with disabilities more open to shocks such as this.

Those who have low education are more likely to be unemployed in both countries, and opportunities for those who live in poverty are few and far between, with many interview participants describing how “those who want to have a small business usually do not have the money to start” (Interview 8, Cambodia), once again highlighting the cyclical relationship between disability and poverty. Others have never had a job “apart from just walking around and looking for what I can do to get money” (Interview 16, Rwanda), and others still had jobs previously, but had to stop working because of disability - “I had difficulties with my back and I couldn’t continue doing these small jobs” (Interview 15, Rwanda). These “small jobs” are common in both Cambodia and Rwanda, and tend to blur the lines between unemployment and informal work, with one participant describing how she “just stays home, but sometimes makes bracelets for [her] sister [to sell at the market], one time a month” (Interview 11, Cambodia). This is likely due to the lack of social safety nets in both countries, where women with disabilities can’t afford to be fully unemployed, due to household responsibilities and disability related costs. As explained earlier by Sarmaa (2023), unless they are receiving some level of support from family members or NGOs, there is no option for most women other than to work (key informant, 2022).

When speaking about wages, most interviewees highlighted the irregularity of their pay as one of the main factors keeping them in poverty. Some participants in Cambodia speak of earning around \$2.50 per day - just below the national poverty line of \$2.75 - and many others in both countries explain that their wages are based on what they can produce, as described above. Many women in interviews also spoke about how this poverty can be generational and difficult to break out of, explaining for example, how they could not go to school or finish education because of living conditions during childhood, and how many now use their incomes to support family members and take care of other responsibilities like healthcare, assistive devices, and rent (key informant, 2022). This responsibility for family

members and pressure to contribute to the household often keeps women in a cycle of poverty which is uniquely gendered, and can compound the disability/poverty cycle by adding extra layers of financial responsibility. These cycles often mean that women with disabilities do not have the opportunities to improve their skills or opportunities for employment outside of the home (Focus group, 2022).

Participants in both interviews and focus groups also discussed how it is common for people with disabilities to be paid less than their non-disabled peers for doing the same work. For example in Rwanda, where women with disabilities “are getting 10,000 FRw (€7) a month while the others [without disabilities] are getting 100,000 FRw (€70) a month... They consider them to be the weak people who cannot earn the same wage as others” (Interview 13, Rwanda). This is a major issue across both countries, where employers routinely underestimate the labour worth of women with disabilities, and therefore try to justify paying them below national average wages (key informant, 2023). In Rwanda, one interviewee raised how women with disabilities are often “not considered as normal employees”, especially when they have complex needs (Interview 13, Rwanda). This is most often because of societal misconceptions about the needs and abilities of women with disabilities. She further explained how she has been through many periods of unemployment due to her disability, usually because employers don’t understand her needs.

All but one of the women with disabilities that I interviewed said that they enjoyed their work, despite working long hours with low wages. One interviewee from Rwanda described that she does not enjoy her work “because there is not a big profit that I make... I can’t say that I earn something because what I get I pay to the moto guy and I end up having nothing.” (Interview 3, Rwanda) On the other hand, another woman in Rwanda explained that despite the low pay, she still comes to work in the handicraft industry “so that I can get money from working instead of just sitting at home.” (Interview 2, Rwanda) Another echoed the sentiment that irregular pay is better than none at all: “I can say that I enjoy the work because even if I am paid a small amount, there are other people who are getting nothing. Even though it’s not enough money, at least I can get something.” (Interview 20, Rwanda) This came up often in interviews in both countries, where participants expressed that “When you are getting money, when you have something in your pocket, no one can disrespect

you.” (Interview 2, Rwanda). In this way interviewees explained that opportunities for jobs represent more than just pathways out of poverty, but also a way to increase one’s social standing in the community and gain respect from peers. This is true across both countries, and participants in Cambodia reiterated that if women with disabilities “have a job and can make income for themselves, it means that the people around them can try to encourage and respect them more” (Interview 2, Cambodia). This shows that disability as an identity factor is heavily influenced by poverty and social class, and that perception of disability can change based on a person’s wealth and contributions to society.

### 6.5.5 Marriage

Marriage is also a marker of opportunities and a way for women with disabilities to improve their social standing in Cambodia and Rwanda, and was an important topic of discussion in interviews. This aligns with other literature from the Global South, where one of the main challenges that women with disabilities shared was finding a suitable marital relationship (Kiani, 2009). According to this paper, one disabled participant stated that many men were afraid of disabled women due to the false belief that disability was contagious. Other women felt that patriarchal cultural norms expect women to perform household chores while bringing in an income. This creates a difficult expectation for women with disabilities, and they are seen by many as ‘unfit’ for marriage (Kiani, 2009). During fieldwork conducted for this thesis, family and marriage were identified as important markers of social standing. In Cambodia, where the nuclear family is extremely important, 50% of participants were married at the time of the survey, compared with 20% of participants in Rwanda.

Participants immediately recognise the benefits and opportunities which come with marriage, and most speak about wanting to get married in the future, if they have not already done so. These benefits include sharing of resources, money, assets, support from family, children, and being able to rely on your partner in all circumstances (key informant, 2023). Participants also recognise that marriage is not always straightforward for women with disabilities in patriarchal societies due to their (perceived or real) inability to perform traditional gender roles, as well as the social stigma they face (Amin et al, 2019). Multiple participants in interviews expressed

how the cultural norms in both countries prevented them from getting married. For example during focus groups one participant explained that in Rwanda: “for a man, no matter if you are ugly, you are crazy, you have a disability, you will always find someone to marry you, but for girls with disabilities, no one will marry you so you will die at your home” (Focus group, 2023). Amin et al (2019) also found that in the Global South, women with disabilities are restricted in marriage and motherhood prospects due to the patriarchal and disabling nature of society. This is generally due to issues with individual agency, familial control, and societal barriers in understanding experiences of disability.

As well as this, participants also recognise that men in general stand to gain more from a marriage in terms of opportunities than women, saying, “if you are a man with disability, it is easier for you to get a wife or a woman to live with, but for us it is not easy. When a man with disability gets married and they have a wife, she comes and helps him, which is an opportunity.” (Interview 4, Rwanda) Here the cultural beliefs about disability combine with the patriarchal attitudes towards women, creating an exclusionary mindset which essentially omits women with disabilities from the marriage market. Another issue highlighted in the literature is the difficulty women with disabilities have in meeting new partners, mainly due to their poor access to wider social participation. In many cases, their lives are restricted to their homes or immediate communities, and mostly involve interactions with their families and disabled colleagues. This in turn leaves women with disabilities with limited opportunities to meet non-disabled partners (Amin et al, 2019).

Women with disabilities may also be excluded from the marriage market based on cultural beauty standards. Participants explained that in terms of physical body, “men are looking for a perfect body woman, pretty and young...there are a lot of traditions here, women have to serve the family. You can’t marry a woman with disabilities because she won’t create a baby for you.” (Interview 1, Cambodia) These comments made by a participant during an interview are emblematic of some of the widely held misconceptions about women with disabilities and their suitability for marriage. Equally in terms of cultural attitudes, “when you [as a woman with a disability] are getting married with a man, he is wondering what kind is this woman, is she mad? Is she a human being?” (Interview 10, Rwanda). Again these societal misconceptions

around disability perpetuate the idea that women with disabilities are not capable of filling those roles of being a wife, mother, or partner, because they are fundamentally different from women without disabilities, and men with disabilities.

Women themselves recognise this inequality, and acknowledge this often difficult reality of living in a patriarchal culture. Many have accepted that for men with disabilities “they will always have someone to get married to, but a woman with disabilities, it’s very hard for them to get married” (Interview 16, Rwanda). This is due to the differences in cultural attitudes towards men and women as described earlier in the chapter. Regardless of if a man has a disability or not, he is still considered to hold the power in society, and assumptions about his capabilities are more favourable in most cases (key informant, 2023).

The other option it seems for women with disabilities, as discussed earlier, is to become successful in spite of your disability. In Rwanda at least, “[if] they get jobs and get well paid, ok, from there they can get married, but if they are earning nothing, it is not easy” (Interview 16, Rwanda). This shows that while disability is an important identity marker in Rwanda, functional capacity is arguably more important for gaining respect from peers, as the greater a person’s ability to work and earn an income, the more respect they can earn from their community.

Finally, 61% of participants have children, and 32% of these spoke about the difficulties of being single parents and needing to rely on those around them for help and support in family matters (key informant, 2022). For example in Cambodia, one participant relies on her family, as her husband died in an accident. “Now [I] struggle to support the children. It is easier to find a job if you have a partner to help with the family” (Interview 14, Cambodia). This complements earlier discussions about how men with disabilities have more opportunities for jobs because it is easier for them to get married - once a woman has children, her responsibilities at home can make it even more difficult for her to find a job if she is not well supported (Amin et al, 2019). Equally in Rwanda, another participant echoed this difficulty in being the sole provider for a family, and wishing for the support of a partner “with the family that I got married in, it was always ups and downs. The husband is there but tomorrow he is gone and left home, and then comes back... So it is always ups and downs.”

(Interview 11, Rwanda) From these discussions about marriage and family, it is clear that women with disabilities need support, and rely heavily on family in lieu of formal structures. The intersecting identities of being a woman and having a disability in these patriarchal societies make it so that women feel the need to rely on others, because they themselves are denied opportunities for employment and growth (key informant, 2022).

### 6.5.6 Summary

In this chapter I have explored the different ways that discrimination based on disability intersects with discrimination based on gender, to limit the opportunities afforded to women with disabilities. The unique combination of expectations placed on women, as well as those placed on people with disabilities means that the knowledge, skills and abilities of women with disabilities are routinely underestimated both in the home and workplace. As a result of these discriminatory attitudes, women with disabilities are routinely excluded from education, employment, and personal relationships. In the next chapter I will further explore these unique identities that shape these experiences of women with disabilities.

## 6.6 Identity

The concept of intersectionality has so far been central to this thesis, and to understanding the impact that gender and disability have on livelihood opportunities for women in the Global South. Disability as a category of identity is often omitted in rhetoric about intersectionality, which has typically considered race and gender as the main factors for consideration. However, disability - like these other identities - is socially constructed, and is one of the many identities that make up an individual. Due to years of misunderstandings and stereotypes, disability as an identity is still liable to misrepresentation, and is often siloed from other issues and experiences. This means that someone identifying as disabled may not be recognised by themselves or those around them as having other identities at the same time (Wickenden, 2023).

A key finding of this research, which became clear during interviews and focus groups, was that participants in both Cambodia and Rwanda gave primacy to disability over all other factors of their identities, simply because it was the one that affected them most on a day to day basis, and the one that is often most noticeable to others (key informant, 2022). Because of this, in most cases, women in interviews considered their identities as disabled to be more important than those as women, even though their experiences were heavily coloured by patriarchal norms. However, as explained previously, in the Global South, it is more than just one identity alone which causes discrimination, but the combination of social restrictions on women, along with the structural and economic lack of accessibility for people with disabilities, that negatively impacts the lives of women with impairments (Pal et al, 2015). In this section, I therefore explore the specific aspects of identity that come with being a woman with a disability in Cambodia and Rwanda, and how these factors of identity influence how participants see themselves.

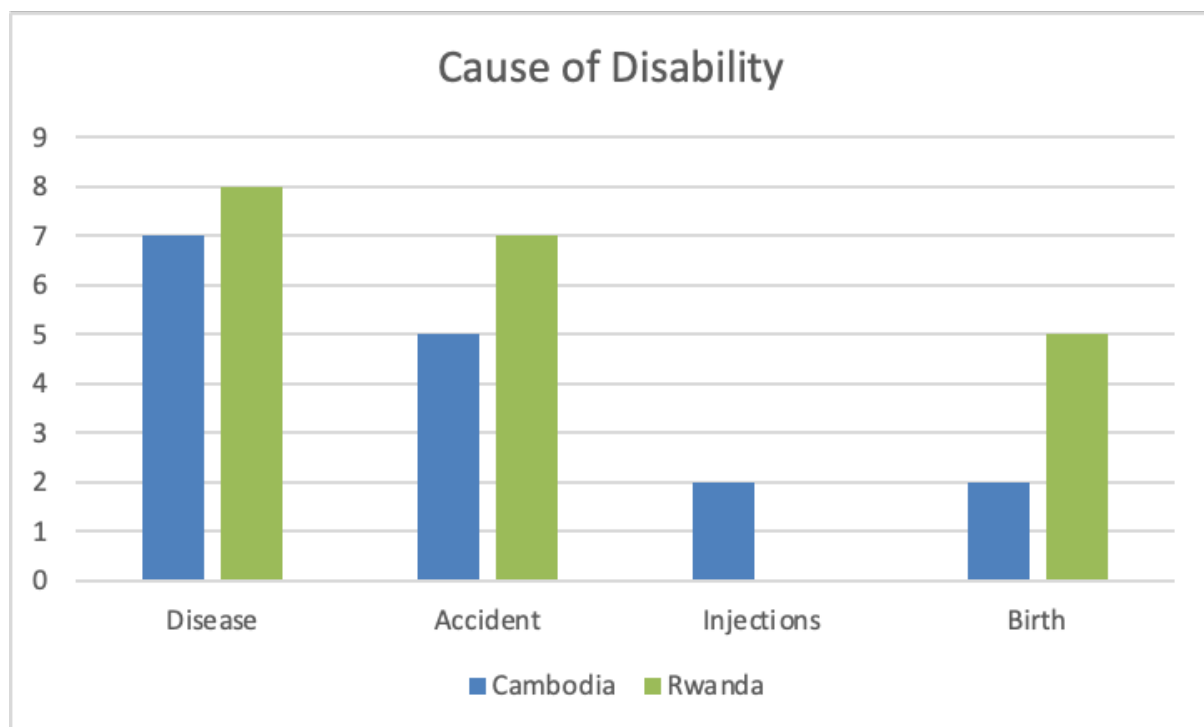
### 6.6.1 Disability

When considering intersecting identities in the context of the Global South, it became clear during interviews that disability is usually the defining characteristic in a person's life - much more than gender, ethnicity, poverty, religion etc. This is because people's experiences and needs are influenced by the way that they are perceived, and different aspects of a person may be responded to by others in either positive or negative ways. Therefore, being a woman, disabled, and also living in the Global South, tends to exacerbate experiences of exclusion for many people (Wickenden, 2023). This is because most societies have a fixed set of expectations for women, people living in poverty, and people with disabilities, and women with disabilities generally fall outside of any of these categories. This research proposes that, while other identity factors certainly have a role to play in a person's acceptance into society, participants in both countries believed that disability and functional capacity were dominant characteristics in their identities.

As captured in figure 8 below, in both countries, most participants in interviews acquired their disabilities later in life, and at very comparable levels - with 56% of participants in Cambodia, and 55% of participants in Rwanda explaining that they

were not born with their disabilities. One participant from Cambodia believed that it is easier for those who were born with a disability because “it doesn't affect our feelings much, but for people with disabilities who got it as part of an accident, it has more of an effect on their feelings” (Interview 5, Cambodia). This is likely related to the switch in identities which occurs when someone develops an impairment, and their experiences change seemingly overnight from those of an able-bodied person, to those of a person living with a disability (Focus group, 2023).

Figure 8: Causes of disability as reported by participants



Most of the women interviewed for this research spoke about their disabilities in very practical terms, explaining how they got their disabilities, how long they have had them, and the impact they have on their lives. This mirrors an earlier point from Cobley (2018), which explained that practical issues such as poverty, health, and exclusion may be more pressing for women with disabilities than those related specifically to disability, as issues of power, agency, and access are what tend to exclude women with disabilities from mainstream society, rather than their impairments alone.

These practicalities of disability formed important identity concerns for participants, and tended to be given primacy over other characteristics and factors. In this way, there tended to be an overlap between discussions of disabled identity and health, as many women considered their health and impairments to be intrinsic to their identities. Again here it was clear that disability was a determining factor in the identities of participants, as gender and health simply do not interact to create exclusion in the same way as disability and health. As presented in figure 8 above, the most common causes of disability according to interviews were diseases and accidents. In Cambodia, 2 participants explained that their disabilities were due to 'injections', and both my translator and a key informant later told me that during the late 1990s, a vaccination programme in certain provinces in Cambodia left a large number of women with physical disabilities due to unsafe injection practices (key informant, 2022). Aside from this, in both countries, participants did not necessarily know a lot about their disabilities in medical terms - for example the names of illnesses or assistive devices - but were happy to describe what they were experiencing. This is likely due to difficulties with accessing healthcare in both countries.

With this overlap of disability and health in mind, it is interesting to consider disability in relation to the SDGs. Health is one of the 17 goals, and focuses not only on addressing morbidity and mortality, but also on improving access to healthcare services for all. Disability is not specifically mentioned in any of these goals, and this is emblematic of a wider trend, where people with disabilities are not discussed or included in the development of strategies for improving access to healthcare services which may play an important role in provision of healthcare for the general population and for people with disabilities (Hashemi et al, 2017). This exclusion leads people with disabilities to experience more acute health crises, and to spend more time and money on healthcare than their non-disabled peers.

This is demonstrated by the fact that many participants acquired disabilities due to preventable diseases like polio and measles, or road traffic accidents in both countries. As described in the context section, in Cambodia access to healthcare is poor, and most people rely on a large network of pharmacies for their everyday needs, as hospitals and doctors are expensive, inaccessible, and often only

available in big cities. Most ordinary people cannot afford adequate medical care, so preventable diseases spread quickly (key informant, 2022). This also means that disability is cyclical in these contexts, meaning that people with disabilities may get sick and cannot afford to go to the doctor, so they become even sicker, leading to an emergency or an ongoing condition. This is common in Global South contexts, where factors such as poverty, diseases, inefficient healthcare systems, inaccessible transportation systems, political instability, and negative attitudes towards disability are common. These healthcare challenges tend to aggravate the existing health conditions of most people with disabilities (McKinney et al, 2021).

While most people in Rwanda have access to health insurance through the Mutuelle de Sante scheme, it does not cover pre-existing health conditions, and the poorest people in Rwandan society often cannot afford to pay the monthly fees. This often excludes people with disabilities on the basis of their conditions, as well as in cases where they are unable to afford the scheme due to poverty (key informant, 2023). Similarly to Cambodia, most people do not live near a hospital or doctor, and if this health insurance does not cover the cost, care can be prohibitively expensive.

As previously mentioned, most participants consider disability to be their primary identity, as this is the factor that people most often react to, which causes the most discrimination and marginalisation. For many women, the reality of living with a disability can feel limiting or isolating. Interview participants described that their disabilities “stopped [them] from getting work” (Interview 11, Cambodia), or limited their job opportunities: “when I got a disability, I don’t know what I should do.” (Interview 7, Cambodia) Here it is clear that the attitudes of families and communities towards disability can have a huge impact on the livelihood opportunities available to women with disabilities, as they tend to internalise the beliefs of those around them about their own capabilities. Where families are supportive and encouraging, women with disabilities are more likely to ‘succeed in life’, whereas if beliefs around disability are negative, women with disabilities are more likely to see themselves as weak and dis-abled (Tefera et al, 2017). As described above, people also take pity on women with disabilities and think “oh poor you, you are a woman with disability.” (Interview 1, Cambodia), or others fail to understand the capabilities of women with disabilities, “they think we are not capable to do anything” (Interview 9, Rwanda). This feeds into

the view of women with disabilities as passive victims of their impairments, and often takes away from their agency and empowerment (Wallace et al, 2018).

In Rwanda, participants put more of an emphasis on disability as an isolating factor in their identities, describing how sometimes women with disabilities - especially deaf women - “are just hidden in their homes, no one wants to show them, no one wants to bring them on board... they are just being discriminated, and doing nothing” (Interview 6, Rwanda). Here key informants emphasised that it is more common for women with multiple or complex impairments to be hidden and isolated, and that these women are often not registered and do not have ID cards, and therefore cannot access basic services. This isolation and marginalisation of women with disabilities is frequently referenced in disability literature, as explained above, where people with disabilities are reported to experience loneliness, low perceived social support and social isolation at significantly higher rates than people without disabilities. Compared to the general population, women with disabilities also have fewer friends, less social support and are more socially isolated (Emerson et al, 2021). All of these experiences of isolation and marginalisation feed into the identities of women with disabilities, and how they perceive themselves as outsiders from many social worlds because of their disability status.

But women with disabilities do not necessarily feel stuck in their identities as ‘disabled’ in all cases, and a core finding of this research surrounds the ability of women with disabilities to overcome obstacles in their lives. For example, many women explained that the best way to get past discrimination and exclusion because of their identities as disabled women is to work hard and gain skills. Interview participants emphasised that “you are treated well as a woman with a disability if you have education and a job.” (Interview 1, Cambodia) This can also change how women with disabilities are treated in their communities, and how much respect they get from peers: “when you are working and [others] are seeing the income generation, now they are accepting that person.” (Interview 12, Rwanda) Similarly, Tina & Kolsani (2023) propose that the economic empowerment of people with disabilities can result in an enhanced sense of self and worthiness, as well as autonomy with economic benefits for society. This was also explored in interviews, where participants described how education and skills can change how people with

disabilities see themselves and their own identities. With improved vocational skills, one interviewee said that “[she] can become normal now from disability” (Interview 2, Cambodia), and another explained that her self-worth has improved, so she now believes that “even if we have disabilities, that we are human beings and that we are able” (Interview 11, Rwanda).

### 6.6.2 Gender

As described in previous sections, women and girls with disabilities tend to have significantly worse experiences of discrimination than their male peers. This is evident across all social arenas, including independent living, employment, education, healthcare, housing, land-ownership, access to cultural capital, and so on (Thomas, 2006). Discrimination in these areas is usually due to the impacts of multiple disadvantage on the lives of women with disabilities, which typically occur because society’s perception of them is complicated by widely held assumptions about the image and role of women, as well as the expectations placed on people with disabilities (Palmer & Woodcroft-Lee, 1990). According to Wickenden (2023), disabled women’s lived realities throughout the world arguably remain difficult, as they have to navigate a myriad of barriers to being heard and able to participate equally alongside other women. Therefore in different cultural contexts, patriarchal and ableist structures may influence the way in which women with disabilities perceive their gendered identities, and further combine and conspire to prevent them from accessing services and support, or achieving their dreams (Wickenden, 2023). In other words, the intersecting identities of women with disabilities tend to exclude them from accessing the same opportunities as their non-disabled peers.

Gender identities therefore have a profound impact on the lives of women with disabilities. In Cambodia and Rwanda, this is seen in the cultural expectations which are placed on both women and men, pertaining to how they should behave both in public and in private. In focus groups in Rwanda, participants echoed earlier discussions on gender, describing how patriarchal norms dictate that the woman takes care of the house chores and the family, and that the man is expected to go to school and work, and to look after the family financially. Children grow up seeing their parents and grandparents following these patterns, so these cultural norms tend

to be deeply ingrained in society (Focus group, 2023). The importance of conforming to gendered identities was underscored during interviews, as women generally spoke quietly, and were often reserved when sharing opinions. This fits with the traditional views of women in both Cambodia and Rwanda, where they are expected to be demure and retiring, and reflects the patriarchal attitudes many participants have likely internalised over many years. As well as this, women both with and without disabilities encounter many negative messages about their capabilities, and their place in the community. These messages include denigration of their appearance, misrecognition of their sexuality, and social and environmental barriers to their participation in society (Mejias et al, 2014).

Gender identities also influence how women with disabilities behave in certain contexts, noting the strong influence of patriarchal and traditional roles on their lives. In both countries, women are expected to be “soft, gentle, and delicate” (Interview 1, Cambodia). Participants in interviews were generally warm, but certainly reserved in sharing their experiences with me. Some interviewees seemed unaccustomed to sharing their views, especially with a Western researcher, and one remarked that she “sometimes doesn’t know how to respond!” (Interview 8, Cambodia) Another, while speaking about her experiences of discrimination and exclusion, didn’t want to use words like ‘crazy’ and ‘stupid’ because she felt it was wrong to use “bad words”, and repeatedly apologised for “speaking rough” when she told me how discrimination made her feel (Interview 6, Cambodia). These interactions are reflections of how women are expected to behave in both cultures, and once again highlight the patriarchal culture which exists in Cambodia and Rwanda, where women are told to always maintain composure in order to save face for the family.

These predetermined identities of women are very clear in both societies because of strong patriarchal norms, but differ in their expressions in society. In Cambodia, women are expected to save face in public, and to adhere to traditional roles, but are generally given some freedom outside the home in terms of finances, occupations, and interactions. In Rwanda, however, the patriarchal influence tends to be stronger in the lived sense, as women often have their finances and occupations controlled for them by their partners (Berry, 2015).

With these differences in mind, in terms of gendered expectations of women with disabilities, Cambodia presents an interesting case for analysis, as the rigid expectations placed on them are defined in Chbab Srey (the Code of Conduct for Women). This is a piece of ancient Khmer literature which is still taught in schools, and passed down through generations, which instructs women on how to behave in Khmer society, and how to properly manage a household (key informant, 2022). Within Chbab Srey, Khmer women are expected to perform domestic duties within the household, and to model accommodating, submissive, virtuous, and demure behaviours when interacting with men (Anderson, 2018). Continuing to teach Chbab Srey and to reference it as an ideal for women may be inadvertently suggesting that the subordination of women to men is authentic and moral in Cambodian society (Focus group, 2022).

A small number of participants in interviews and focus group discussions brought up Chbab Srey in the context of how women with disabilities often struggle to fit into this ideal of the perfect woman. This is true in both countries, where women with disabilities feel that they have to be extra feminine to compensate for their impairments. One participant spoke about how she felt ashamed for laughing too loud in our interview, as she explained that this is not how a traditional Cambodian woman should act (interview 6, Cambodia). Another described how “women always have to be shy and quiet” in the Rwandan culture (Interview 17, Rwanda), and how it is difficult for women with disabilities to have the confidence to stand up for themselves. Within this context, focus group participants recognise that there is a vast difference between men and women with disabilities, owing to the patriarchal nature of society, and how these gendered expectations are played out on a day-to-day basis.

When considering the other identity constraints that come with being a woman with a disability in Cambodia or Rwanda, participants were quick to point out the differences in opportunities for men and women. As described in earlier sections, a woman’s primary job is usually considered to be within the household, so any work they can do “in easy jobs, usually from home” is most suitable so that they are able to contribute, while still upholding their caring roles (Interview 15, Cambodia). From a young age, eldest daughters are usually expected to act as second mothers in

families and look after siblings, with younger girls helping to take care of household chores, to prepare them well for marriage (Focus group, 2022). On the other hand, “normally the men are free, they do not have children to take care of, they do not have household tasks, they are moving away if they want. They have more opportunities than women” (Interview 12, Rwanda). This implies that in Cambodia and Rwanda, where social norms dictate that a woman’s role is primarily reproductive, the binaries of gender identity play a large role in access to livelihood opportunities.

This is where intersectionality between identity factors is highlighted, because while there are identity constraints associated with living as a woman in Cambodia or Rwanda, there are even more identity constraints associated with living as a woman with a disability, and participants are very aware of this. This is because the opportunities and challenges for both women and men with disabilities echo those within the general population, where women are often disadvantaged. As argued by Wickenden (2023), once someone has disability as an identity factor as well as others, then the inequalities that they face tend to increase, and the uneven power gradients between men and women, and between non-disabled and disabled people, combine to create strong patterns of disadvantage. Interview participants echoed this, by explaining there is a hierarchy of identities in Cambodia and Rwanda, with male and able-bodied being at the top, and female and disabled being at the bottom. The ways in which these different identity factors intersect with each other in any given context can then lead to either a provision or denial of opportunities, and tend to exclude women with disabilities from education and employment.

This was frequently referenced in interviews and focus groups, where participants asserted that women have less opportunities than men, “but if you talk about disability it’s even more layers.” (Interview 1, Cambodia). Across both countries, most participants agreed that being a disabled woman is “more unfortunate” than being a disabled man (Interview 2, Cambodia). When talking about how gender and disability combine to limit opportunities, one participant from Rwanda explained: “Once you are a girl, it's hard. And once you are a girl with disabilities, it is like a crisis in a crisis. It is hard to understand how a girl can work certain jobs which are

only for men, and when you have a kind of a disability they feel like you can never [do it]" (Interview 8, Rwanda). A core finding of this research is that it is this intersection of gender and disability, coupled with the patriarchal values of societies, which most often exclude women with disabilities from employment and livelihood opportunities.

These societal limitations on the intersecting identities of women with disabilities are further exemplified in an anecdote told by a focus group participant in Rwanda, who said that an employer she met with told her that they do not employ women with disabilities because "normally a woman is weak, and when you add disability, unless we change our entire vision, she cannot work here" (Focus Group, 2023). Interview participants also described how, in addition to economic exclusion, women with disabilities also face social discrimination because of these overlapping identities. As a woman with a disability "they kind of like spit on you, people don't understand women with disabilities... they just want to avoid." (Interview 1, Cambodia) These identities can also leave women with disabilities more vulnerable to abuse and gender-based violence than others. This violence however, should not be considered as just a subset of gender-based violence (GBV), instead, it is an intersectional category all of its own, which deals with both gender-based and disability-based violence. Therefore, the vulnerability of women with disabilities to a higher risk of violence emanates from the convergence of both gender and impairment (IWDA, 2017).

In these cases, the intersections between gender and disability can make women with disabilities up to 10 times more likely to experience gender based violence than women without disabilities (CBM, 2018), and in patriarchal structures like Cambodia and Rwanda, reporting and protection against these types of violence is low (key informant, 2022). As explained in the literature review, this vulnerability to GBV results from a complex web of factors, including limitations in ability to perform expected roles in households and society, as well as experiences of dependency and low self-esteem, which are common to many women with disabilities (Gilson, 2001).

GBV was not brought up often by participants - especially in Cambodia - as this topic is very taboo and associated with shame, meaning that participants may have felt ashamed to share this with me. It is, however, very prominent in the literature surrounding women with disabilities (e.g CBM, 2018; Pearce, 2015; Dunkle et al, 2018), and was expressed by some women in Rwanda during interviews. In Rwanda, participants described how rape is a huge concern for women with disabilities because often they are not seen as human, especially if they have psychosocial disabilities, and are therefore targeted for sexual violence. One participant explained how many deaf girls “end up getting unwanted pregnancy and others face GBV because most of them don’t have anywhere to sleep or anywhere to work” (Interview 6, Rwanda). In focus groups, participants expanded on this, describing how it is often assumed that girls with disability will be raped in Rwanda. Families often fear for the security of girls with disabilities when they are outside the home because it increases their risk of rape (Focus group, 2023). As described in the literature review, this is one of the reasons why women with disabilities may be ‘hidden’ in some countries, especially if they have complex needs, as families believe that keeping women with disabilities inside the home will reduce their risk of sexual violence. This again highlights the inherent vulnerabilities associated with both being a woman and having a disability, which disadvantage women with disabilities in society.

### 6.6.3 Self Confidence at the Nexus of Gender and Disability

As well as lower rates of salaried employment and education, women with disabilities are also reported to have significantly lower self-cognition and self-esteem than women without disabilities, owing to the discrimination they face at the intersection of their identities (Nosek et al, 2003). One of the most significant findings of this study is that in order to be comfortable in their identities, participants explained that self-confidence is central to everything they do. Most women with disabilities explained that they were not initially confident in themselves due to the structural and social isolation and exclusion they face on a daily basis, and many still struggle with self-worth. This is likely related to some level of internalised misogyny that participants have taken on, owing to the constant barrage of patriarchal norms around them, as well as a belief that they cannot trust their own skills due to the attitudes of those

around them. The concept of internalised misogyny is frequently written about in literature (e.g. Cherry, 2018; Einhorn, 2021), however women with disabilities are almost always left out of this discourse, and as yet, there is no significant writing around how internalised misogyny affects their self-perception and self-confidence. Despite the lack of evidence, this was described as a reality for many participants, and the development of self-confidence to overcome these issues was expressed as one of the most important parts of their identities as women with disabilities (key informant, 2023).

Self-confidence and self-esteem are not often discussed in the literature surrounding women with disabilities, but those that do cover this topic explain that women with disabilities have significantly lower self-cognition and self-esteem, and greater social isolation than women without disabilities (Nosek et al, 2003). In both countries, interviewees spoke about feeling a lack of confidence in their abilities to learn, as well as to get a job, because of the societal perception of women with disabilities and their capacities. Focus group participants described how often women with disabilities will “self-discriminate” because they are aware of how they are perceived by their communities, and often know in advance that they will not be selected for opportunities such as jobs or education. These experiences of discrimination and exclusion can be internalised by women with disabilities, and can cause them to doubt their own abilities and self-worth (Focus group, 2023). Interestingly, the inverse is also true, whereby women with positive school and social environments, and more affection in the home, tended to experience less social isolation due to increased self-confidence. In these cases other intersecting factors such as age, education, and disability severity were effectively cancelled out by self-esteem, and were not significantly related to social isolation (Nosek et al, 2003).

In Rwanda more than in Cambodia, participants described how discrimination from an early age impacted their self-confidence. One participant put this ‘self-discrimination’ across particularly well, saying:

*when you feel a person calling you stupid, you end up thinking that you are just useless in this society, and you end up by stigmatising yourself. You end up not reaching for anything in life (Interview 11, Rwanda).*

Another spoke about how this self-stigma can be a vicious cycle,

*when no one wants to talk to you, you end up discriminating yourself...*

*[thinking] I can't do anything if I'm rejected by everyone. I can't work, I can't get something. If I'm not working or I have nothing, everyone will disrespect me (Interview 16, Rwanda).*

A deaf participant also explained how deaf people often have low self-confidence “because they find it hard to communicate with others, including their parents” (Interview 6, Rwanda). This means that they experience even more ‘self-discrimination’ than others, because of their difficulty in communicating their needs, which may lead to further exclusion from opportunities for self-development. This experience of collective marginalisation is quite specific to women with disabilities, and highlights the importance of gender as an identity factor in their lives. As explained above, participants often mentioned how men with disabilities find it easier to be self-confident and pursue opportunities, highlighting how even experiences of confidence building and self-belief are tied to gender identity.

When considering how women with disabilities are expected to behave in these societies, interviewees also reflected on how they themselves internalise cultural standards and practices, especially in Rwanda. As a person with a disability, “for men and women you have to behave yourself and carry yourself well. You have to prove your worth” in society (Interview 5, Rwanda). Many women described feeling a pressure to prove that despite their impairments they can still fit into this ideal standard for women, which exists in the patriarchal societies around them. Further to this, in order to get jobs and put themselves forward for opportunities, women with disabilities must start to make changes within themselves. “We should be confident enough and feel like we can do different things” (Interview 7, Rwanda).

As discussed in earlier sections, the structural stigmas that women with disabilities face on a daily basis also necessitate self-confidence, as women with disabilities are expected to fight for themselves and their needs in most areas of day-to-day life. As explained in Cambodia, “you have to be able to fight for yourself!” (Interview 1, Cambodia), and most feel that they are surrounded by lots of men and able bodied people “feeling like you are stuck there silently buried.” (Interview 1, Cambodia)

Women in interviews therefore feel that they need to have the inner strength and self-belief to be able to speak up for themselves and ask for what they need.

Generally, participants in both countries also felt that women are less likely to believe in themselves than men, saying for example that “men are self-confident much more than women. We need to give value to women and girls with disabilities so that no one is left behind.” (Interview 10, Rwanda) In order to combat this structural stigma and improve their self-confidence, women with disabilities should be taught about wellness and their rights, so that they are more aware about themselves and their capabilities (Interview 13, Cambodia). Focus group participants explained that one of the best ways to do this is through bringing women with disabilities together in groups (focus group discussion, 2022). These groups and collectives can be very empowering for women with disabilities, as pride and self-confidence tend to stem from group identification, which also helps to counteract exclusionary messages from the outside world (Mijas et al, 2014). This sharing of experiences, stories and advice between women with disabilities can be very important for social inclusion and mutual support (Interview 12, Rwanda).

Key informants also explained that psychological support is often needed over and above social groupings, to address the deep-rooted lack of confidence experienced by many women with disabilities. This will in turn encourage better engagement with programmes and training, as women with disabilities better understand their capacities (key informant, 2022). Women interviewed for this research also believe that improved self-confidence and self-belief is key to improving both livelihood opportunities and positive identity associations for women with disabilities. As one young woman in Rwanda told me “if you have confidence, it will change everything.” (Interview 7, Rwanda) This also has implications for the intersecting identities of women with disabilities, as improved self-belief helps them to develop a positive disability identity, and to gain new information regarding the ability and right to identify as women, thus helping them to identify with two of their intersecting identities (Mijas, 2014)

An outcome of improved self-confidence, highlighted in 6 interviews, is better livelihood opportunities. As described by Tefera et al (2018), participation in

employment and social roles which are valued by communities, can lead to the adoption of other valued social roles. For example, a woman with a disability who is educated and employed may be confident enough to strive for additional socially-valued roles, such as marriage and motherhood. On the other hand, internalising stigma results in rejection, exclusion, and discrimination, thus limiting the opportunities for women with disabilities to achieve their potential and increasing the likelihood of poor treatment by others in society (Tefera et al, 2018).

A key issue here is that women with disabilities need to have the confidence to apply for positions and roles in the first place, but most “don’t have the self-confidence that they can pass the exams” (Interview 10, Rwanda). This is where self-belief becomes extremely important, “if you feel like you can do something, you can do it” (Interview 5, Rwanda). Participants demonstrated that, essentially, if you are confident enough in your diverse identities, you can pursue diverse opportunities, explaining “if you are wise and smart, you can get any job” (Interview 7, Rwanda). It is also important to highlight the overlap between functional capacity and self-belief here, where women with disabilities must be aware of their own impairments and physical capabilities, while also believing in their strengths and abilities. Many women also feel very empowered by starting their own businesses and meeting other women with disabilities because they “realise they are not alone,” and can recognise their own talents and capacities (Interview 12, Rwanda). Interviewees also described how being together makes them “feel welcomed, and no one is discriminating us” (Interview 15, Rwanda), so that they can feel “proud of their disabilities” (Interview 13, Rwanda).

As a response to improved self-confidence, many of the women in this study have now become advocates for themselves and their communities, and this represents one of the most important findings of this research. Many of the women that I spoke to during interviews hugely value their identities as disabled advocates, as it not only improves their own lives, but also the lives of others, who share these identities of female and disabled. In both countries, participants spoke about wanting “to show the whole world how women and girls with disabilities are capable” (Interview 8, Rwanda), and wanting “to show our ability, I mean special ability more than disability” (Interview 6, Cambodia). Others also want to use their knowledge and skills to help

others with disabilities to improve their lives. For example a participant in Rwanda wants to “[give] women with disabilities knowledge, and everything will be possible” (Interview 17, Rwanda), and in Cambodia, another spoke about wanting to “show people with disabilities that they have the ability to do the same as others” (Interview 5, Cambodia). There is very much a sense of hope among participants, where women are extremely resilient, and highly motivated, and want to use this motivation to help others. Some participants really exemplified this when talking about what they wish for others with disabilities:

*I just want to tell people with disabilities, don't feel hopeless or lose motivation in yourself. Don't think that disabled people cannot do anything. Disability is just a black cloak, we can take it off. We will see the bright side in the future (Interview 5, Cambodia).*

*People who already have disability like me, you have to know who you are. You have to accept what you have. Don't be upset or hopeless, or whatever can cause you to stop your determination for your own bright future (Interview 6, Cambodia).*

*People with disabilities, we are geniuses, but people don't think that (Interview 9, Rwanda).*

*Life can continue, can go on, even if we have disabilities (Interview 16, Rwanda).*

When these participants speak about the hope they have for their communities and the wishes they have for other women with disabilities, it is clear that self-confidence plays a key role in how women with disabilities determine their own identities (Mijas et al, 2014). If they feel confident in themselves, they are able to see their impairments as something that can be overcome in their lives, and disability is no longer seen as the sole determining factor in their identities. In this way, it is often the women's own perseverance that has led to positive changes in their lives and their communities.

Where women with disabilities are able to believe in themselves, they are able to become successful and fulfilled. Participants in Both Cambodia and Rwanda shared their personal stories of hope, including a lady in Rwanda who says “if you have any kind of disability, it does not mean that you have no capability to do anything. You are capable as another woman without disability. We are very capable, we can do everything” (Interview 8, Rwanda). And another in Cambodia who says “I feel very motivated in my life, feel proud that I am successful in my life. I am strong. [But] I cannot be strong only by myself, I have to make other people around me strong too” (Interview 5, Cambodia). This feeling of altruism was echoed many times in interviews, and as a researcher I felt a sense that the community of women with disabilities in both countries feels quite bonded by their social exclusion, and therefore works hard to lift each other up. I saw this often in the way interviewees would speak in the collective, for example about how “we should be confident enough and we feel like we can do anything, we can perform, we can do different things” (Interview 7, Rwanda), and in giving advice to others “we have to know that self-care and self-love are the most important. If we have these two things, we can achieve anything” (Interview 1, Rwanda).

#### 6.6.4 Summary

In this chapter, I have summarised the key identity characteristics of women with disabilities in Cambodia and Rwanda. Participants described disability as a defining identity factor in interviews, as it impacts all other areas of their lives. Gender, as a secondary characteristic, tends to combine with disability to create intense patterns of disadvantage and discrimination in the patriarchal structures of Cambodia and Rwanda. In an effort to combat this discrimination, women with disabilities in this study emphasised the transformative effect that self-confidence and support from other women can have on their lives and opportunities. This support will be further explored in the next section.

### 6.7 Support

While this thesis has so far discussed employment opportunities for women with disabilities and the importance these opportunities have in social and economic empowerment, it is also important to acknowledge that employment is not a suitable or healthy option for all people with disabilities, at all times. Fakhri (2023) proposes that it is important to move beyond this notion that being employed is the only way for disabled people to be respected in society, and to be capable of sustaining a decent life for themselves and their families. Even in cases where employment is possible, due to issues around marginalisation, isolation, and disability related costs, both formal and informal supports are crucial for the empowerment of women with disabilities (key informant, 2022).

Supporting one another is an intrinsic element of community life, especially in many areas of the Global South, which are often more community- and family-centred than in the Global North. This means that disability inclusion is fundamental to the functioning of society, and therefore requires community support for persons with disabilities (Vasquez et al, 2021). This was highlighted several times by participants in interviews and focus groups, who explained that while employment is central to their livelihood opportunities, due to their intersecting identities, women with disabilities still need a variety of supports, and receive them in a variety of ways from those around them. Sometimes this support is given formally, through programmes and policies run by governments and NGOs, and other times it is more informal, like the support provided by communities and family. Regardless of the source, participants believe this support to be vital to their success, explaining that, no matter how well they appear to be doing, “if they have no support or motivation, it can become serious” (Interview 2, Cambodia).

### 6.7.1 Formal Supports

Formal, or high-level supports for people with disabilities often include human assistance and assistive technology to support communication, decision-making, personal assistance, mobility, housing, and other life activities (key informant, 2023). These supports are important tools in integrating people with disabilities into mainstream society, but throughout the Global South, are usually difficult to access, under-developed or simply non-existent, due to limitations in resources and

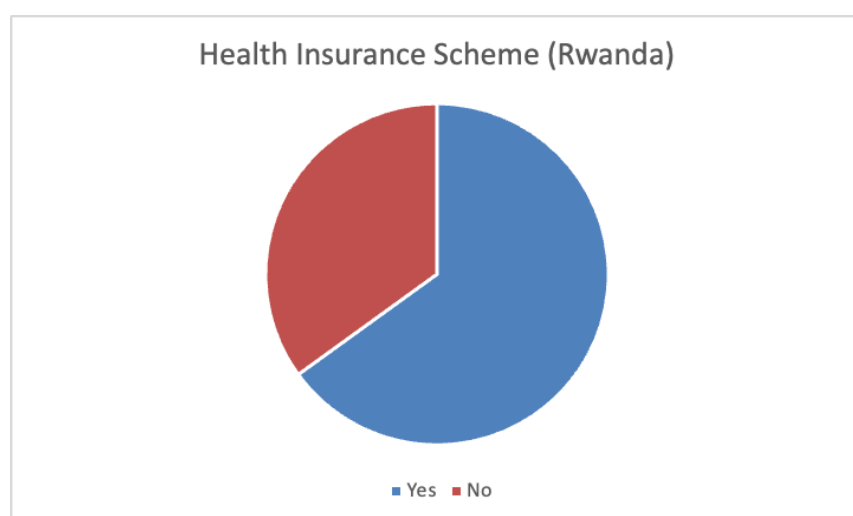
knowledge. Grech et al (2023) highlight how, in the Global South, practical needs can tend to dominate strategic ones in contexts of poverty and inequality, meaning that implementation and localisation of instruments like the CRPD, or even the SDGs, can be considered of secondary importance. Poverty can therefore influence how these processes happen, what can be invested, the barriers met on the ground, and what can realistically be achieved. This means that government support for people with disabilities tends to be low as the limited resources they have are stretched over a number of priorities.

Often, the few support services which do exist for people with disabilities are provided by NGOs, usually with little to no government engagement, and no overarching policy framework, leaving support services scattered, disorganised, and often informal (Vasquez et al, 2021). In the lives of women with disabilities, who tend to lack access to information in general, this can mean that they are unable to find or access the support that they need, even if it does exist.

In Cambodia and Rwanda, traditional supports, like social welfare and insurance do not exist to the same degree that they do in the Global North. Key informants in both countries argue that there are no country-wide or blanket initiatives for people with disabilities, with the sole aim of making society more accessible. In these cases,

where supports from the government are not available, NGOs and local organisations often fill this gap, and participants describe the importance of organisations providing skills and training to women with disabilities. This kind of semi-formal support often takes the form of vocational training, skills workshops, and improving education (key informant, 2022). In Cambodia AGILE was mentioned often as an important provider of these skills and trainings, along with UNABU in Rwanda, who have supported many participants with skills and opportunities.

Figure 9: Proportion of participants in Rwanda with access to health insurance



When comparing the two countries, support tends to be more formalised in Rwanda, with more organisations for people with disabilities in existence, and more variety in the supports that they provide. These organisations form an important link between formal and informal supports for women with disabilities, and often link them to their wider communities. As previously mentioned, most of the population of Rwanda has health insurance under the Mutuelle de Sante scheme, but this does not cover all illnesses and impairments, and 35% of interview participants are excluded from this scheme for various reasons, as displayed in figure 9 above. Other types of formal welfare and support like monthly payments, food subsidies, and grants are also not common in either country, with 25% of participants in Cambodia receiving some form of welfare, and only 10% of participants in Rwanda. When considering the disparity in incomes between countries, these figures are surprising, but most participants in Cambodia are supported by local initiatives and NGOs in their communities, which are far more common and widespread than in Rwanda. In cases where welfare does come from the government, it is not necessarily based on unemployment or poverty status in either country, but is more likely to be circumstantial, like for example the Genocide Survivors Fund in Rwanda, or based on who else is living in the household in Cambodia (key informant, 2023).

In terms of formal support, it can be extremely difficult for women with disabilities to get an education and to find vocational or skills training. This means that many women with disabilities are dependent on governments, NGOs, and local organisations to meet their basic needs (Focus group, 2022). As mentioned above, the main form of government support in Rwanda is the Mutuelle de Sante health insurance scheme, although this is not available to all people with disabilities, and often women with disabilities are excluded “because their families do not want to give them the insurance” (Interview 6, Rwanda), meaning that families who have collective insurance will exclude people with disabilities from joining, or will withhold assistance in accessing and joining individual plans. In Cambodia, households which fall below a certain income level are given an ID Poor card, which entitles them to rations of food, and in some cases money. This scheme can be difficult to access for women with disabilities, as information is often inaccessible and complex, and the financial support received if women with disabilities qualify for the scheme is generally low (Interview 9, Cambodia).

The UN Disability and Development Report (2018) also highlights the importance of access to financial services as a means to effective economic participation. Without a bank account, for example, individuals often face higher costs for conducting financial transactions. They may also find it more difficult to save and plan financially for the future, leaving them more vulnerable to medical or job emergencies that may endanger their financial stability. The report also highlights that banks and other service providers may not be physically accessible to people with disabilities, while online services may not be virtually accessible, leaving people with disabilities unable to access certain services at all. This is particularly relevant to women with disabilities, as they tend to be more dependent on family or spouses for financial decisions, as well as less financially literate due to lower education, meaning they may be excluded from financial services entirely, and therefore unable to plan for shocks.

### 6.7.2 Healthcare

Health was an important topic of conversation during interviews in both countries, and healthcare is one of the main ways in which participants bridge this gap between formal and informal supports. While debates in the literature around different models and understandings of disability are useful, participants highlighted that disability, pain, and health related complications still have a profound impact on their day-to-day lives, and that access to healthcare and medical treatment is an important consideration for people with disabilities. Many women in this study rely on local health centres, pharmacies, traditional medicine, and family care in order to continue to function. It is these formal and informal community structures which support women with disabilities in their everyday lives (key informant, 2022).

Formalised healthcare is expensive in both Cambodia and Rwanda, with participants and key informants explaining that they would rarely see a doctor if they can help it, owing to the cost of treatment. In Cambodia, pharmacies and drug outlets are usually the main sources of care for the majority of citizens because of the availability of medication, short waiting time, and ability to control the cost of treatment. Unfortunately, no enforcement of pharmacy regulations and little

consumer and staff education contribute to a potentially harmful unregulated drug market, which may eventually result in higher costs and prolonged illness (Yang et al, 2004). This reliance on pharmacies means that most women with disabilities do not get the specialised medical care that they need, and this can increase the prevalence of disability (focus group, 2022).

In Rwanda, around 80% of the population is covered under the State's Mutuelle de Sante health insurance scheme, but costs for this scheme vary based on a number of factors, and tend to be around Frw 3,000 per month, which many women with disabilities cannot afford. As described earlier, this scheme does cover many impairments, and has made healthcare accessible to many, it does not cover rehabilitation and prosthetic requirements of people with disabilities. It also does not address the physical inaccessibility of health centres across the country (IDA, 2019). Complex disabilities and impairments are often not covered under the scheme, making medical care for those with specific needs costly and difficult. One participant who is not covered by the scheme due to her disability, explained how she had to sell her farm animals to be able to pay to give birth at the local hospital (Interview 12, Rwanda). In these cases, participants described how women with disabilities may turn to religion or traditional methods of healing in search of support for their impairments.

Participants in both countries spoke of the difficulties they had experienced within formal health systems, if they could access them. For one participant in Cambodia, when she was pregnant with her daughter, the doctors and nurses at different hospitals in the area assumed that she could not deliver her baby vaginally, owing to a disability with her legs, and forced her to have a c-section. She believes that this is because "people don't understand how the body of a woman with a disability works" (Interview 1, Cambodia). In Rwanda, another interviewee spoke about the disability she acquired as a result of the genocide, and how she previously went to the hospital for treatment "but there wasn't enough technology" so they misdiagnosed her and her "condition got worse" (Interview 5, Rwanda). These are examples of how the discrimination and misunderstandings that women with disabilities face on a daily basis can have a profound impact on their lives at all levels.

As previously described, most participants in this study across both Cambodia and Rwanda acquired their disabilities later in life, and most came from accidents and diseases. Many of these causes of disability as reported by participants, are preventable, like road traffic accidents, landmine detonation, measles, or polio. Due to inaccessible healthcare, many women continue to report disability as a consequence of diseases which are almost or totally eradicated in the Global North. Taking interviews as an example, some women in this study reported becoming blind as a result of measles (Interview 6, Cambodia), losing a limb due to polio (Interview 1, Cambodia), contracting a respiratory disease (Interview 2, Rwanda), and struggling to walk due to scoliosis (Interview 9, Rwanda). Adequate formal healthcare was cited as a way forward by participants to both prevent and relieve disability in the future. While causes of disability were similar in both countries, experiences tended to be more traumatic in Rwanda, with significantly more participants reporting impairments due to injuries from accidents, genocide, and beatings (e.g. Interview 11 & 17, Rwanda), this is likely due to stronger patriarchal norms in Rwanda, as well as the prevalence of GBV.

Some interviewees, especially in Cambodia, were unsure of the cause of their disability, but were able to explain their experiences and the adaptations they have made to their lives. This is likely due to the aforementioned lack of adequate and affordable healthcare (key informant, 2022). Over half of the interviewees in the study use an assistive device in their daily lives, and these range from screen readers and phone software, to wheelchairs and prosthetics. These devices generally make life easier for participants, but can be costly to acquire and maintain, and access may be limited. In Cambodia interviewees and advocates described how prosthetics are not always well suited to the environment, which can be hot, humid and dusty. Some women spoke about receiving prosthetics, but not being able to use them because of discomfort or difficulty with the fit, and because they make it difficult to get around by motorbike (Interview 4, Cambodia). These prosthetics are often old models which are difficult to maintain properly, and are unfit for use in these environments in the first place. Meanwhile in Rwanda, according to focus group discussions, prosthetics may be more suited to the environment, but the cost is generally prohibitive, as health insurance does not cover this expense. In both countries, there are problems with management and upkeep of prosthetics and

access to information surrounding these devices (focus group, 2022). Largely this conversation centres around the suitability of prosthetics for the context, and training participants on proper use and care once they gain access in the first place. In general, participants considered that their assistive devices improve the functional capacity of women with disabilities, thereby allowing them to integrate better into society.

### 6.7.3 Informal Supports

Informal or community support refers to those support services provided directly by people in the community to people with disabilities, without state or private support, such as unpaid assistance and peer-support. If well implemented and coordinated, these supports can enable and leverage accessibility and inclusion efforts by creating more inclusive communities. In doing so, community support systems ensure the most marginalised are not left behind, increasing opportunities for women with disabilities, and enabling them to have better control over their own lives (Vasquez et al, 2021). On the other hand, however, these informal supports can be highly gendered, where the burden of caring for family members and people with disabilities may be placed on other women in the family, as part of their caring roles. This may be because of the many societal and cultural demands on women to adopt the traditional role of a family-caregiver (Sharma et al, 2016). This may limit the household earning potential and prevent other women (both with and without disabilities) from pursuing opportunities for education and employment. While these informal supports tend to replace some of the services that should be provided by governments, they are not necessarily free to those who provide them, and may represent a huge 'cost' in terms of opportunities.

Regardless of who takes on the role of carer, women in this study reported feeling more supported through informal rather than formal channels of care, including through community groups, family support, and local advocacy. Participants in Cambodia spoke about receiving support when they need it from commune chiefs, friends, and local schools. One of the participants in this research, who is herself a woman with a disability, has also set up a food bank for vulnerable people in Siem Reap, which in turn supports others in lean periods (Interview 8, Cambodia). It is

clear that in Cambodia community and village ties are very strong, and inclusion in the local community is a central part of everyday life, but especially for women with disabilities. As mentioned above, support is more formal in Rwanda, but even within these organisations, women with disabilities tend to rely on each other and their communities as VSLAs and unions, as well as at work and socially (Interview 5, Rwanda). Support from local organisations also tends to extend beyond merely the practical, into improving the well-being and self-confidence of women with disabilities.

These networks of support are also important for forming social ties and meaningful relationships, as women with disabilities often find it difficult to develop genuine friendships (Kiani, 2009). Most participants would agree that their main support comes from other women with disabilities, and the communities they themselves have created. Many rely on those around them for advice, jobs, and assistance. There is a sense of understanding, compassion, and respect between women in both countries, and one participant described how they as women with disabilities have “joined together to create a union and share experiences... to improve [their] lives.” (Interview 13, Rwanda) This community support is vital to combat the marginalisation and isolation often experienced by women with disabilities in patriarchal societies. The ability to come together to discuss issues, share experiences, and to meet with others is vital for the emotional health and well-being of women who are so often on the margins of society (focus group, 2023).

#### 6.7.4 Family Support

It is also important to note that in cases where the State does not provide welfare, such as in many countries in the Global South, most often families of people with disabilities step in to fill this gap. This family support is sometimes the only support available to women with disabilities, and plays a significant role in their lives, particularly in cases where education, employment opportunities, and marriage prospects are limited, and social security benefits are inadequate (Sarmaa, 2023).

In both Cambodia and Rwanda, family values are extremely important, and culturally it is expected that the family would be a tight-knit unit (key informant, 2023).

Participants often spoke about the impact that their families had on both their lives and their perceptions of self, and the degree to which these were viewed positively or negatively often related to the family's support or perception of disability. The findings of this study, as well as previous research, highlight that women with disabilities face multiple social problems which make them dependent on their families or others throughout their lives. This dependence on families is not inherently associated with their physical impairments in most cases, but is socially constructed based on their systematic exclusion from actively participating in society (Sarmaa, 2023).

As explained previously, some interviewees described how their parents had discriminatory attitudes towards disability, and that parents often don't know how to treat children with disabilities. One participant explained that "my parents give up on me because I have a disability" and assumed that she will be dependent on them forever (Interview 1, Cambodia). This view of women with disabilities as passive, and unable to get an education or a job is common among families, and many women stated that their parents did not believe in their abilities. Often this is because families do not fully understand disability, and therefore "do not know how to help you and how to make you have a good life" (Interview 6, Cambodia). In some cases, participants even argued that parents "don't want to help [children with disabilities], and they don't take care of them" (Interview 20, Rwanda). Here it is clear that the lack of formal support services can negatively impact both women with disabilities and their families, by making them overly dependent on family or community members who may not have favourable attitudes towards disability. This in turn limits the social and economic opportunities of both individuals with disabilities and their families or communities (Vasquez et al, 2021).

By contrast, if families are supportive and nurturing, women with disabilities report the positive effects this can have on not only their well-being and self-confidence, but also their employment opportunities. In Cambodia, an interviewee described how she gets "a lot of motivation and encouragement from her family who support her in case she wants to do anything", and now she has set up her own successful stall at a local market (Interview 2, Cambodia). Another also highlighted that even if her family and community did not support her in the first place "when they see that she is

successful and has a job, she is strong so they encourage her” (Interview 5, Cambodia). This mirrors earlier discussions surrounding how the identities of women with disabilities can be shaped by their wealth and employment status, thus earning them respect by families and communities. It is also likely that women with disabilities receive more support from family members if they are (relatively) wealthy, as they experience fewer opportunity costs in caring roles, and also may have more resources to support family members with disabilities (key informant, 2023).

Over half of participants in this study have children, and many spoke of working hard and wanting to create a better life for their children. This is especially true in education, where women frequently describe not wanting children to be illiterate, and praying for them to do well in school. In many cases, women with disabilities have one or multiple jobs outside of the home in order to feed their families, but in others, women work from home, or bring children to work with them. In Rwanda one participant describes how “working with a baby is not easy”, and slows down her work, but she has few other options (Interview 2, Rwanda). Of these families, 25% reported having a child who also has a disability, and these range from physical, to psychosocial, to combined, complex disabilities. In the most severe cases, while a participant is at work, she “just leaves her [daughter with disabilities] at home sleeping, she can’t do anything” (Interview 1, Rwanda). Others send their children to mainstream or specialised schools, and all speak of trying to provide the best possible care for their families regardless of their difficulties.

In many cases the family unit is also much wider than just the parents and children, and participants speak of living with aunts and uncles, grandparents, and family friends. Thus, it is important to note here that in the Global South, the individual with disabilities cannot always be disassociated from the family or other collective units. Rather, disability has a cascading impact on these units as a whole, to a greater or lesser extent (Singal & Muthukrishna, 2014). In other cases, women with disabilities may have no family support at all, especially in Rwanda where it is more common for children to be orphaned. For example, one interviewee explains “I have siblings but no one can take care of me or help me at all... They may have some family gatherings and no one can invite me because of me having a disability”, leaving

women isolated from both formal and informal support structures (Interview 11, Rwanda).

All of this support is important in allowing women with disabilities to develop their own self-belief and their own voices. When women are supported through both formal and informal channels, it not only helps them to become more confident and improve their socio-economic development, but also encourages them to reach out further and improve the lives of others in their communities.

### 6.7.5 Summary

In summary, women with disabilities in this study receive support from both formal and informal channels, but tend to rely more on informal support, as government and NGO programmes may be inaccessible, costly, or unavailable. Family support is one of the primary ways in which women with disabilities receive assistance, as families tend to be tight knit groups, and this is often the only support available. This may however further patriarchal roles within the household, as women are most often expected to take on these caring roles for family members with disabilities. In the next section I draw conclusions from all of the data presented above, and later present recommendations around how women with disabilities can be better supported in society.

## 6.8 Conclusion

In this chapter I have analysed the empirical evidence from 36 in-depth interviews, 2 focus group discussions, and 24 key informant interviews conducted with women with disabilities and their communities in Cambodia and Rwanda. These conversations explored the complex realities of living with a disability in low- and lower middle-income countries, and highlighted how culturally specific perceptions of both gender and disability tend to limit the opportunities available to women with disabilities. Women with disabilities described the discrimination they face in many areas of life, especially in the way that they are perceived in society, the opportunities available to them, the identity constraints that they face as both women

and people with impairments, and the lack of formal supports provided to them. These findings were gathered using a theoretical framework based on intersectional feminism and critical disability studies, and therefore aim to demonstrate the relationship between gender and disability in the day to day lives of women with disabilities in Cambodia and Rwanda, and how these are influenced by perceptions of their intersecting identities.

In both countries, participants highlighted the profound impact that strong patriarchal norms had on their life experiences. In interviews it was expressed that the unique combination of expectations placed on women, as well as those placed on people with disabilities combine to exclude women with disabilities from a wide range of opportunities. Often, women with disabilities do not fit into the traditional categories of womanhood prescribed by these cultures, as they may struggle - or be assumed to struggle - to fulfil traditional roles such as care-giving, looking after the household, and producing children. Participants described disability as a defining identity factor in their lives, as it is the most obvious factor perceived by others. However, participants also emphasised the importance of the gendered part of their identities, and how this impacted both the opportunities presented to them, as well as how they perceived themselves in society. This gender-based discrimination was stronger in Rwanda, where participants felt more constrained by their identities, and reported a much higher rate of trauma and gender-based violence. The patriarchal culture is likely stronger here due to deeply entrenched gender norms, as well as the societal emphasis placed on collective identity, and an individual's social worth.

Quality education and accessible vocational training were also important to participants in both countries, and many spoke about their value in creating more opportunities for women with disabilities, and emphasised that each individual woman's interests and functional capacity should be taken into account when designing these. Educational outcomes are better for women with disabilities in Rwanda, as the Government has taken a strong and coordinated approach to inclusion. Despite this, both salaries and employment are higher in Cambodia, due to the size of the job market, and the relative ease of entry into low-skilled jobs.

Additionally, due to the governmental commitment to inclusion in Rwanda, formal supports for women with disabilities are more widely accessible, and provide some benefit to women. Even where this support is absent, women with disabilities emphasise the importance of community in both countries, so that they can rely on each other, and eventually integrate into society. Most importantly, participants highlighted the community-wide advocacy that they are already undertaking, and how this could be amplified to empower women with disabilities everywhere.

# Chapter 7: Conclusions & Recommendations

## 7.1 Introduction

This research has aimed to understand the intersections between gender and disability in Cambodia and Rwanda from the perspectives of women with disabilities themselves. I have been particularly interested in the livelihood opportunities available to women with physical disabilities in these areas, as I have seen time and again in my roles working with international NGOs, that this population is underserved in the development space, and is most likely to live in poverty.

This is often stated in research too, where the UNDP argues that the human capital of women with disabilities, encompassing their educational, professional, activist, artistic, political, economic, and all other potentials, often remains invisible (UNDP, 2023). Patriarchal societies such as those that exist in Cambodia and Rwanda, combined with numerous social prejudices, and inadequate institutional mechanisms, fail to create an adequate environment for the dignified and fulfilling lives of women with disabilities. As participants highlighted above, often when development programmes do include people with disabilities, they are almost always targeted at men first. It is for these reasons that I wanted to work in a participatory way to share the stories of women with disabilities living in the Global South, and to utilise a methodology that would convey care, trust, and respect for these women and their life experiences. Many of the women involved in this research were sharing their stories on an international platform for the first time, and often during interviews, participants thanked me for taking the time to listen to them, and for working with women with disabilities specifically (for example: Interview 19, Rwanda & Interview 3, Cambodia).

As previously stated, much of the research and literature around disability is produced in and by the Global North, and often does not account for the unique experiences of women with disabilities, as distinct from men with disabilities (Boutros & Fakhri, 2023). In order to redress this, and to acknowledge the agency of women

with disabilities in the Global South, this study has focused specifically on these 'Southern' experiences of disability, which I found to be both unique and culturally specific. By foregrounding empirical evidence collected in Cambodia and Rwanda, with women with disabilities themselves, I have attempted to share the stories of these women as advocates for themselves and their communities. This is one of the major takeaways of this study for me, that women with disabilities themselves have powerful voices, know what they need, and should be listened to. This is the only way forward to both achieve the Sustainable Development Goals by 2030, and to advance the UN's (2004) motto 'nothing about us without us' in a gender-inclusive way.

## 7.2 Core findings

The core findings of this research generally correspond to the research questions posed in my methodology. These questions around intersectionality, opportunities, and support, now frame the findings and conclusions of this study.

The most significant finding of this study is the compounding negative effect of gender and disability on all outcomes of the lives of women with disabilities. In both countries, women reported feeling disadvantaged by both their gender and their impairments in the areas of education, jobs, and marriage. These effects are also compounded in low-income settings, where women with disabilities face poverty alongside other citizens, but also face additional challenges because their gender and disability status make it harder for them to compete for the available resources with their non-disabled peers (Tefera et al, 2018).

Women with disabilities in this study reported feeling discriminated against on the basis of both their gender and their disability, and felt that this intersection put them at a disadvantage in society. This demonstrates that there is a relationship between gender and disability in these countries, and that this intersection is context dependent. In this case, women with disabilities tended to face more extreme instances of discrimination and marginalisation in Rwanda, due to stronger patriarchal values, and more entrenched traditional beliefs about disability. It is this

intersection of gender and disability, coupled with the patriarchal values of societies, which most often exclude women with disabilities from employment and livelihood opportunities. It is also worth noting that the recent conflicts in both countries played a role in the experiences of participants. While this role was found to be minor in the grand scheme of their lives, participants still felt the effects of the trauma from this time, and the impact of conflict on the social norms in both countries was clear.

A key finding here is that societal perceptions of both gender and disability tend to place more restrictions on the lives of women with disabilities, and to limit the opportunities available to women with disabilities, by precluding them from certain jobs and milestones. In patriarchal societies, perceptions of gender combine with perceptions of disability to perpetuate discrimination against women with disabilities. This patriarchal dominance was highlighted in both Cambodia and Rwanda, and is mainly because of the traditional division of labour in many households in the Global South, where women are expected to take on caring roles within the household, while men are expected to be the main breadwinners (Qiu, 2023). As well as this, the cultural context of a country also has a role in shaping how women with disabilities are treated in society, especially in terms of how women are expected to behave. This was evident in both countries, where women were expected to be demure and quiet, and where women with disabilities were expected to perform model femininity, in order to be considered 'normal'.

Women with disabilities across the board in this study reported experiencing discrimination in many areas of society. Depending on the strength of patriarchal and ableist norms in a country, they may face significant discrimination in their everyday lives due to their intersecting identities. In Cambodia and Rwanda, this is because women with disabilities are seen as outsiders in society, who are dependent on others for survival. In these cases, these attitudes tend to lead to extreme marginalisation and cultural discrimination against people with disabilities (Morgan & Tan, 2011). This can be seen for example in the educational opportunities afforded to children with disabilities, which are often restricted due to negative attitudes of parents towards the education and employment prospects of their children (Tefera et al, 2017).

Another core finding of this study is that the discrimination and ostracisation experienced by women with disabilities throughout their life cycles often results in poverty and exclusion from the labour market. Livelihood opportunities for women with disabilities in this study were found to depend on the favourability of attitudes towards them by society in general, and how their intersecting identities influence the roles available to them. This is heavily influenced by religion in both countries, which in these cases see disability as a course of divine intervention, and something that can only be controlled by God or spirits. These beliefs tend to perpetuate the charity model of disability, and lead to a denial of opportunities and independence for women with disabilities in both countries, based on the societal perceptions of their intersecting identities.

Another significant finding of this study is that women with disabilities face many barriers to pursuing opportunities in education, employment, and marriage. As explained earlier by Kiani (2009), women with disabilities often feel blocked from realising their potential by the expectations that society imposes on them based on their identities as both women, and as people with disabilities. Obstacles such as negative cultural attitudes towards disability, financial and physical barriers to participation, lack of skills and confidence, and household responsibilities tended to stop women in this study from engaging with education, training, and the labour market. Despite this, the women with disabilities in this study pursue diverse livelihood opportunities, including sewing, handicrafts, retail, NGOs, massage, media, and finance.

Almost 30% of participants in this study are self-employed, and reported being proud of their work, despite the difficulties they may have faced in starting their own businesses. Martiz & Laferriere (2016) argue that this self-employment can lead to greater inclusion of people with disabilities in society, as they are seen to be engaging in opportunities which are traditionally viewed as unattainable due to their impairments. This was expressed by participants across all sectors of work, who found employment of all types to increase their social standing and respect in communities. Participants also highlighted the importance of self-confidence in their lives, explaining that many initially felt a lack of confidence in their abilities to engage with education and employment, but through changing their own perceptions of self,

and improving their own self-confidence, they were able to pursue diverse opportunities and overcome stigma. This improvement in self-confidence was generally as a result of being in a collective or group of other women with disabilities or working with DPOs, where women with disabilities found that they are not alone.

Participants also spoke about marriage as an important opportunity for people with disabilities, explaining that it is much easier for men to get married no matter their disability status, because they hold the power in patriarchal societies. Marriage in these cultures is seen as an opportunity for sharing resources, companionship, and time, but is not always available to women with disabilities. Although marriage is much more common amongst women in Cambodia, multiple participants described how the cultural norms of both countries prevented them from getting married due to cultural beauty standards, as well as widely held misconceptions about disability and the suitability of women with disabilities to engage in the traditional roles of motherhood and care (Amin et al, 2019).

Despite many similarities, women with disabilities in Cambodia and Rwanda have different priorities for inclusion in society, highlighting the importance of cultural context in conversations around disability. In Rwanda, participants emphasised the impact that patriarchal norms had on their everyday lives, describing greater concerns surrounding gender-based violence against women and girls with disabilities. As well as this, according to women in this study, employment opportunities and wages are lower in Rwanda, representing the widespread underestimation of the abilities of people with disabilities here. Finally, participants in Rwanda receive more formal support from the government than in Cambodia, and rely more heavily on the political will for inclusion, due to the centralised governance structure here.

While patriarchal norms also had an influence on the lives of women with disabilities in Cambodia, most of the focus here was on the social perception of disability, and the importance of community acceptance and inclusion, in a society that presents itself as highly collectivist. Quality education and skills training were also more of a concern for women with disabilities in Cambodia, as wages for skilled labourers are higher than in Rwanda. In terms of support, women with disabilities tended to rely

much more on informal support systems such as family and communities, and were primarily concerned with access to healthcare, in the absence of the types of health insurance which exist in Rwanda.

Women with disabilities also emphasise the need for support from others through both formal and informal channels, because they themselves are denied opportunities. While participants in Rwanda have more access to formal supports through government programmes like Mutuelle de Sante, in most cases, the few services which do exist to support women with disabilities are provided by local and international NGOs, often with little to no government engagement, and no overarching policy framework (Vasquez et al, 2021). Women across both countries reported feeling more supported through informal rather than formal channels of care, especially through community groups of other women with disabilities, family support, and local advocacy channels. It was also emphasised that greater support, especially from families and communities, leads to more self-confidence for women with disabilities, which in turn leads to greater self-development, and the ability for women with disabilities to engage in advocacy in their wider communities.

Finally, the women with disabilities who took part in this study emphasised that they are their own biggest advocates, for both themselves and for their communities of others with disabilities. They are connected and drawn together by their shared experiences of marginalisation, and as such provide a huge amount of support to one another. This mutual support and collectivism is one of the most important findings of this study, as it shows that women with disabilities are capable and resilient, and defy societal norms every day.

### 7.3 Recommendations

The core methodology of this research has from the very beginning been participatory and emancipatory, with a focus on spotlighting the experiences of women with disabilities themselves. One of the key findings from this study is that women with disabilities are most often their own biggest advocates, and know what it is that they need for success. Therefore, I now present some of the

recommendations made by the women involved in this research, along with those from my own analysis of this project as a whole.

### *Government Policy*

- Improve education on disability among government and local government workers as a means of reducing stigma. This could be for example among government ministers, district officials, and local government.
- Commit to a strong political will for disability inclusion, and mainstream this across all laws and policies.
- Push for the representation of women with disabilities in particular at decision-making level.
- Make insurance and welfare schemes accessible to women with disabilities, for example by working with the ministry of health to map numbers of women with disabilities in a community, and ensure that they can access non-contributory schemes.
- Provide improved practical support in the everyday lives of women with disabilities. This may include training them to recognise their rights, exempting them from taxes, and teaching them sign language.
- Ensure full implementation and monitoring of current disability policy in order for advocacy work to be more effective. As explained by one participant: “the policy is there but it is like it is sleeping!” (Interview 13, Rwanda)
- Reduce or remove school fees and vocational training fees for women with disabilities.
- National level policies should promote access to employment for women with disabilities, in culturally appropriate language, which does not essentialise or pity women.
- Improve education around disability at the village level, to challenge community understandings and education around disability, especially around causes and possible treatment for people with impairments.

## *Employers*

- Avail of sensitisation training from DPOs at all levels of management.
- Develop guidelines for the protection of women with disabilities at work, and monitor the implementation of these.
- Practise non-discriminatory hiring processes, and be open to the unique capabilities of women with disabilities.
- Provide scholarships, grants, and training programmes specifically for women with disabilities, to equip them with the skills needed to enter the workforce.
- Promote opportunities for women with disabilities to be seen as holders of valuable knowledge and skills in their communities, for example through asking them to lead workshops, promoting their businesses, and training them in useful skills.

## *NGOs*

- When conducting research and programmes which include women with disabilities, ensure that time is taken to get to know participants, to build up trust, and to establish a mutually beneficial relationship.
- Develop programmes targeting quality education for women and girls with disabilities across a variety of age categories. This may also include teacher training, or physical accessibility adjustments.
- Develop programmes which focus on the eradication of diseases which may lead to disability.
- Any vocational training programmes targeted at women with disabilities should incorporate hands-on training, and present participants with a clear sense of how to move forward and apply these skills.
- Teach skills tailored to the preferences and requirements of different communities, so that women with different functional capacities have the opportunity to improve their incomes.
- Train women with disabilities on how to apply for jobs, including where to find job postings, writing a CV and application letter, and interview techniques.

- Promote collectivism for women with disabilities, encouraging them to meet, work together, and share stories in groups of their peers.
- Facilitate courses or workshops which focus on and promote self-confidence and self-belief for women with disabilities, in conjunction with, or separate to, vocational and skills training.
- Lobby governments to improve formal supports and healthcare for people with disabilities generally, and for women with disabilities in particular.
- If prosthetics or assistive devices are provided, ensure recipients are provided with the right device for their lifestyle, and train them on proper use and care.
- Recognise and encourage the provision of informal and family support for women with disabilities, through inviting family members and caretakers to events, and holding workshops for this population specifically.

## 7.4 Thesis Contribution

This thesis contributes to the wider body of feminist and disability research by bringing the two together to explore the intersection of these identity factors, and the practical impacts they have on the everyday lives of women with disabilities. Using a framework of intersectionality which is both participatory and empowering, this study highlights the experiences of women with disabilities themselves. By basing my study on empirical evidence gathered from women with disabilities, their advocates, communities, and families, I have aimed to 'localise' disability studies in the Global South, to begin to redress the dominance of studies from the Global North in this area. In working with NGOs, both local and international, in Cambodia and Rwanda, this research also contributes to the push for disability inclusion in NGO programmes going forward.

I also wish to acknowledge here the contribution of the communities of women with disabilities that I spoke to in both countries, to this thesis. Without their insights, encouragement, and openness, I would not have been able to conduct this research, and share their ideas on an international platform.

## 7.5 Future research

This thesis has contributed to a growing body of evidence on the intersection between gender and disability in Cambodia and Rwanda. In depth analysis in other countries, as well as more quantitative studies featuring women with disabilities would be useful in representing a wider array of women, as well as adding statistical significance to what have so far been mainly anecdotal studies.

Suggestions for future research therefore include:

- Large-scale quantitative studies of the education and employment opportunities available to women with disabilities in the Global South.
- Similar qualitative-based studies in different countries in the Global South, to demonstrate that understandings of disability are context specific.
- The prevalence of gender-based violence against women with disabilities and how this impacts their lives.
- The influence of religion on perceptions of disability in different countries/regions.
- Investigations into informal employment for women with disabilities.

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Title of the research:

Employment Opportunities For Women with Physical Disabilities in Cambodia and Rwanda.

Principal Researcher:

*Jennifer Byrne, PhD Candidate - Centre for Global Women's Studies , School of Political Science & Sociology, National University of Ireland, Galway.*

You are invited to take part in this research. Before you make your decision, it is important that you understand why this research is being carried out and what it will involve. This participant information sheet will tell you about the purpose and risks of the study. Please feel free to take as much time as you need to read the following information carefully and ask the researcher if there is anything that is unclear, or if you would like more information. You should only decide to take part in the study when you feel you understand what is being asked of you, and you have had enough time to think about your decision.

What is this research about?

The aim of this research is to better understand the employment experiences of women with physical disabilities in Rwanda, as well as supports available from NGOs and the government. I will ask about your education, your job, your community, if you've ever experienced discrimination because of living with a disability, how you think supports could be improved for women with physical disabilities, and other questions. You have been asked to participate because of your involvement with a local disabled person's organisation or NGO. The interview will take about 30 minutes, and will be conducted in Kinyarwanda, with the help of a translator.

What will be asked of me if I agree take part?

With the help of a translator, we will ask you some questions about your experiences. Some of these will be short questions, and others will ask you to give your opinion or explain your experience. There are no right or wrong answers, and anything you are comfortable sharing is valuable. You do not have to answer any question you are not comfortable with. You are free to let us know at any time if you are uncomfortable, would like to take a break, or to stop the interview. Once the interview is finished you will not need to do anything else for the research, but if you would like to be involved in creating

Date:



recommendations for future supports for women with disabilities, you can tell the researcher at the end of the interview.

Are there any risks to participating?

Participating in this research will not cause any risk, other than the potential discomfort of answering some of the questions. If this happens, you can refuse to answer, or you can end the interview. In case of distress, you can contact The Rwanda Women's Network. There is no payment for participation in this research. If you decide not to be part of this research, there will be no consequences, and we will not ask you to give us a reason. You are free to ask questions before you make your decision.

Information gathered from the interviews will be reported as group data, for publications and media, and will not identify you in any way. All data will be stored in a password-protected file on a secure drive accessible only through password-protected computers. When we report the research findings, we will never indicate any individual's name or location, and will only describe general patterns and findings from all participants.

I need some extra support, can you accommodate me?

This research aims to be as inclusive as possible, but for now we are only researching physical disabilities. You will be asked what kind of accommodations you need during the planning stages of the interview, and we will do our best to meet these needs. We can also facilitate online interviews.

If you have any questions or problems, please email the principal researcher, Jennifer Byrne at [j.byrne41@nuigalway.ie](mailto:j.byrne41@nuigalway.ie), or whatsapp +353863309708.

If you have any concerns about this research, you can contact my supervisor, Dr. Stacey Scriver at: [stacey.scriver@nuigalway.ie](mailto:stacey.scriver@nuigalway.ie)  
Or the NUI Galway Research Ethics Committee at: [ethics@nuigalway.ie](mailto:ethics@nuigalway.ie)

Thank you for your consideration.



Each interview will be split up into 2 parts, structured multiple-choice questions, and semi-structured, open questions, with a break in between. The interviews have been designed this way to ease participants into the interview process, and also to get them thinking critically about the themes of gender, disability, and employment.

The interview should take under an hour, including time for a 10 minute break in between sections. Interviews will be audio recorded.

Part 1 - Structured Questions:

How old are you?

18 - 25

26 - 30

31 - 35

36 - 40

41 - 45

46 - 50

51 - 55

56 - 60

61 - 65

What province are you originally from?

(List Provinces)

How long have you lived in Siem Reap/Kigali?

(If applicable) Why did you move here?

Can you read and write in Khmer/Kinyarwanda?

Have you completed any of the following?

Primary school

Lower secondary

Upper secondary

University

Post-graduate degree

Are you satisfied with your level of education?

Yes/No

Have you received any vocational training?

Yes/No

If yes, what was it in?

Who was it provided by (govt./NGO)?

Are you currently in employment?

## Annex 2: Sample Interview Guide



OLLSCOIL NA  
GAILLIMHÉ  
UNIVERSITY  
OF GALWAY

Yes/no

Do you have more than 1 job/income-earning activity?

Yes/no

What is your main job/income earning activity?

What sector do you work in (e.g. farming, textile, education, NGO)?

Are you self-employed?

Yes/No

Do you enjoy your work?

How many hours on average do you work each day?

How much on average do you get paid each month?

Do you get paid in cash?

Yes/No

Do you have a bank account?

Yes/No

Do you receive any welfare payments?

Yes/No

If yes, Are these payments from the government?

Yes/No

If no, where do these payments come from?

Do you have an Equity Card (IDPoor Card)?

Does anyone else live in your household with you? If yes, who?

Is there any other income in your household?

Yes/No

Have you lived with a disability all your life?

How would you describe the type of impairment you experience?

Do you have a prosthetic/assistive device (e.g hearing aid, wheelchair)?

BREAK



Part 2: Semi-Structured Questions:

Are you satisfied with your level of education?

Can you tell me about any vocational training you've had?

Tell me a bit about your job and what you do?

Have you experienced any challenges in finding/keeping employment?

Are there any supports in place to assist you at work?

Are you involved with any disabled persons' organisation or women's organisation? Can you tell me about this?

Do you think that there are stereotypes about the types of work that women with disabilities can do in Cambodia/Rwanda?

Do you think men with disabilities are given more opportunities for employment than women with disabilities?

Have you ever experienced discrimination based on being a woman with a disability?

What do you think could be done to improve the lives of women with disabilities in Cambodia/Rwanda?

Interview Number:

Name:

Date:



Each interview will be split up into 2 parts, structured multiple-choice questions, and semi-structured, open questions, with a break in between. The interviews have been designed this way to ease participants into the interview process, and also to get them thinking critically about the themes of gender, disability, and employment.

The interview should take under an hour, including time for a 10 minute break in between sections. Interviews will be audio recorded.

Part 1 - Structured Questions:

How old are you?

18 - 25

26 - 30

31 - 35

36 - 40

41 - 45

46 - 50

51 - 55

56 - 60

61 - 65

What province are you from?

(List Provinces)

How long have you lived in Kigali/Gisenyi?

(If applicable) Why did you move here?

Did you attend school as a child?

Yes/No

If yes - How many years of formal education did you receive (not including university)?

1 - 3

4 - 6

7 - 9

Have you completed any of the following?

Primary school

High school

University

Post-graduate degree

Have you received any vocational training?

Yes/No

Are you satisfied with your level of education?

Annex 3: Sample Interview Guide - Rwanda



Yes/No

Are there other skills that you think you would benefit from having (e.g. wood-working, IT skills, english language etc.)?

What is your job title?

What sector do you work in?

Are you self-employed?

Yes/No

How long have you been working in this job?

Less than 1 year

1 - 2 years

3 - 4 years

More than 5 years

Since I started working

How many hours on average do you work each day?

How often do you get paid?

Daily

Weekly

Bi-weekly

Monthly

Other

How much on average do you get paid each day/week/month?

Do you get paid in cash?

Yes/No

Do you have a bank account?

Yes/No

Do you receive any welfare payments?

Yes/No

If yes, Are these payments from the government?

Yes/No

If no, where do these payments come from?

Is there any other income in your household?

Yes/No

Does anyone else live in your household with you? If yes, who?

What types of household tasks do you usually perform at home?



Do you feel that women or men usually perform more of the household tasks at home?

Women/Men

Have you lived with a disability all your life?

How would you describe the type of impairment you experience?

Part 2: Semi-Structured Questions:

Firstly I would like to know a little bit more about you as a person. Can you describe yourself to me in three words?

What do you think is your best personality trait?

Are you satisfied with your level of education, or would you like to study more?

Can you tell me about any vocational training you've had?

Are you involved with any disabled persons' organisation or women's organisation in Rwanda? Can you tell me about this?

As a woman do you feel that you have power over the decisions that are made in your household?

Have you experienced any challenges in finding/keeping employment?

Are there any supports in place to assist you at work?

Do you feel respected in your workplace?

Do you think that there are stereotypes about the types of work that women with disabilities can do in Rwanda?

Do you think men with disabilities are given more opportunities for employment than women with disabilities?

Are you aware of any national strategies to promote the rights of people with disabilities?

How do you think women with disabilities are treated in Rwanda?

Are there cultural stigmas around women with disabilities?

Have you ever experienced discrimination based on being a woman with a disability?

Annex 3: Sample Interview Guide - Rwanda



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What do you think could be done to improve the lives of women with disabilities in Rwanda?

Do you have a female role model, or someone you'd like to be like?

How would you like the role of women in Rwanda to change in the next 10 years?

What are your aspirations for the future as a woman in Rwanda?



Title of Research:

An Exploration of the Employment Opportunities Available to Women with Physical Disabilities in Cambodia and Rwanda.

Principal Researcher:

*Jennifer Byrne, PhD Candidate - Centre for Global Women's Studies , School of Political Science & Sociology, National University of Ireland, Galway.*

1. I confirm that I have read/been read the information sheet dated \_\_\_\_ (version \_\_\_\_ ) for the above study, and have had the opportunity to ask questions.
2. I am satisfied that I understand the information provided and have had enough time to make my decision.
3. I understand that my identity will not be revealed while the study is being conducted or when the study is published.
4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
5. I agree to take part in the above study.
6. I agree to be voice recorded during this interview for the purpose of data processing.

Name of Participant:

Study Identification Number:

Signature/Mark:

Date:

Signature of Researcher:



ចំណងជើងនៃការស្រាវជ្រាវ៖  
ការស្វែងយល់ពីឱកាសការងារដែលមាន  
សម្រាប់ស្ត្រីដែលមានពិការភាពរាងកាយនៅក្នុងប្រទេសកម្ពុជា និងប្រទេសវ៉ាន់ដា។

អ្នកស្រាវជ្រាវបង្គោល  
Jennifer Byrne បេក្ខជនបណ្ឌិត - មជ្ឈមណ្ឌលសម្រាប់ការសិក្សាស្ត្រីសកល  
សាលាវិទ្យាសាស្ត្រនយោបាយ និងសង្គមវិទ្យា សាកលវិទ្យាល័យជាតិអឺរ៉ុប ទីក្រុង Galway ។

- ១. ខ្ញុំសូមបញ្ជាក់ថាខ្ញុំបានអាន/ត្រូវបានអានឱ្យនូវសន្លឹកព័ត៌មានចុះថ្ងៃទី \_\_\_\_ (កំណែ \_\_\_\_)  
សម្រាប់ការសិក្សាខាងលើ ហើយមានឱកាសសួរសំណួរ។
- ២. ខ្ញុំពេញចិត្តដែលខ្ញុំយល់ពីព័ត៌មានដែលបានផ្តល់ ហើយមានពេលគ្រប់គ្រាន់ដើម្បីធ្វើការ  
សម្រេចចិត្ត។
- ៣. ខ្ញុំយល់ថាអត្តសញ្ញាណរបស់ខ្ញុំនឹងមិនត្រូវបានបង្ហាញទេ ខណៈពេលដែលការសិក្សាកំពុងត្រូវ  
បានធ្វើឡើង ឬនៅពេលដែលការសិក្សានេះត្រូវបានបោះពុម្ពផ្សាយ។
- ៤. ខ្ញុំយល់ថាការចូលរួមរបស់ខ្ញុំគឺស្ម័គ្រចិត្ត ហើយថាខ្ញុំមានសេរីភាពក្នុងការដកខ្លួននៅពេលណាក៏  
បាន ដោយមិនចាំបាច់ផ្តល់ហេតុផលណាមួយឡើយ ដោយគ្មានសិទ្ធិស្របច្បាប់របស់ខ្ញុំត្រូវ  
បានប៉ះពាល់។
- ៥. ខ្ញុំយល់ព្រមចូលរួមក្នុងការសិក្សាខាងលើ។

ឈ្មោះអ្នកចូលរួម៖

លេខសម្គាល់ការសិក្សា៖

ហត្ថលេខា/សម្គាល់៖

កាលបរិច្ឆេទ៖

Annex 6: Sample Consent Form Kinyarwanda



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Umutwe w'ubushakashatsi:

Ubushakashatsi ku mahirwe y'akazi aboneka ku bagore bafite ubumuga bw'umubiri muri Kamboje no mu Rwanda.

Umushakashatsi mukuru:

Jennifer Byrne, PhD Candidate - Centre for Global Women's Studies , School of Political Science & Sociology, National University of Ireland, Galway.

1. Ndemeza ko nasomye urupapuro rwamakuru yo ku ya \_\_\_\_ (verisiyo \_\_\_\_)  
kubwinyigisho zavuzwe haruguru, kandi nagize amahirwe yo kubaza ibibazo.
2. Nishimiye ko numvise amakuru yatanze kandi mfite umwanya uhagije wo gufata icyemezo.
3. Ndumva umwirondoro wanjye utazamenyekana mugihe ubushakashatsi burimo gukorwa cyangwa igihe ubushakashatsi bwatangajwe.
4. Ndumva ko uruhare rwanjye ari ubushake kandi ko mfite umudendezo wo kuva igihe icyo ari cyo cyose, nta mpamvu n'imwe.
5. Nemeye kugira uruhare mu nyigo yavuzwe haruguru.
6. Nemeye kuba amajwi yanditswe muri iri tsinda ryibanze hagamijwe gutunganya amakuru.

Izina ry'abitabiriye:

Inomero iranga Kwiga:

Umukono:

Itariki:

Umukono wumushakashatsi:



Title of the research:

An Exploration of the Employment Opportunities Available to Women with Physical Disabilities in Cambodia and Rwanda.

Principal Researcher:

*Jennifer Byrne, PhD Candidate - Centre for Global Women's Studies, School of Political Science & Sociology, National University of Ireland, Galway.*

You are invited to take part in this research. Before you make your decision, it is important that you understand why this research is being carried out and what it will involve. This participant information sheet will tell you about the purpose and risks of the study. Please feel free to take as much time as you need to read the following information carefully and ask the principal researcher if there is anything that is unclear or if you would like more information. You should only decide to take part in the study when you feel you understand what is being asked of you, and you have had enough time to think about your decision.

What is this research about?

The aim of this research is to better understand physically disabled women's experiences of employment in Cambodia/Rwanda, as well as the initiatives that exist to support them at NGO, government, and policy level. During the focus groups, we are interested in hearing from a wide range of NGOs, DPOs, disabled advocates, and other interested parties, to gain an understanding of how NGOs work in Cambodia/Rwanda, and what level of disability inclusive programming currently exists in the country. What cultures exist in Cambodia/Rwanda around disability? Are there any supports already in place for women with disabilities? Are organisations interested in becoming more inclusive? These are some of the questions we are interested in exploring during the focus groups.

What will be asked of me if I agree to take part?

You have been asked to participate as a representative of an NGO/DPO, Advocate, or other interested party. You will be asked - as a representative of your organisation - to follow the researcher's instructions, and give your responses. I am interested in hearing your honest opinions and reflections on this topic, and will conduct a series of activities to help you think critically. There are no right or wrong answers, and anything you are comfortable sharing is valuable. You are free to let me know at any time if you are uncomfortable, would like to take a break, or would like to stop. The focus groups will last for a maximum of 2 hours, including a break, and will be conducted in both English and Khmer/Kinyarwanda. Once the focus group is finished you will not need to do anything else for the research, but if you would like to be involved in creating recommendations for future supports for women with disabilities, you can tell the researcher at the end of the focus group.

Date:

Annex 7: Participant Information Sheet: Focus Groups with NGOs, DPOs, Advocates and Others.



Are there any risks to participating?

Participating in this research will not cause any risk, other than the potential discomfort of answering some of the questions. If this happens, you can refuse to answer, or you can choose to leave the focus group. There is no compensation for participation in this research. Participation is completely voluntary and you can withdraw from the study at any time. If you decide not to be part of this research, there will be no consequences, and I will not ask you to give a reason. You are free to ask questions before you make your decision.

Information gathered from the focus groups will be reported as group data, for publications and media, and will not identify you personally in any way. Your organisation may be credited in the acknowledgements, if you wish, but otherwise all data gathered will be anonymised. All data will be stored in a password-protected file on a secure drive accessible only through password-protected computers. When I report the research findings, I will never indicate any individual's name or location, and will only describe general patterns and findings from all participants.

I need some extra support. can you accommodate me?

This research aims to be as inclusive as possible, but for now I am only researching physical disabilities. You will be asked what kind of accommodations you need during the planning stages of the focus groups, and I will do my best to meet these needs. I can also facilitate sign language and online attendance.

If you have any questions or problems, please email the principal researcher, Jennifer Byrne at [j.byrne41@nuigalway.ie](mailto:j.byrne41@nuigalway.ie), or whatsapp +353 863309708.

If you have any concerns about this research, you can contact my supervisor, Dr. Stacey Scriver at: [stacey.scriver@nuigalway.ie](mailto:stacey.scriver@nuigalway.ie)  
Or the NUI Galway Research Ethics Committee at: [ethics@nuigalway.ie](mailto:ethics@nuigalway.ie)

Thank you for your consideration.

Date:



These focus groups are intended to be participatory and energising in nature. They should last approximately 2 hours, and comprise no more than 8 participants. The researcher will lead and moderate discussions as well as providing direction on activities, but thoughts and feelings should be generated by the group as a whole. Tea, coffee, and cake will be provided, and participants will be encouraged to stay and network after the focus group has finished.

The room should be arranged so that participants can sit comfortably in a circle (with enough room for accessibility).

Things I need:

Function room

Chairs

White board

Pens

Post it notes

Blue tack

Notebook

Dictaphone

Video camera

Gifts for participants

Snacks

### Activity 1: Introduction.

Have everyone introduce themselves, discuss what it's like to work in the NGO sector in Cambodia.

*Questions for discussion include:*

Approximately how many NGOs are currently registered with the government? An estimate is fine.

What do participants think is the most common area of intervention (e.g . education, healthcare, WASH etc)

Are they mostly run by foreigners or locals?

Are there barriers or difficulties to working in the NGO sector in Cambodia/Rwanda?

What is the aim of the NGO sector in Cambodia/Rwanda? Do foreign and local NGOs have different priorities?

### Activity 2: Thinking about women with disabilities.

Ask participants to think about the women in their communities. What kind of services do they need, or use in their daily lives? For example access to healthcare/hospitals, markets, banks, etc.

- Ask participants to then think about women with physical disabilities in Siem Reap/Kigali How many of these services are not accessible to them based on physical barriers? How about other barriers?



- What kinds of services are the least accessible to women with disabilities in Cambodia/Rwanda? Why? What are the barriers to access?

Activity 3: Culture surrounding women with disabilities.

- Ask participants to describe what words that generally come to mind when talking about women with disabilities (for example: handicapped, inclusion, poverty, blindness etc.).
- Write these on a flip chart sheet.
- Talk about the words they have written and why they associate these specific words with disability. What does disability mean? Is there a difference between experiencing disability as a man and a woman?

*Questions for discussion:*

How are women with physical disabilities generally treated in the culture?/Is the culture accepting of women with disabilities?

What influences how women with disabilities are treated in Cambodian/Rwandan society?

Do you think women with disabilities struggle to find employment in Cambodia/Rwanda?

What kind of jobs do women with disabilities usually do?

Do you think there's a relationship between gender, disability, and poverty in Cambodia/Rwanda?

Activity 4: Supports for women with disabilities.

*Questions for discussion:*

What supports currently exist to support women with disabilities?

Ask participants if any of their NGOs run programmes which include people with disabilities?

Can they tell the group about them?

Are there any programmes that they run that have the potential to be inclusive? How? Are there any ways to specifically include women with disabilities?

Challenges to becoming inclusive?

Are you aware of any national strategies to promote the rights of people with disabilities?

What other organisations exist to support women with disabilities in Cambodia/Rwanda?

Are NGOs interested in becoming inclusive?



Title of Research:

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Principal Researcher:

*Jennifer Byrne, PhD Candidate - Centre for Global Women's Studies, School of Political Science & Sociology, National University of Ireland, Galway.*

1. I confirm that I have read/been read the information sheet dated \_\_\_\_ (version \_\_\_\_) for the above study, and have had the opportunity to ask questions.
2. I am satisfied that I understand the information provided and have had enough time to make my decision.
3. I understand that my identity will not be revealed while the study is being conducted or when the study is published.
4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
5. I agree to take part in the above study.
6. I agree to be voice recorded during this focus group for the purpose of data processing.

Name of Participant:

Study Identification Number:

Signature/Mark:

Date:

Signature of Researcher:



I have been contracted to translate or interpret interviews and focus group discussions as part of a research study being conducted by Jennifer Byrne, PhD researcher at the Centre For Global Women's Studies, University of Galway (formerly NUIG), Ireland.

During the course of interpreting interviews and discussions, I will refrain from expressing any personal opinions, or doing anything else that might be considered an activity other than interpreting.

### **Confidentiality**

I agree to respect the confidentiality of any conversation I interpret. I also understand that research focusing on women with disabilities can be sensitive. Therefore I will not communicate, publish, or share any information from the research study with any individual or organisation other than the researcher named above. This includes names and identifying characteristics of participants involved in interviews and focus group discussions.

### **Accuracy and Completeness**

To the best of my ability, I will execute a complete and accurate translation/interpretation, not omitting or changing anything discussed in the course of the interview.

### **Impartiality**

At no time will my personal opinions be allowed to interfere with any communication, and any unsolicited comments or suggestions will be made strictly to improve the quality of communication.

---

Translator/Interpreter's Printed Name

Date

---

Translator/Interpreter's Signature



Participants may experience distress during interviews, due to the nature of disability as a sensitive topic in Cambodian and Rwandan culture. Participants will not be asked to describe the circumstances that lead to their disability, or any other specifics relating to their impairment/condition, as this is not relevant to the research, but may experience some discomfort in describing situations of discrimination or stigma. During the semi-structured part of the interviews, difficult topics may naturally arise as participants speak about their experiences, including memories of the traumatic past of both countries, or of personal tragedy or hardship related to gender/disability. It is important to be aware of these possibilities, and to know how to deal with the situation, should a participant experience significant distress.

These interviews will take place within the framework of existing NGOs in Cambodia and Rwanda. This means that local disabled person's organisations and women's organisations will be actively engaged at all stages of this research in order to minimise possible distress to participants. The leaders of these organisations have been asked to feed into the methodology, in order to make this as sensitive as possible, and will also provide psycho-social support to participants during fieldwork.

### Step 1: Indication of Distress

- A participant indicates that they are experiencing a high level of stress.
- OR
- A participant exhibits behaviours which suggest that the interview is too stressful such as excessive crying, shaking, difficulty breathing, etc.

### Step 2: Initial Response

- Stop the interview and recording immediately.
- Ask the participant how they are feeling and how they would like to proceed.
- Suggest the participant take a break from the interview.

### Step 3: Review

- If the participant feels able to carry on, resume the interview.
- If the participant is unable to carry on, go to Step 4.

### Step 4: Referral

- Discontinue the interview and accompany the participant to a quiet area.
- With participant consent, refer them to a local women's organisation and disability support service, where they can access counselling and other supports. Contact information for local counselling and psychosocial support will be provided to all participants.

### Step 5: Follow Up:

- Follow up with participant through means of initial contact (telephone call, whatsapp, email etc.) as a courtesy call.
- OR
- Encourage the participant to get in contact if there is anything they would like to discuss.

Date:



Additionally, the researcher and fieldwork team may experience distress during the course of this research due to both the sensitive nature of the information being disclosed, as well as the nature of conducting fieldwork in the Global South. Protocols for managing distress in the research team will be implemented in the following phases.

### Pre-data Collection Phase:

- The researcher should consider the potential physical and psychological impact on the research team of the participant's description of life experiences.
- The researcher should consider how many interviews can be undertaken and transcribed in a week.
- The researcher should be aware of the potential for emotional exhaustion.
- Schedule an initial call & face to face meeting with the researcher, fieldwork team, and a local disabled persons organisation in Cambodia/Rwanda for sensitisation training.

### Data Collection Phase:

- Ensure the translator and sign language interpreter (if needed) are well briefed, and understand the sensitivity of the topic before fieldwork begins, and hold weekly debrief meetings during fieldwork.
- Schedule regular check-ins with supervisor and mentors.
- The researcher will keep a journal of their thoughts and feelings.
- Plan for time off during fieldwork.

### Analysis Phase:

- Ensure transcribers are alerted prior to transcription of potentially difficult material.
- Keep a clearly documented termination for the transcription process, if needed.
- Continue regular debrief sessions.

### Follow-up Phase:

- Encourage the research team to stay in contact and follow up with the research supervisor if they experience distress.
- Provide contact information for local supports in appropriate countries for members of research team.

Date:


Content analysis part 1: Census Data

Census Data				
Variable	Disabled population Cambodia	General population Cambodia	Disabled population Rwanda	General Population Rwanda
Total Population	784,000	16,000,000	442,000	13,000,000
% Prevalance of disability	4.90%	--	3.40%	--
% of males with disability	4.20%	--	3.10%	--
% of females with disability	5.50%	--	3.60%	--
% experiencing significant disability	6.30%	--	*Few	--
% experiencing moderate disability	19.40%	--	*Some	--
% experiencing some disability	74.30%	--	*Most	--
% of population who are married	68.60%	78%	38.10%	50%
% of population who have received education	70.90%	88.50%	65%	81%
% of population in employment	52.90%	68.60%	24.80%	56.50%

\*\* The most recent census from NISR does not provide numbers or percentages of people who experience each category of disability, but instead describes how 'most' people experience some disability etc.


Content analysis part 2: NGO data

NGO Data		
Variable	Cambodia	Rwanda
No. of NGOs	385	483
No. of local organisations	132	61 (approx)
No. of international organisations	253	422 (approx)
No. of local disability inclusive organisations	25	13
No. of international disability inclusive organisations	33	22
Overall main focus of all organisations	education	education
% of all organisations which are religious	38%	21%
% of all organisations working on disability inclusion	15%	5%
% of organisations working on disability inclusion which are health focused	53%	73%
% of organisations working on disability inclusion which are advocacy focused	46%	66%
% of organisations working on disability inclusion which are religious	39%	26%