



 **Hi·D·SA**

Strengthening community & civil society voice



**AMPLIFYING THE VOICE OF WOMEN WITH
DISABILITIES AFFECTED BY GENDER BASED
VIOLENCE AND SEXUAL VIOLENCE**

ACKNOWLEDGEMENTS

We are grateful to all WWD, caregivers and the key stakeholders who selflessly shared experiences, views and perspectives on WWD and affected by GBV. We sincerely hope your voices will be instrumental in rehabilitating communities and strengthening GBV programming for your benefit.

To all research assistants and colleagues, who participated in collecting data, thank you for taking your time to listen to and capture the voices of WWD presented in this report.

Study commissioned by Hlanganisa Institute of Development in Southern Africa and the Joint Gender Fund.

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ACRONYMS

BPFA	Beijing Platform for Action
CBO	Community-Based Organisation
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CRPD	Convention on the Rights of Persons with Disabilities
CSVR	Centre for the Study of Violence and Reconciliation
DSD	Department of Social Development
DVA	Domestic Violence Act
FGD	Focus Group Discussions
GBV	Gender Based Violence
IPV	Intimate Partner Violence
NDP	National Development Plan 2030
NGO	Non-Governmental Organisation
NPOs	Non-Profit Organisations
PWD	People with Disabilities
SAHRC	South African Human Rights Commission
SAPS	South African Police Service
SASL	South African Sign Language
SRHR	Sexual and Reproductive Health Rights
StatsSA	Statistics South Africa
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VAW	Violence Against Women
WHO	World Health Organisation
WPRPD	White Paper on the Rights of Persons with Disabilities
WWD	Women with Disabilities

DEFINITION OF KEY TERMS

Caregiver: An unpaid or paid person who helps another individual with an impairment with his or her activities of daily living whether in a residential home or institutional setting.

Intimate partner violence: Behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Lack of access to services: The inability to seek and obtain legal protection and redress because services are not availed due to lack of awareness of the issues that women with disabilities face in regard to their vulnerability or other barriers and constraints.

Patriarchal attitudes: Attitudes towards women in patriarchal societies combined with vulnerabilities related to the impairment itself.

Powerlessness: The perceived powerlessness of women and girls with disabilities who are less able to defend themselves or seek support because of their isolation which may arise from their being hidden away, that the nature of impairment leaves them isolated, or that they may not recognise that what is happening to them is unacceptable and not their fault.

Sexual violence/sexual assault: Any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object (WHO, 2013).

Violence against women (VAW): Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UN General Assembly, 1993).

Women with disabilities: Women with disabilities include those who have perceived and/or actual physical, psychosocial, intellectual, neurological and/or sensory impairments who, as a result of various attitudinal, communication, physical and information barriers, are hindered in participating fully and effectively in society on an equal basis with others.

1. INTRODUCTION

1.1 Background: Gender Based Violence in South Africa

Gender-based violence (GBV) can be defined as violence that targets individuals or groups of individuals on the basis of their gender. GBV is a global concern and Violence Against Women (VAW) is a key form of GBV. The United Nations (UN) defines VAW as 'any act of gender-based violence that results in, or is likely to result in physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.'¹ A recent World Health Organisation (WHO) fact sheet shows that one in three (35%) women worldwide have experienced a form of physical or sexual, intimate partner or non-partner violence, in their lifetime. ² Chapter 12 of the National Development Plan (NDP) shows that South Africa has unacceptably high rates of GBV.³ Gender-based violence is about power and control. Even if both men and women experience gender-based violence in South Africa, research shows that men are often the perpetrators of violence, and women and children the victims.⁴ GBV remains a high concern in South Africa with recent incidents of femicide across the country getting high media attention. Women's subsequent responses, through social media and gender-based advocacy bodies, show a deep concern about the lack of political will towards containing and preventing GBV, by the responsible stakeholders.

1.2 Legislation and Policies on GBV

South Africa has the most progressive framework relating to GBV in the southern African region. Key examples include the following:

- The South African Constitution (Section 9)⁵
- The Domestic Violence Act (no 116 of 1998)
- The Criminal Law (Sexual Offences and Related Matters Amendment Act no 6 of 2012)
- The Maintenance Act (no 99 of 1998)
- The Protection from Harassment Act (no 17 of 2011).

Although the Domestic Violence Act and the Sexual Offences Act are central in GBV litigations, South African Constitution, The Maintenance Act and the Protection from Harassment Act also contribute towards fighting GBV and advocating for the protection of all citizens. These instruments are also critical in promoting empowerment for gender equality for all vulnerable bodies and those marginalised by violence. More so, South Africa is a signatory to multiple global conventions for the prevention of GBV, and particularly those that focus on promoting the rights of women and children, such as:

- The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).
- The African Charter on the Rights and Welfare of the Child.
- The Beijing Platform for Action (BPFA), 1995.
- The UN Resolution 1325 on Women, Peace and Security, 2000.
- The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 2003.⁶

Although efforts to curb GBV are clearly visible in the work of government institutions and various civic organisations, meaningful and recognisable benefits of such efforts remain eclipsed by the high levels of GBV, particularly VAW, which continues to rise.³ In addition, numerous scholars and activists, whose work is based on different frameworks, have also challenged and advocated against GBV in South Africa.^{7,8,9} A recent report by the Centre for the Study of Violence and Reconciliation (CSVR)¹⁰ shows that cultural, religious, social and economic factors contribute to driving violence, with women and girls mostly presenting as victims. Furthermore, researchers who explore GBV attribute its occurrence and pervasive nature to multiple contested factors. In some accounts GBV is linked to the history of apartheid, where it is associated with a perceived crisis in masculinities, driven by what have been labelled 'damaged men,' 'broken men,' who have been emasculated by historical violence.^{11,12} Other researchers see persistent violence as being linked to socially entrenched patriarchal values that perpetuate unequal gender relations in all contexts of South Africans' lives.¹³ Yet some

debates associate it with persistent economic marginalisation of young men,¹⁴ which is also linked to class and race. In all these debates there are very few studies that explore the phenomenon of GBV among women with disabilities. Similarly, while in GBV advocacy, numerous organisations are working towards promoting the rights of women, there is very little attention paid to GBV on people with a disability, particularly violence against women and children. Yet studies show that women and girls with a disability are more exposed to abuse than women and girls without a disability.^{15,16}

One key research report with such a focus,¹⁷ is more than a decade old, yet violence, broadly, is one of the most researched areas in South Africa. The Centre for Disability Law and Policy, in partnership with the Cape Mental Health Society, and the Gender, Health and Justice Research Unit (2013)¹⁸ recently studied the GBV experiences of women with psychosocial and intellectual disabilities, but their work focuses on promoting access to justice for women with these disabilities.

It is evident that there is a huge gap in information on women with disabilities (WWD) and GBV. It is therefore important to acknowledge that women are not a homogenous group. Whilst they are all exposed to risks of GBV in South Africa, it is necessary to adopt a process that considers the multiple intersecting factors that shape their different experiences of violence in order to design responses that are specific to their unique positionality.

The Hlanganisa Institute for Development in Southern Africa (HIDSA) through the Joint Gender Fund programme has, therefore, commissioned this study to investigate the GBV risk factors for women with disabilities (WWD) and make recommendations on how disability can be mainstreamed into GBV programming.

2. THE INTERSECTION OF GENDER AND DISABILITIES AS VULNERABILITY FOR WWD

Women with disabilities are often seen by their societies as weak, worthless and, in some cases, subhuman, and such perceptions heighten their risk of GBV. The situation is exacerbated by other factors like gender, race and class, as all these work together to create vulnerability to GBV. Research shows that disability reduces opportunities for education, work, training and employment, particularly for women in disadvantaged communities, magnifying their vulnerability to violence.²⁰ The situation is worse for black women who, in most cases, would suffer multiple oppression, since they are most likely to also be poor, destitute, and illiterate.^{21,22,23} WWD have also been found to be more psychologically vulnerable than non-disabled women, and they are twice as likely to be victims of sexual abuse, rape and intimate partner violence (IPV) than their non-disabled counterparts.²⁴



Global research suggests that Africa has the highest rates of physical and sexual intimate partner violence, and non-sexual violence in the world, with 35% of women reported to be victims of violence.²⁵ In South Africa, GBV incidents have become a common media headline with statistics currently showing a femicide rate that is five times more than the global rate, and more than 50% of the perpetrators being intimate partners.²⁶ Although these South African rates do not show prevalence among WWD, research elsewhere shows that WWD experience IPV more than their non-disabled counterparts.²⁷ In Spain, one study found that three out of ten WWD were abused by their partners.²⁸

Sexual myths and fetishes associated with bodies with a disability heighten the risk of sexual violence for WWD. In most communities persons with disabilities are often perceived as either asexual or oversexed.^{29,30} Misrepresentation of sexuality of WWD can create fetishes around sexual encounters with WWD which expose WWD to sexual violence at the hands of their intimate partners and non-partners. For example, women with albinism are vulnerable to sexual abuse by males who believe that sex with a person with albinism will bring them wealth.^{31,32} At the same time, WWD are vulnerable to sexual abuse because some men may want to satisfy sexual fantasies by having sex with WWD.³³

3. METHODOLOGY

The main objective of the study was to characterise the sexual violence experienced by WWD, and explore the factors that contribute to their heightened vulnerability and how these can be addressed in GBV programming.

3.1 Research objectives

The study sought to:

- a) Explore GBV risk factors for women with disabilities
- b) Understand the factors that increase the vulnerability of WWD to sexual violence
- c) Understand barriers to accessing sexual violence related health care and justice services for WWD
- d) Make recommendations for policy and practice

The report will be used to inform GBV advocacy efforts and refine and strengthen disability inclusivity in GBV programming.

3.2 Data collection

Data was collected from five provinces: Gauteng, KwaZulu-Natal, Eastern Cape, Limpopo and the Western Cape, in South Africa in September 2018.

The methods used to gather data included:

- Focus group discussions (FGD) with women with different forms of disabilities as profiled below,
- Semi structured individual interviews with women who gave support to WWD, and
- Semi structured interviews with key stakeholders and representatives of institutions working with people with disabilities in different portfolios at district, provincial and national levels.

3.3 Description of the sample

The sample consisted of women in care institutions and those in different communities who were accessed through the assistance of either their associations, their coordinators or through snowball sampling. FGDs were held with groups of women

with similar forms of disability. For example, there was a group of women paraplegics, and a group of hearing-impaired women, in which a sign language specialist guided the FGD. Women with mental challenges comprised another group and the services of a resident social worker, who worked with the women, were secured to facilitate appropriate communication with the group. A group of women with visual impairment and two groups of women with a variety of physical disabilities, which included women with albinism and those with a visual impairment, were also convened. Attention was paid to ensuring involvement of all participants in such groups, with identifying codes utilised to enable participants who had visual impairments to follow and participate in the discussions. These details are summarised in the table in Annexure 1.

All data was transcribed verbatim and analysed thematically. Findings are presented thematically, with attention paid to distinctly outlining disability specific voices. The voices of the women were coded by province as indicated below.

Eastern Cape	KwaZulu Natal	Gauteng	Limpopo	Western Cape
EC	KZN	GP	LP	WC

4. FINDINGS: PERSPECTIVES OF WWD

The research findings are organised around risk factors identified such as, isolation and neglect by families, disabilities and risks of GBV, sexuality and myths, lack of knowledge around disabilities, dependency related abuse, WWD's experiences of GBV, experiences with the criminal justice and health services sectors. Additional themes that came out in this research speak to perceptions of support staff and those of key stakeholders. It should be noted that some of the experiences, examples and perceptions given here might apply to all people with disabilities, however, this study only focused on the voices of WWD.

4.1 Risk Factors

4.1.1 Isolation and neglect

In almost all focus groups, WWD indicated how difficult it was for their families to live with and support them. A particularly common feature which exposed WWD to GBV risk was isolation and neglect by family members. This manifested in different ways in different contexts. Firstly, caregiving family members who did not have any form of support in caring for WWD were forced to lock them away when they went out to work, or when they needed to take care of other household responsibilities:

It is true, GBV happens because most people are locked up in houses. (WC)

WWD are locked up. Some people say they are protecting us by locking us up, but it doesn't help. (WC)

Secondly, sociocultural stigma associated with disabilities caused some families to lock WWD away and keep them hidden from their communities. Family shame and fear of community responses pressured families into such practices. This 'locking up' was generally considered a protective measure but WWD saw this practice by families as abusive and potentially risky, since it attracted particularly male perpetrators who targeted the isolated and vulnerable women:

When you see us disabled persons it hurts, it is a shame..., because others are locked up in houses so that they do not meet other people. (WC)

...because some parents, think they will be laughed at. Because people laugh. People who think they will never have a child with a disability will make fun of people with disabilities. (WC)

People laugh, they stigmatise and isolate you, they laugh. Some will come in maybe they see that there are people with disabilities, they think we defile them. (WC)

Other families handled such stigma in their own way:

For those who are unable to get out of bed, they are locked indoors and neighbours told that this person left a long time ago. (KZN)

In all different circumstances of being locked away, WWD indicated that this was not only emotionally challenging but it left them open to potential abusers who targeted them because they were vulnerable and isolated.

4.1.2 Access to social grants and exposure to violence

Being recipients of the social disability grant exposed WWD to further abuse by those very close to them. Although they understood that the money was needed for their care, some respondents felt that families had a tendency of using the grant for their own needs, excluding and neglecting them in the process. An element of helplessness was raised here as the women felt that they were neither in control of their resources nor part of any decision making. They felt disregarded and despised because of their disabilities:

Your grant is used to pay fees for other children, buy groceries and salon visits, and yet you are unable to have your own hair done because they say that you won't even see your hair, who will see you anyway. (KZN)

We have this grant but I realise that it is a source of violence in families. You are always the last to get a thing out of it. Your mother and sisters take your money and

you are only given a few coins. You don't know what happens to your money and you have no say about your money. (EC)

At times the risk escalated to violence as some family members aggressively sought access to the social grant. Examples were given on how some WWD were physically attacked if they refused to share their grant (with family members):

My brother wanted my grant and when I refused he beat me up and I was left with an injury here (touching her upper arm) and I was taken to the hospital and the doctor said I should have him arrested but my family said no they will talk to him, but they didn't do anything. (LM)

In some instances, WWD indicated how they consented to sharing the grant unaware that they were being taken advantage of because of their vulnerability and disability status. A participant indicated how she would share her grant with her partner. After the grant was used up, the partner would suggest that she borrows money from the community 'loan shark,' which she did, and such a practice subjected her to further risk of exposure to potential violence from 'loan sharks':

I used to give my able-bodied boyfriend half my grant, and he would use it all to drink. When it got finished he would ask me to use my grant card to get him more money from the loan shark, which I did. I ended up in debt and my father beat him and chased him away. (LM)

These examples show how WWD felt disregarded by their families. They were excluded from decisions made on their grants, associating such exclusions to their disability status. They also showed how they can easily be deceived and exposed to even further violence by potential partners.

4.1.3 Disability impairment as a risk factor

Some respondents argued that all disabilities predisposed women to GBV risks:

blind, paraplegic, we are all vulnerable to GBV, and I think the risk is the same. (EC)

I don't think there is a disability that is better than another disability, so if we're talking about vulnerabilities, we are all exposed to risk, we're all vulnerable in our different forms of disability. (EC)

However other women had a different perspective, indicating how different disabilities meant different vulnerabilities. They emphasised how certain disabilities heightened the risk of GBV when compared to others.

WWD argued that women with visual impairments and those with mental challenges were much more at risk of GBV than women with other forms of disabilities. The assumption made was that those with a visual impairment would not be able to identify perpetrators and those with mental challenges may not remember what could have happened:

Risks for GBV are high for people who are mentally challenged. Most of them are at a higher risk of being violated, because they (offenders) know that they (victims) won't remember anything. Because they do not have the ability to know what happened. No matter what you do to them they won't know what you did. (WC)

Such sentiments were supported by women with visual impairments as they highlighted how the responses of the justice system to women with visual impairment who have been affected by GBV denied them justice, leaving them hurting and potentially easy targets (see also below, a detailed exploration of the phenomenon).

Women with hearing impairment also highlighted how GBV remained heightened in their contexts, particularly when they are young:

When I was small my experience is that a man will touch you and harass you sexually, and mostly it happens because the child couldn't tell her mother or father that this is happening, so they will be quiet because they won't be able to express themselves and say what has happened especially when you are small. (GP)

Women with mental challenges acquiesced to these views sharing their vulnerability to GBV. As highlighted above, locking WWD in rooms and houses as a protective measure by families and caregivers actually attracted potential perpetrators who capitalised on their vulnerability and isolation. A number of women shared how there were attempts on their lives and incidents of abuse in such contexts because of their disability status forcing them to find refuge in spaces of care and support:

It is risky to be left alone if you are like us (mentally challenged); people once knocked and I peeped and saw a man. I screamed and he ran away. On another day another one came, I threw hot water at him through the window and he ran away. That is why my daughter brought me here. (LP)

Before I came here I used to stay by myself. This boy once tried to open my door using a knife; he opened but there was a chain preventing the door from opening further and that saved me from being attacked. (LP)

In these examples emerges another issue that needs attention in programme designs, which is, the abuse of young girls with disabilities. Linked to this is lack of knowledge about what constitutes abuse and how young girls with disabilities can identify and report abuse. A participant reflected on GBV experiences at a special school she attended some years back.

One of the major findings of this research was that there was a compounded risk of experiencing GBV for girls who were in specialised schools or institutions of care. Although institutions of care offered the much-needed protection from GBV, some participants shared experiences of abuse in special schools as young girls in hostels. Firstly, young girls were expected to care for their colleagues who needed extreme care as they had extreme disabilities:

I would ask for people to pay attention to special schools. Girls are abused there. I will share my own experiences. Some special schools may fail to protect girls from abuse. I remember when I was attending this school, as girls we

were expected to care for those who could not take care of themselves. It was difficult even to say anything at home as your parents would not understand. I remember when we were asked to bath this girl who had extreme disabilities and was menstruating at the time. We took very hot water and poured it on her bed, we were fed up of cleaning her mess all the time. In retrospect that was abuse she didn't deserve, it, we were all abused at the time. I had not started menses then but I couldn't understand why we were asked to bath this bleeding girl. We were nasty and the innocent girl was burnt. All I am saying is caregivers can be very abusive particularly to young girls... at times the older girls will bring in older boys and they sexually abused the younger more defenceless girls. The aunts will be in their houses watching TV. We never even spoke about this and it was later that we realised this was rape when we got to know about GBV. (EC)

This extract raises a number of issues about gender-based violence and sexual violence in special schools. Firstly, young girls were expected to do care work, taking care of fellow students who have extreme disabilities. This is the work of caregivers but they took advantage of these girls who also need be supported. Secondly, sexual abuse emerges as there were a number of young girls that were reported to have been raped by older male learners. A key concern is that when all this happened the younger girls did not see it as 'rape' or violence, neither did they talk about it at school or at home. This multi-layered violence was sadly normalised.

This example points to a gap in knowledge about the rights of young girls with disabilities and violence among young women with disabilities. Perhaps sensitisation is also required for caregivers who might not even be aware of such kind of sexual violence in the schools. The different layers of violence raised here are summed up in the phrase 'we were all abused', since the young people were not even aware they were being abused.

A key factor underlined in the experiences reported above is that different disabilities pose different risks to GBV. If improving the lives of people with disabilities is a fundamental concern it is necessary to understand disability specific risks for GBV programming so that disability specific responses are designed. The overarching concern emerging here is the general lack of disability awareness by communities and the lack of knowledge of disability rights by some people with disabilities. This lack of understanding by both families and communities in which WWD live, and the lack of knowledge about disability rights and what constitutes GBV to WWD, needs urgent redress. Examples of the potential risks created by lack of knowledge in both families and communities are further outlined below.

4.1.4 Lack of knowledge

A general lack of knowledge about disabilities was raised by women in most of the groups. This lack of awareness started with families, and extended to communities and service providers. The resulting attitudes exposed WWD to risks of GBV, as shown here, and as will be emphasised throughout the presentation of these findings:

I think the other thing is that there is lack of understanding and knowledge about disabilities in most communities, people don't understand and people don't know.

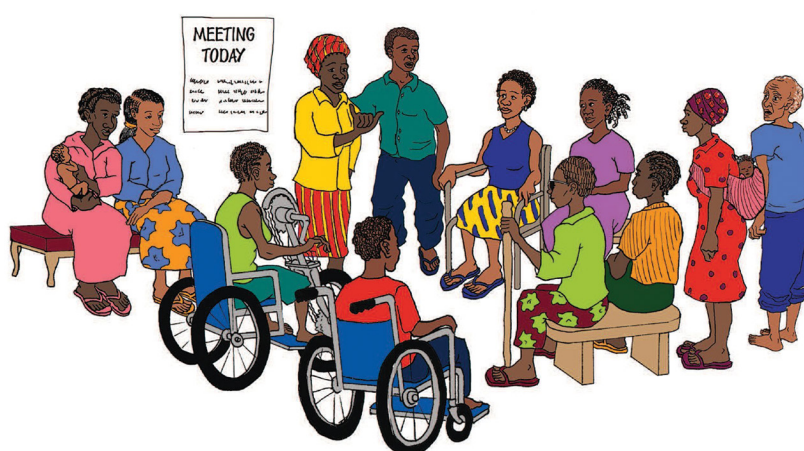
There is no information. In most cases people in communities expect disabled people to just sit there and do nothing and wait for their social grants day in and day out, sitting and doing nothing. (EC)

Stigma starts at home and families are perpetrators. (EC)

WWD revealed that their families saw them as invalids who were helpless. Ironically, while such perceptions were at times meant to protect them, they were inadvertently communicated to communities. Communities, thus perceived WWD as vulnerable, and it was such perceptions of vulnerability that made them easy targets for GBV. Literature also shows that it is a common phenomenon that people with disabilities are marginalised as disability is associated with illness, or brokenness in most communities.³⁴

Respondents with hearing impairment felt vulnerable in their own families, and frustrated because of a communication barrier that rendered them helpless. They constantly felt isolated, excluded and vulnerable at different levels which made their associations with other people outside their homes equally challenging. Respondents with hearing impairment believed that their challenges would lessen if parents and family members had the opportunity to learn sign language. In this way they would assist their children particularly in issues of self-esteem, as a lack of self-esteem was a potential risk for GBV:

...to add on, parents must learn sign language for their children so they can build relationships and be able to communicate with their children. So, parents must access information and teach their kids how to love themselves and be independent out there. (GP)



4.1.5 Culture, sexuality and myths

The assumption that WWD are asexual has been raised in a number of studies looking at the experiences of WWD across the globe.³⁵ WWD are perceived to be incomplete and therefore incapable of sexual practices, or they are assumed to be hypersexual. In this study such beliefs about WWD's sexuality emerged as participants indicated how such notions emanated from their own families and spread out to the communities. Misconceptions about WWD's sexuality were abundant and such misconceptions paved way for potential violation of rights by families as shown here:

Stigma begins with the families, I was told that I am an invalid and there is not much I can do, I cannot get married. They believe that because you have a disability, marriage and intimate relationships cannot be of relevance to you - it is almost like disability means asexuality and that is not okay as we also have feelings that need acknowledgement. Even if family does this to protect us, they undermine us, undermine our sexuality and it does not feel okay. (EC)

I also think that awareness is very crucial as it is the underlying factor in understanding disabilities. For example, you find people assuming that because you're disabled you cannot afford to be pregnant, you cannot, you cannot love and have a sexual relationship, people assume that you don't have feelings. It is necessary for people to know that we are human beings, we want love and we want to be loved and have children so that they can look after us tomorrow. (EC)

A lack of understanding of WWD's sexual and reproductive rights by families further complicated their situation exposing them to violation of their right to bodily integrity as enshrined in Chapter 2 Section 12 of the Bill of Rights:

There is also this one lady I know. She is from the Eastern Cape and they found out that she is deaf and the parents were so worried and they asked a doctor to tie her (fallopian tubes) so that she will not have more children who are deaf like her and when she grew up she didn't know that they had tied her tubes and then she got a boyfriend and got married but she couldn't get pregnant. (GP)

Respondents found this way of thinking about WWD easily normalised and perpetuated outside the families, opening them up to more risks of violence in their communities. Numerous myths associated with disabilities positioned the bodies of WWD as a 'spectacle' which, in turn, attracted potential violent attacks from perpetrators:

Also, another thing is that boys normally have this thing of saying they don't understand how people with disabilities have sex because in their heads there has

to be a difference in the way well abled and people with disabilities have sex. (GP)

You get men saying I want to sleep with you and find out how you are because you are a different (woman with albinism) from other women, and some women saying I cannot have a man to myself but have to share with other women and therefore have to be in a polygamous relationship. Why should I be the one to share all the time? (KZN)

More examples of myths associated with the sexuality of people with different disabilities were shared across provinces by groups with different disabilities:

And others will tell you that people with disabilities cannot acquire HIV. Yes! Because they insist that... they cannot contract HIV if they sleep with us who have disabilities. So, I end up asking myself that if something like this can be popular and widely spoken of, exactly what kind of people are we? because HIV, the last time I checked does not choose who it infects. But no, they have this belief. (GP)

And they also have this notion that people with disabilities have desperation and they take advantage of people with disabilities under this guise because they think that we are desperate. They think that we are desperate to have a boyfriend or in need of someone to help us sexually. (GP)

This strong fetish and obsession with the bodies of WWD posed a serious risk, particularly of sexual violence, as shown by women with different disabilities and particularly those with hearing impairment:

I have a friend she was raped by five men but I cannot tell you what her name was, but five men raped her. She was always walking in the street and these men were like we want to test if she can cry or something... she was deaf, these men wanted to know if she can scream... because they were always like hey and she would not reply or even notice or give them any attention so they were like this one will not even be able to tell anyone and they went and raped her, five men, and that girl went to the police and they couldn't understand her. (GP)

Such examples are a clear indication that disability awareness is lacking in most of

our communities. These voices show a complete lack of understanding of disabilities which expose WWD to inhuman attacks as highlighted. Such experiences of WWD are not unique to South Africa as evidence shows that such myths on WWD's sexualities abound³⁶ in different communities.

4.1.6 Economic dependency and poverty

Advocates for gender equality and scholars have all emphasised the centrality of economic empowerment for women as a GBV preventative factor. The same sentiments were raised in most groups as women felt that dependence on families, partners, spouses and carers for those who could otherwise work, opened them up to abuse. At the same time, employment prospects were highly limited by attitudes to PWD in general, as they encountered huge challenges with attempting to get employment. Research shows that there are intersections that result in some women becoming more vulnerable to violence than others and the interface between disability and poverty seems to be one such example. WWD living in poverty have limited opportunities to economically empower themselves, leading to economic dependency and this has a bearing on social protection. This lack of economic empowerment was seen by respondents as a risk that left them reliant on the grant and their caregivers, and such reliance made them vulnerable to abuse:

...for example, when it comes to employment no one is keen to employ a person with a disability, look at these women here most of them are learned. Some of them have computer skills, some of them have done other skills but no one employees them because they are disabled. All I am saying is that we are undermined and that exposes us to GBV risk. (EC)

At the same time attitudes to PWD in general played a significant role in shaping the economic status of WWD, who felt that some women ended up looking for boyfriends not because they wanted to date but because they had hope of being financed, these would be transactional associations:

minute they find out and realise that she is blind, Yho! They will tell you that the resources are a problem to government and tell you that government does not have resources for people that cannot see. How, when it is government? So, you can't say there are jobs; it's better to have a boyfriend cause then maybe he will give me money so that I can also live a nice life. Sometimes people think of such things because companies do not want to hire them. (GP)

These attitudes were also linked to a lack of knowledge about disabilities by different stakeholders and such marginalisation from economic empowerment posed the risk of WWD getting exposed to GBV through dependency and associations of desperation.

4.1.7 Other forms of dependency

Respondents also indicated how at times biological parents, step-parents and caregivers, all people well known to WWD, posed a major risk of sexual violence in their lives. A young woman with a mental disability shared how she had consistently been abused by her step-father until she got pregnant and also contracted HIV:

At home my father left and my mother got married to another man who came and lived with us. When my mother went to the clinic my step-father raped me and I then told my mother, but she said I was lying. I got pregnant and my brother chased my step-father away. I went to a mobile clinic and they told me I was HIV positive and I told them about my step-father. I was 17yrs at the time. We got him arrested and because he was a friend of the police they set him free. When I had the child, my aunt took the baby away because they said I am crazy. The social worker said I should go to a home that is why I am living here. But my step-father later died. (LP)

Another respondent explained how she also ended up at a support centre because she was almost sexually assaulted by her caregiver. This was someone known to the family and lived with the family assisting the respondent on her trips to the doctor and all:

... like if I needed to go for check-up he would accompany me, or if I needed to go do some other stuff he would help me. So that night he almost raped me and it

wasn't nice, my mother was there, I screamed, I told her what he was trying to do, we both trusted him. Ever since then, he has never come back to the house... That is when I decided to look for a place like this one. (WC)

In one instance a respondent also shared how at times parents used their daughters with a disability as a way of raising money. Here the mother would permit men who were able to pay a small fee to sexually assault her daughter who had disabilities:

...say I am disabled in a wheelchair, and my mother abuses alcohol. There are tendencies where parents prostitute their disabled daughters for a small amount. Men speak out. You hear people say Mama so and so allows us to sleep with her child for a small fee. Parents abuse their own disabled children for personal gains. I have heard stories of how some girls get pregnant and do not know who has impregnated them because they are exposed by their own parents... It gets difficult at times, the difficulty of speaking out if you know of such abuse is that the social workers and even police expose you and you can get killed for interfering in such things. (EC)

Respondents also indicated that GBV perpetrated by parents and caregivers had a potential to be normalised by the community and escalated, thereby placing them in double jeopardy:

But there are many things that are happening in their lives, especially when the community or when your family is not treating you correctly, the community will not treat you right either. They will feel like it's right to abuse you, you see. When you start being abused by your uncle at home and being raped by your uncle at home, the community also then thinks, no, this is right and end up telling themselves that they will also do it to you. (GP)

These voices raise multiple other layers of concern in the lives of WWD. The respondent who shared the sexual abuse of the woman with disabilities by her mother indicated that she was very close to the abused woman. She had a number of pregnancies resulting from the abuse and unfortunately passed on due to complications at childbirth. Such

practices were a common phenomenon in this community, however social workers are said to be removing WWD who experience such abuse from these contexts.

4.2 GBV Experiences WWD

Experiences of GBV among WWD varied for women with different disabilities and perpetrators ranged from the family sphere, intimate partners, caregivers and sometimes, strangers who preyed on their isolation and neglect. Even though women in South Africa are generally vulnerable to one form of gender-based violence or another, it was very clear is having disability was a huge risk factor to experiencing GBV for WWD. Experiences of violence took places in institutions of care, at schools and sometimes in a home setting. What was underlying for most of these experiences, was a general lack of understanding of disabilities by close family and service providers alike. Parallel to the lack of understanding was a general disrespect of people with disabilities, that led to violation of the rights of WWD as shown in their voices below.

4.2.1 Intimate partner violence

Several respondents in this study indicated that they were not in intimate relationships. However, in all the FGDs there were issues of intimate partner violence (IPV) raised, indicating further risks of GBV in their relationships. Violence manifested in different ways. Examples of physical violence were shared:

...After marriage he started beating me and his family members were abusing me, despising me because of my disability. I decided that I should move to a site that we had bought. I consulted with a social worker as I was badly beaten at that point. So bad that I almost lost my uterus as I was bleeding badly. I was taken to the hospital by my mother in law who insisted that I should never mention the abuse to the doctors. But as soon as I got to the doctor I told the truth. I had to make sure I speak in English so that my mother in law could not follow as she does not understand English. (EC)

I remember with my previous boyfriend, when we got into an argument he would

threaten me with physical violence. I would quickly keep quiet because I knew I had no power or strength to defend myself. In most cases I would agree with what he suggested because every time we argued he would threaten to beat me up and I knew that if it got to that point I would not be able to defend myself. So, I preferred to keep quiet instead. I knew I would not be able to run away from him, or to defend myself so I would give in out of fear and helplessness. (EC)

Violence was also experienced within the support and care centres where the women had sought refuge and security, which their communities had not offered. One respondent shared how her intimate partner came to the residential home and assaulted her in full view of the administrators and other residents. Threatening to kill her as he did so:

...there was a man I was in a relationship with. Then we had a disagreement, and I wasn't taking his calls. Then we disagreed on the phone, so I stopped answering his calls, then he came here (to the residential home). When he got here we were sitting outside by the front entrance... So, when he got here, he asked why I wasn't taking his calls and I told him I wasn't taking his calls because I didn't want to talk to him. I thought it would end there. But I was wrong. He got rowdy and attacked me in full view of the other residents and the administrators, right here in this home. He was shouting, I will kill you, I will kill you. I realised that he wasn't joking because he pulled out a knife. When he pulled out the knife he was also holding a tablet and a phone. He then assaulted me, hitting me with tablet. You see this black scar here (pointing to one side of her face) is the outcome of that assault. So, after that I decided this guy is not playing, he had come prepared, so I have to report him. I went and reported him at the police station and he was arrested. (WC)

Such audacious acts of GBV raise further concerns around safety and security of WWD, and the normalisation of GBV in communities. This kind of thinking about male power and the silence of the community to such kinds of attacks is summarised by one respondent. She thinks perpetrators who are able-bodied men in this case, believe that falling in love with a WWD is doing them a favour and some communities venerate

men for getting into these relationships. When they get abusive, community watches in silence, 'the man has done you a favour after all':

If you look at our communities, they know I am in love with this person and he is abusing me. It is like he is doing me a favour by falling for me. He gets credits for loving me in the first place and no one bothers him about abusing me. There is nowhere to go, nowhere to hide. You talk to people they say to you, knowing your situation (disability status) did you think intimate relationships were a child's play? Do yourself a favour and leave intimate relationships to able-bodied women. You are not strong enough. What they forget is that we also want to be loved. (KZN)

These responses capture undertones and layers of myths on the sexuality of bodies with a disability, as unpacked above. These sentiments were also shared by other respondents who spoke about their experiences with emotional violence:

I was in an abusive relationship although at the time I didn't notice it. This was a childhood sweetheart. He used to ask for sex and I used to tell him that I will wait till I am 21...I fell pregnant... My boyfriend supported our child. Although he was not physically abusive, he was emotionally abusive and would sometimes tell me that he did me a favour by making me pregnant. He would call me nasty names. I felt that physical abuse was better than emotional abuse... (KZN)

Emotional abuse further manifested in other forms as respondents shared abusive practices in their intimate relationships. Although these were 'sincere' intimate partnerships, respondents felt cheated and deceived. Their partners professed love for them 'only at night' and pretended they did not know them during the day:

I am not sure whether men need to be educated, but I have experienced this challenge. You declare your disability to your partner from the onset and they claim understanding. I am partially blind and If I am in a relationship you realise that men visit you at night, during daytime he doesn't know you. You are a night lover and nothing links you by day, I have been there and this is humiliating. (EC)

Your partner is humiliating you by dissociating himself from you by day and sneaking into your room and making false promises and tricking you into sexual intercourse by night. Taking this to the police or sharing it with others is another layer of humiliation. No one wants that. But this is sexual violence. (EC)

I once was in a relationship that I didn't realise was abusive. My boyfriend used to take me out of his house at 4am and then come for me later at night when no one was watching. I only started noticing that this was abuse when I attended gender-based violence meetings. I noticed that he never wanted to be seen in public with me... I left that relationship after a long time. There was a point when I almost killed myself... in the evening he always came to me for sex only. (KZN)

Such experiences were seen as humiliating and the respondents felt that they were being abused. The challenge was that these were consensual relationships and they did not know how to handle them and they often found themselves as 'victims' of this practice now and again. Information is also crucial for WWD as indicated here, it was only after receiving empowering information that this respondent had the power and understanding to leave the relationship. At times respondents were well aware of these abusive and exploitative encounters, particularly perpetrated by able-bodied men. They knew their partners only came to them for sexual encounters, and in some cases for their social grants as well, as shared by this participant from a group of women with visual impairments:

So, when a boy is in a relationship with you he wants to get what he constantly comes to see you for, which is sex. He doesn't even understand when you are angry with him or when you don't want to sleep with him because he comes when you have gotten your grant money, and when he wants to sleep with you, and that thing shows you that he doesn't love you, but that he is just using you and abusing you. So, this is the thing that sometimes you find that visually impaired people or people with disabilities end up saying to themselves that I will never fall in love with a non-disabled person because they are looking at these things that happen,

that a well abled person does not understand how a person with a disability should be treated. (GP)

A respondent further shared how such an instance of emotional abuse in a consensual relationship had fatal consequences. She shared how a friend who had a hearing impairment like herself committed suicide:

Abuse is so bad when it is emotional, it is so painful because my friend died because of it. She was dating a non-disabled man who emotionally abused her. The man was emotionally abusing her and she committed suicide by throwing herself in front of a train at the train station and it was so painful. It is miscommunication, some of it is finances and some of it is because of lack of trust of each other, cheating and affairs. (GP)

They did not trust each other and the phone, when they open your phone and see who were you communicating with this one and that one. (GP)

Lack of self-esteem was raised as a serious risk factor for WWD. The lack of love and care experienced in families by WWD, opened them up to GBV by intimate partners. The same lack of esteem equally encouraged WWD to remain in abusive relationships as the perpetrators would have been the only people who would have expressed love for them, something their families denied them all their lives:

You see at home they call you names. This makes you lose self-esteem as a woman. You feel like you are less of a woman because no one shows you any love or any form of affection. A man approaches and proposes, uses all the terms that make you feel special, terms no one has ever shared with you. You feel like a princess, you are in love. When the guy turns around and starts abusing you, forcing himself on you, cheating on you, controlling you, do you leave? Remember he is the only person who has told me how beautiful I am. I can't leave because it has taken this long to get someone to tell me I am beautiful. (KZN)

Although some of the challenges raised here are synonymous with challenges faced by non-

disabled women as well, some subtle nuances related to lack of confidence and self-esteem were raised here, and one could pick this underlying lack of self-esteem from some group members as they engaged in the group discussions. A clear explanation of why some women remain in abusive associations is also emphasised here.

Examples of being threatened when attempting to leave an abusive relationship also emerged:

My boyfriend was threatening to kill me. I told my sister and she told our parents. Our parents told his parents. So, I was protected because his parents and my parents knew. It was difficult for him to do anything because both of our parents knew so that's sort of silenced him and in that way, I was able to leave that relationship. (EC)

In such instances respondents believed that telling others, speaking out about abuse or intended harm exposed the perpetrator and provided one with time to extricate themselves from potential violence. Support systems played a major role in enabling respondents to extricate themselves from violent contexts. Respondents also revealed instances when, at times it was challenging when much needed support was denied because of communication barriers for women with a hearing impairment:

I have a friend and her boyfriend is abusive. They are both deaf and this man is always beating and abusing her and the woman once ran away and went to the police and reported, and the deaf man ran away and they tried to follow him and his parents were covering up because the girl comes from a different place and the boy is from around the location and everyone knows him. The problem is the girl is from somewhere far away from this place that they stay in. So, she thought of leaving this boy and she didn't have money to take a taxi and she went to the police and the police was like 'zimumumu' (you deaf people). She was using signs and she was looking for an interpreter but there was no interpreter, and she had to go back to the boyfriend. She didn't have money to leave and her home is far so she had to go back to the boyfriend and wait for the grant money, and when she got the grant money she packed everything and went home. (GP)

to GBV with violence, when she stabbed her intimate partner, but also emphasised how her violent act had been turned around to trap her in an abusive context until she had the courage to involve her family:

He would accuse me of sleeping with other men and one time he was up to his games and I stabbed him with a pair of scissors. Luckily, I missed his heart, otherwise I would have killed him. He covered up the fight and told his family that he had been stabbed by tsotsis, and then used that as a way to trap me. Whenever I wanted to end the relationship he would threaten to report to the police and tell them that I had stabbed him. I stayed in that abusive relationship and faked to enjoy sex to make him think that he was good and yet I had stopped loving him a long time ago... I eventually told my family about the extent of the abuse, they turned on me and blamed me for keeping quiet, saying he could have killed me. (KZN)

4.2.2 WWD's experience with law enforcement and justice

Reporting perpetrators of GBV was seen as a huge challenge by a number of respondents. Failing to report meant that they were left within reach of the perpetrators and in continued exposure to GBV. Yet some found it difficult to report perpetrators who were closely connected family members and bread winners:

If I can give you an example... you see one of the people we know was abused at home and was raped at home. When she tried to tell her mom and said, "Mama, I was raped." Her mom said hey my child you want your father to fight with me, your father is the one who brings bread to the table blah blah blah. We end up not being able to expose these things happening because the man is the one who provides for the home. You will speak and say what? You won't say anything anymore. You will end up just talking about it when you meet other people like you who are also having disabilities. Otherwise parents do not know how to support us sometimes and that is why blind people prefer being independent. (GP)

Even in cases of IPV, respondents also found it very difficult to report perpetrators arguing that perpetrators were very close to them. In some case families discouraged

reporting of cases of abuse to the police suggesting that cases be dealt with by families:

I considered going to the police but couldn't go through with it because he was the father of my child. (EC)

In another instance, a medical support provider suggested that a case of physical abuse and grievous bodily harm not be opened against a perpetrator who was a spouse, advising the survivor to get out of the situation and claim maintenance instead:

The doctor insisted that I do not go back home because of the magnitude of the abuse and allow him (my husband) to support me while I am with my family as the abuse was very bad. The doctor insisted that I should not report him to the police because I still needed his support, but I should leave him. I got a letter transferring me from KZN to the Eastern Cape for medical attention and that was how I left him. I did that and filed for maintenance. But he refused to maintain me claiming that I should return to KZN if I wanted his money. (EC)

Yet, at the same time there was fear of repercussions. Consequences of reporting perpetrators were weighed and some respondents were afraid to report:

...fear because when you live with someone, it is not easy to report them. For example, if you consider the issue of this lady (with albinism) who knows what would have happened had she reported the matter to the police? She didn't report because of fear and not knowing what would happen to her afterwards. (KZN)

Experiences with the justice system were cause for concern for a number of respondents whose final appeal was that if the justice system was effective in punishing criminals, the life of WWD would improve significantly. WWD felt that the biggest challenge with the police was that they did not take them seriously or gave them the attention accorded people without disabilities. In most cases the women felt that other than having disability, their challenges also had a gender face. One of the participants shared how her car was stolen, and she reported the case to the police. Her car was recovered and towed to the police station. She did not recover the car as police kept

looking for her docket until she gave up:

The police towed the car to the police station. Later there were challenges with the docket. But to cut a long story short, I had to move places and I moved to a new a different place, but I never recovered my car. (EC)

Respondents also raised the fact that not all police officials were sensitised about people with disabilities which made it very difficult for them to obtain the support they needed. In one case a respondent with a paralysis had gone to the police station to report that her child was missing as he had not returned from school. As soon as she entered the station, a police attendant assumed she was drunk and continued to ridicule her:

...there's a time when my child got lost and I went to the police camp to report. My husband with a disability went with me. As soon as I came through the door, the police assumed that I was drunk. They asked where I was when the child got lost... Someone took the child to the police camp, so the child was already at the police camp when we got there. The police officer said to me 'how would the child not be lost if the mother is drunk and the father is disabled? I don't drink. You see such attitudes are not okay. I felt violated, that was abuse. (EC)

Such experiences were seen as a lack of patience and understanding by the police. Similar cases of a lack of sensitivity on the part of the police were shared:

I am not right, September is the month that I was abused by a family member, and I reported the matter to the police. When I called the policeman working on the case, he told me that he doesn't serve me alone but serves 127 other people. I called three times to ask when the matter will be heard, but still no joy. 30 September remains etched in my mind because at 1am I was almost killed, and this still traumatises me, am not fine at all. My prayer is that these issues will be addressed and that we will ultimately be able to educate other people about the challenges that we face in our lives as disabled women. (KZN)

At the same time police were seen to be working in cahoots with perpetrators as raised

by one respondent earlier on. After getting her step-father arrested for sexually abusing her, and infecting her with HIV, he was released the following day:

He was arrested one day, and he was released because he was friends with the police. (LP)

My late sister's daughter who is disabled (deaf and cannot talk properly), was raped. When I reported and followed up the case, I was told that the magistrate didn't find any witness or evidence... I later heard that the police were bribed, and the docket disappeared. (KZN)

It is such practices that discourage survivors from reporting abuse. Women with different disabilities also encountered challenges that were different and specific to their disabilities. Women further shared responses they found common and specific to women with visual impairments:

You see rape; it happens that a person with a disability gets raped ne, and it happens often and when you go there to report the case, isn't it they are supposed to take you to the clinic and to the doctor right? But when we go to the police station... when you are raped the first thing you need to do is call the police right? But when the police get there they ask you; How did you get raped when you cannot see? Who raped you? How will you be able to identify them? Do you understand? These are the questions that they ask us; How will you see him because you cannot see? In other words, right now, we do not have a case because you cannot identify this person. So obviously it will end up being like you don't have a case, they no longer take you to go for the tests and get the rape kit and everything because you did not see the perpetrator, right? You won't be able to describe him, and they will ask you to describe the events; who were you with when this all happened? So, when you don't have answers to these, or if you were alone, they will take it as if it is not a case, meanwhile you are hurting inside. The pain is felt by you. These are some of the challenges that we come across. (GP)

Depending on other people puts you at risk especially if you are blind. (KZN)

If you are blind and are raped, people will always blame you for walking on your own; they will ask why you were on your own without a helper. (KZN)

At the same time, women with hearing impairment narrated how they found it difficult to be heard when seeking support after GBV challenges, yet there were programmes in place to teach police officers sign language. The women shared their frustration with the justice system:

... like at Wits also, they have got volunteers who can go teach at the police stations, but still people do not learn the language, and for us we are really struggling and sometimes we do write, but we don't understand why they can't understand what is written down. So, they get impatient with us because sometimes we do not understand what is written and some of us deaf people do not write English properly, and people will be like what is this, but that is how we write. (GP)

The challenges raised here were summarised by another respondent with a different disability in this way:

It is very difficult because police always want proof. In most cases people don't speak about sexual abuse because of stigma, and you get embarrassed in many ways as police always want proof. (EC)

4.2.3 Barriers to accessing health and social services

The research showed that there are significant barriers to women and girls' access to sexual violence related care and information. WWD interviewed also spoke of challenges with health services providers which were also associated with lack of knowledge and understanding of their sexuality, as well as the sexual and reproductive health rights (SRHR) of WWD. This lack of understanding resulted in frequent violation of their sexual and reproductive health rights. It should also be noted that such a lack of understanding permeated their entire communities, and service providers were reproducing and normalising the community stigma, as shown here:

...when I got pregnant with my first child. I concealed the pregnancy, then I told

my sisters, but they were also scared of my mother. So, we did not tell her. I tried to be careless thinking she will notice I was expecting, but she didn't. When I got to 7 months I told her I was going to the clinic for antenatal check-up. I could see the shock in her face, but she never said a thing to me. Neither did she shout nor ask any questions 'wamane walocka,' 'she just kept quiet.' I went to the rural clinic in ---(name given). This Sister at the clinic looked at me, tore a piece of paper from a book and took a pen and asked me to write down the reasons I got pregnant knowing I had a disability. I sat there and stared at her as she went on with her duties. I was ignored as I did not write anything on that piece of paper. I finally left without being attended to... (EC)

In this instance, the respondent and her sisters could not even share her pregnancy with her mother, because her mother did not expect her to be in a sexual relationship. In addition, the nurses at the clinic were perpetuating the same stigma and attitude evident in the family. This attitude within health services providers was further emphasised by women with a visual impairment:

At the clinic you go sometimes and they check you for rape. And at times it happens that you were not raped but you slept with someone that you were in a relationship with and it was consensual sex resulting in a pregnancy. When you get to the clinic they will ask you, 'Why are you pregnant? Who got you pregnant? who were you raped by?' They don't understand that we are also allowed to be in relationships, but think we shouldn't be in relationships like that. They also ask what are we going to do with a child when we can't see? That is the thing they always ask us first. (GP)

The underlying factor here has been emphasised all along; the lack of knowledge of disabilities heightens the risk of GBV for women with different disabilities, and the experiences of women with hearing impairment are further complicated by the lack of disability specific services like sign language specialists in support service centres as reported by some respondents:

Then there is no help, there is no communication, and they will just leave them even if a deaf person wants to ask. So, it is always about a hearing person, or a normal person, but for a deaf person there is no help at all, and they do not even get access to information about the baby. So they exclude them and we do not even know what to do, so for me as a deaf person who is pregnant, it is so bad because there is no help and they will be like, yes just wait there, and sometimes you even give birth while you are waiting there, and you will have to scream that something is happening; so it is really off. (GP)

... yes, and for deaf people there is no counselling, number one, and you know after you get raped you need to get counselling, but they do not get any counselling but they are just left like that. (GP)

Such a lack of qualified personnel creates barriers that interfere with the rendering of appropriate support when needed for victims and survivors of GBV.

4.3 Addressing the challenges and barriers faced by WWD

Respondents had numerous suggestions for GBV programming and intervention strategies to mitigate GBV among women with different disabilities. This section presents their suggestions. These suggestions are further integrated into the recommendations offered to various stakeholders below.

The general sentiment among WWD who participated in the research was that inability to find employment hampered empowerment and self-efficacy, and this presented a huge risk for predisposition to GBV. In some cases, WWD felt like they were treated like worthless members of society and this too presented a risk. The research participants proposed an education intervention for families and the communities in which they lived. They felt that if WWD were given employment opportunities, this would lead to a change in attitude about women with disabilities.

They advocated for WWD to be the face of campaigns on issues relating to disabilities, arguing that they needed to talk for themselves, instead of having able-bodied people

talk on their behalf. They felt that they were made invisible, even on issues that affected them. The research participants further suggested that CBOs giving support to people with disabilities needed extensive support to enhance their capacity to render adequate support to PWD.

Recommendations were also made by women who had similar disabilities, for example, women with physical disabilities. These participants showed concern about the myths associated with bodies of WWD arguing that these created a conducive environment for violence and therefore, were a huge risk factor contributing to potential violence.

Participants suggested awareness raising on the fact that physical impairment does not mean inability was necessary. They demanded that their feelings and rights should be respected by all stakeholders offering support in government designated spaces.

They appealed for sensitisation on disabilities arguing that use of inappropriate terms, and derogatory terms and language stigmatises them, and communities needed to be educated on disability sensitivity.

Blind and partially sighted women appealed to service providers to handle those with hearing and visual impairment with great sensitivity. Sensitisation was therefore needed for service providers. The nature of disability required them to ask for assistance. They therefore felt that they were always at risk of being assisted by a potential perpetrator.

There was a general lack of trust in interpreters among deaf women. They were of the view that some of them do not uphold ethics and confidentiality (If I am abused or raped I will be scared that they will tell someone). They proposed that parents must learn sign language for the sake of their children so that they can build relationships and be able to communicate with their children. They called for better access to information for parents so that they can teach their kids how to love themselves and be independent.

They also appealed for key service providers to learn sign language. However, the presence of interpreters was seen as both welcome and also intrusive. They cited that

while an interpreter needed to be there for discussion of sensitive issues as well as HIV counselling because the counsellor doesn't know sign language, the interpreter's presence meant that that the privacy and freedom needed for them to express themselves had been breached because of the need to have that third person always.

Finally, women with mental challenges expressed that their families needed education on mental illness, as they did not know how to protect their mentally challenged family members. All the mentally challenged respondents were in institutional care and this seems to heighten this sentiment. They felt vulnerable and needed protection. While they are being looked after in homes, there is no one who has time to offer the protection they felt they needed. They expressed a need for family support and attachment, which was not available in support centres.

The trend among mentally challenged women placed in institutions of care was that many had been abused - there was a feeling of 'a little too late' to save us from abuse. These participants intimated that police ought to pay the same attention given to other WWD to mentally challenged women when they report abuse. Their view was that service providers did not take them seriously, yet they are soft targets facing a higher risk of GBV. They felt that one of the ways of protecting mentally challenged women and girls was making accessible services available especially in rural areas.

5. FINDINGS: PERSPECTIVES OF CAREGIVERS AND OTHER STAKEHOLDERS

5.1 Caregivers

Caregivers based at institutions brought to the fore the issue of neglect of WWD by their families. These caregivers emphasised most of the points raised by respondents in the focus group discussions. The biggest concern coming out of this group was a lack of support from families. Such lack of support was emphasised throughout for different types of disabilities. As raised by the respondents, the biggest challenge impeding support was lack of education about disabilities. A strong message emanating from these interviews was that WWD needed love, and families were best positioned to make them feel loved. However, families struggled to look after their loved ones, and those with a mental challenge were seen to be at very high risk as they were abused by both families and their communities:

You find families locking up their mentally challenged and leaving them with a plate of food and a bucket. To families this is protecting them from abuse, but that is abuse! They only take them out to go and collect their grant. That is not good.

There are 26 women in this centre and they are all here because they have been abused or several attempts of sexual assault were made on them.

This was a clear indication of the severity of GBV risks for women with mental challenges, as perceived by a director of a home for mentally challenged people. Although caregivers were tasked with looking after those with mental challenges whilst families went to work, caregivers at times also locked them away and left them unattended, which equally heightened risks of abuse for them:

One of the elderly women who participated in the group, her child had hired someone to look after her whilst she went to work, but the carer locked the woman in the house and left her alone and she was raped. Her daughter then decided to bring her here after that experience.

Caregivers equally emphasised the challenges women met when reporting cases of sexual violence:

Police do not do much at times, especially for mentally challenged women. We had a case of another woman who was raped by a mentally challenged man as well. The case was reported to the police and in court they were saying what she was saying did not make sense. It was like it's 'a case of mentally challenged' people and nothing could be done.

These examples strongly resonate with the sentiments raised by WWD concerning the lack of knowledge about disabilities among service providers. At the same time, caregivers highlighted that there were indeed success stories, where perpetrators were arrested:

Justice was denied for... Lucy (not real name) but for Katy (another survivor, not real name) the case was pursued and the perpetrators were arrested.

Some caregivers thought women who have hearing and visual impairments were equally positioned as being at high risk to GBV. One caregiver had this to say about perpetrators:

...would say one can attack a blind person because they would say that they will not be able to identify them, and also with deaf people, I would say they are equally at risk also because perpetrators will think that they will not be able to speak, and the case that involves a deaf person normally goes on for years, and sometimes it ends up being dismissed because they cannot find an interpreter.

Sentiments raised by the caregivers were in line with those of the respondents as they emphasised the perspectives of WWD on risk factors for GBV. As caregivers, they believed that protecting WWD from GBV was possible, although it would be costly. Whilst homes and care centres provided care to those who needed extreme care, close monitoring of WWD was seen as a protective measure:

Women with high risk to GBV can be protected through constant checking or by putting them in day care centres by day and collecting them after work. I know that day care centres can be expensive, but something needs to be done to protect the vulnerable women.

Some caregivers mentioned that the general assumption is that people with blindness and those with physical disabilities were the only people with disabilities. To ensure inclusivity for PWD it is necessary to dispel this way of thinking. Such thinking makes other disabilities invisible, and therefore puts people with these disabilities at risk of GBV.

5.2. Stakeholders

5.2.1. Disabilities and vulnerability to GBV

The stakeholders consulted for this study were varied and effort was made to access the voices of different stakeholders, at different levels. Consideration was given to ensure inclusion of perspectives from organisations that had not been represented in both the interviews and focus group discussions. A very important finding was that, although interviews with stakeholders had focused on the national and provincial logistics and contexts of WWD, respondents in this group also raised and re-emphasised the GBV risk factors that had been raised by most of the women in focus groups discussions. Although some women FGD participants had indicated that WWD face similar challenges irrespective of disability, some key stakeholders indicated that it would be a mistake to assume that disabilities were the same, and therefore challenges and responses to challenges should be modelled in the same way. There was key emphasis on the notion that although disabilities made women soft targets and vulnerable to violent attacks, some forms of disability heightened risk factors to GBV, a point that women in the FGDs had also underscored. Responses to GBV should therefore consider the type of disability and be designed appropriately to mitigate risk challenges associated with that particular disability. Designing strategies that offer a blanket response to all WWD's experiences of violence will therefore be inappropriate:

All disabilities cannot be treated with a blanket response. Each disability has its own challenges around safety and security, and responses need to take this into account.

Stakeholders equally perceived women with mental disabilities as highly exposed to GBV risks when compared to women with other disabilities:

For example, I am a soft target, I think before I venture out. I am defenceless. A person with a mental disability is more challenged over me about safety. We can't treat them as if they are the same. For example, if I am raped you cannot treat me like you would treat a non-disabled woman, I have specific needs.

These perspectives were further confirmed by another stakeholder who was representing an organisation specifically advocating for people with albinism. What also emerged here was that women with different disabilities faced different challenges, and solutions to challenges should be designed to meet the specific challenge of each group. Examples to illustrate the different challenges in this regard pointed to the myths and fantasies associated with the perpetration of GBV against women with albinism:

There are myths going around that people with albinism do not die, they disappear. That when you have sexual intercourse with a woman with albinism, your HIV status will be cured, and that is a serious risk which women with albinism face. Now the biggest challenge is that we are attacked and kidnapped from our own homes during the night, and perpetrators are men and family members.

Some people believe that people with disabilities are good luck charms, and they might not do it because I hear people with disabilities saying you hardly hear a person with disability being mugged because people believe that they are good luck charms.

Whilst other women with disabilities grappled with different challenges that posed GBV risks for them, for women with albinism the main challenge lay in community myths and beliefs, and was further amplified or lessened by their contexts.

Perpetrators use women with albinism to satisfy their fantasies and mythical beliefs. They take them to shops and coerce them into shoplifting because they believe that they bring them luck.

5.2.2. Poor coordination of GBV intervention among organisations

A key concern raised by different stakeholders was that although a lot of work was carried out by numerous organisations across the country, there was a tendency to work in “silos”, and such approaches limited access to knowledge and services where needed. In terms of advocacy and representations for WWD, stakeholders indicated that there was no communication at provincial or national levels on what was happening with WWD:

Who is dealing with it? Where, and how? Who is doing the monitoring and evaluation? We are not getting information at provincial level as stakeholders. We can't even get simple answers to questions from the ministry of women in the presidency. What is being done for WWD and where? These are huge gaps.

Finally, there seems to be a lack of solid work on WWD in South Africa, and no one seems to have answers concerning WWD. It is not clear who is doing what work for WWD and at what levels. Similarly, there are questions on who they are talking to and the regularity of interventions that could be in place. A harmonised approach to working with disabilities is imperative for improving the lives of PWD, and particularly WWD.

5.2.3. Inadequate funding

The other concern raised at this level was the issue of budgets and financial assistance. Stakeholders noted that some organisations were better placed to raise own funding, but at national level, remote areas needed particular attention as it is in rural areas where most women are at risk. National budgets were often inclined to urban settings, leaving the rural population marginalised in terms of appropriate resources. Most organisations lack funding, and without funding it would be impossible to provide meaningful structures and strategies to support WWD. Suggestions for cost cutting strategies were raised by one stakeholder who thought that it would be beneficial

if organisations not only networked and collaborated, but also shared premises and rentals, with such measures assisting in cutting costs and encouraging sharing of resources.

Possible success from resource sharing was shown by a head of a disability unit at a tertiary institution who emphasised how working collaboratively and networking with other stakeholders provided WWD a fulfilling experience in their own context. Whilst the disability unit focused on making resources disability compliant, there was a psychologist and a counsellor she constantly worked with for referrals. If such a collaborative approach were to be adopted by community-based organisations dealing with PWD, WWD would receive improved services.

Generally, disabilities are mainstreamed in all services. However, stakeholders felt that although such an approach encouraged inclusivity for PWD, most support services were still not disability compliant in terms of structure and human resources. It is therefore not surprising that WWD and affected by GBV find key service providers hostile. Inclusivity of WWD in mainstream organisations is welcome, but so is attention needed to ensure adequate provision of both human resources and structural necessities for women with different disabilities.

Lastly, stakeholders believe that South Africa has multiple organisations working with PWD, however, each organisation is doing its own work, oblivious of what other organisations are doing.

6. CONCLUSIONS

Findings from this study show that WWD are at high risk of GBV. Firstly, women spoke about a lack of knowledge about disabilities, which appeared as the overarching challenge exposing them to potential risk in their social spaces, as well as in their encounters with support services. The lack of understanding of disabilities started within their families who were shown to have immense challenges in offering them support. One area of support which ultimately turned out to be a huge risk factor was the practice of locking WWD in houses and rooms. This practice was exposing them to potential risk. When locked up and isolated WWD become easy targets for potential male perpetrators.

Secondly, participants spoke about the different risks particular to different types of disabilities, citing women with mental challenges, and those with visual and hearing impairment as being predisposed to high risk. The biggest concern here was that the police did not have patience or appropriate capacity to take down victim statements, as well as the will to follow up on reported cases, citing a lack of evidence. This led, in most cases, to a lack of evidence indeed and non-prosecution of offenders. Perpetrators were believed to capitalise on these police gaps to perpetuate violence on these particular groups of women.

Thirdly, the data collected shows that perpetrators of sexual violence against WWD sometimes had a fetish about bodies with a disability, coupled with a distorted understanding of WWD's sexuality. This phenomenon opened WWD to sexual violence by men who wanted to satisfy their fantasies. Mythical beliefs about bodies of women with albinism were part of this challenge. Able-bodied men also reported to sexually exploit unsuspecting WWD, visiting them for sexual encounters under cover of darkness, and dissociating themselves from them by day. Such exploitative encounters included those relationships that were intended to syphon social grants from the women. It is also necessary that WWD be educated on their rights and on such risks, as one participant confessed to have only understood the exploitative nature of her relationship after exposure to a GBV awareness campaign.

Fourthly, women raised challenging encounters with the criminal justice system, when reporting GBV cases. There was a challenge of reporting perpetrators who were close family members and breadwinners, with families proposing to solve cases of such abuse internally. Such scenarios meant that WWD were left in potentially violent situations and within reach of the perpetrators. In cases where reports had been made, a few cases made it all the way through the criminal justice system resulting in the conviction of perpetrators. Most cases were unsuccessful. There was a general feeling that the police did not take WWD seriously, particularly those with a mental challenge. In cases where they attempted to, the police also faced barriers which included lack of capacity to assist women with hearing impairments. There are no sign language specialists in most police stations, and women with hearing impairment felt that justice was already denied before they attempted reporting cases. In extreme cases, they were expected to bring their own sign language interpreters, and they found it a huge challenge to be expected to pay to be heard. Such experiences were also noted in healthcare centres. Here, respondents once again raised concerns around lack of knowledge which resulted in stigma associated with both the sexuality of WWD, and their right to bodily integrity, when faced with challenges of a sexual and reproductive nature.

Perspectives of caregivers were in line with the concerns raised by WWD. They emphasised that families needed education on disabilities. They felt that even if they supported WWD in home and care centres, the family should still play a fundamental role in nurturing and protecting their members. The general feeling was that families 'dump' their relatives in centres and continue with their lives. No visitations were made, and no contact was made, and this affected the women in this case.

Key stakeholders also validated most of the voices of WWD. Key concerns raised were to do with lack of knowledge which resulted in myths and stereotypes that place WWD at high risk of GBV. They indicated that South Africa had multiple bodies advocating for PWD, but these bodies were all working in isolation and no one knew what the other group was doing. Except for the Western Cape which has a very effective alliance, the

Western Cape Network on Disabilities, all the other provinces had organisations that operated mostly in bubbles, thus stifling disability inclusivity attempts.

Finally, WWD appealed for education and awareness on disabilities for all stakeholders, including families of PWD, communities, the criminal justice system as well as health support services.

7. RECOMMENDATIONS

Stakeholders and relevant government departments, NPOs and NGOs working on disabilities need to work on the following:

7.1 Protective factors and practices by NPOs/CBOs

There is need for education and sensitisation programmes for raising disability awareness in families, communities and among different service providers supporting WWD. Knowledge and attitudes are crucial in mitigating violence against WWD and avoiding re-stigmatisation.

- WWD strongly appeal for education in disabilities as both a protective measure against GBV and an intervention strategy necessary in GBV programming.
- NPOs and CBOs should work with WWD to implement campaigns aimed at challenging attitudes that result in violation of the constitutional rights of WWD.
- Campaigns should focus on and be led by WWD. WWD are keen to drive these campaigns. They are keen to educate their own communities and feel that such campaigns would be more effective if championed by WWD themselves.
- Campaigns should target the root causes of risks. Patriarchal attitudes are a huge concern in South Africa, and concerted efforts by all stakeholders are needed to work towards educating communities and dispelling myths around WWD's sexuality.
- Suggestions on what forms the campaigns could assume include street theatre, radio programmes, use of various media of popular culture, community gatherings and education, and the internet where appropriate to rehabilitate communities. Popular social media platforms such as Twitter and Facebook could be utilised where there is technology access.
- There should be production of social behaviour change communication targeting caregivers and parents with intention of shifting attitudes.
- CBOs need to implement school-based interventions targeting both learners and teachers.

7.2. Educating and supporting families by responsible ministries

- The first institution that needs knowledge on disabilities is the family. Social

workers should be supported to reach out and educate families on caring and protecting WWD from abuse. Family visits or contact should aim at providing information on support services available in the community; contact numbers for organisations relevant to the family member's disability needs; and disability communities to access for more knowledge on disability of family members.

- CBOs should involve families in disability campaigns. There was a general feeling that lack of knowledge about disabilities impacted heavily on the families' responses to the needs of their loved ones and such lack of knowledge was a risk factor to the individual who expected to be protected by the family. Families should be exposed to success stories. There should be focus on changing attitudes of families before changing those of communities, and social workers are expected to play a central role in this effort.
- Survivors of violence need their families, and families are encouraged to work together with caregivers to provide fulfilling lives to their members.
- WWD lack self-esteem, it is the duty of families to inculcate love of self by showing love to family members with a disability, and support should be given to families in this regard. Social workers are better positioned to work with families in such contexts.

7.3. Government support services for WWD

- The relevant government departments need to put in place strategies to equip relevant service providers with appropriate skills and knowledge to accommodate and support WWD victims and survivors of GBV. Mainstreaming disabilities into available services for all women experiencing GBV is ideal, but also means ensuring that these services are disability compliant in terms of structure and human resources.
- DSD should provide funding for the rehabilitation of existing support services for both support and upholding of the rights of WWD in service provision.
- CBOs working with WWD, including PWD, do not have enough information about services available to them. Adequate information and knowledge would assist in responses to GBV for WWD. If services were already available, priority should be given to building the self efficacy of WWD, through facilitating increase in

knowledge through provision of programmes and material better suited to them.

- SAPS officers and health workers lack an understanding of disabilities as well as capacity to deal with emergencies associated with violent attacks on WWD. Trained disability sensitive personnel should be prioritised by government institutions offering services particularly in the justice and health sectors.
- Although the experiences of responses by police, among WWD, was synonymous with those of most other women who have survived violence, WWD emphasised that there was a general lack of respect for them, which constituted a violation of their rights. There is need to educate, capacitate and empower police officers with appropriate knowledge and skills to support WWDs. South African sign language specialists are needed at police stations and the government, through responsible ministries, should capacitate service providers for inclusivity of WWD.
- More research is needed to understand the experiences of WWD in other provinces of South Africa not covered in this study.
- Funding is needed for campaigns on disability awareness and disability knowledge of rights, and for disability rights awareness in special schools and in communities
- Support is needed for government to ensure there is disability sensitised personnel in all government service provision centres.

7.4 Learning from success stories

- In the Western Cape there is evidence of strong networks for PWD as shown in literature and confirmed by a provincial representative of one such network, who was interviewed for this study. Such networks are necessary to build appropriate capacity for responding to the needs of PWD and particularly WWD who encounter GBV, and should therefore be encouraged and supported.
- Stakeholders are concerned about organisations working in 'silos'. There is a general feeling that cooperative and collaborative approaches to responding to the needs of WWD will yield success for organisations offering support services to WWD.

Annexure 1: Profiles of Focus Group Discussions

Province	Group description	Demographics of group participants
Eastern Cape (Mthatha)	Mixed group of women with different kinds of physical disabilities. Some were from the urban, others semi-rural contexts.	Ages ranged from 33 to 41 and only one participant was in her 50s. This group was participating in learnerships offered in the district.
Western Cape (Cape Town)	A group of paraplegics from a support centre for paraplegics.	One participant was in her late 20s and others ranged between 30 and 48 years of age. Two participants were doing learnerships and the rest were resident in a care institution
Limpopo (Mokopane)	Women with mental challenges from a support centre.	Participants' ages ranged from 21 to 50 for most of the group except for two elderly women who were aged 70 and 82. They were included in the group as sexual violence survivors. All participants were resident in the home which initially provided services for only 3 months. However, some of the women had been in the centre for up to two years.
Kwazulu Natal	A group of women with different disabilities.	The women were involved in I skills development learnerships in the locality and their ages ranged from 26 to 47.
Gauteng	A group of women with visual impairment.	Ages ranged from 29 to 34 years. All were unemployed but had attained matric.
	A group of women with hearing impairment.	These were all teachers at a school for the deaf. Ages ranged from 23 to 37 years.

In-depth individual interviews

Number of interviews	Group description	Demographics of group participants
Four	Caregivers and support staff in each of the provinces except for KZN.	Support staff from a care institution; a social worker at another home for the disabled; a Director for the home; an educator for those with hearing impairment.
Four	Key stakeholders working with WWD at provincial or national level.	A national advocate for PWD; A district coordinator for PWD; A higher institution of learning disability unit representative; A provincial representative for a provincial alliance.

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