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## Barriers to gender-based violence services and support for women with disabilities in Cape Town, South Africa

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### ABSTRACT

Globally, South Africa has one of the highest rates of gender based violence (GBV). While little is known about the levels of GBV against women with disabilities in the country, less is known about the accessibility or inclusivity of post-violence support and services. The paper draws on data from interviews and focus group discussions with thirty women with disabilities and nineteen disability and GBV service providers in Cape Town, South Africa. Thematic analysis revealed that women with disabilities experience unique disability-related barriers to GBV care and support. Disability-related stigma, accessibility barriers, inadequate training, limited resources and lack of funding contributed to poor GBV service provision for women with disabilities. Awareness and training, accessible information, reasonable accommodations, increased funding, and disability relevant referrals need to be integrated into existing GBV services to ensure sustainable and accessible pathways to inclusive violence prevention, support and responses in the country.

### ARTICLE HISTORY

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### KEYWORDS

Disability; gender-based violence; violence prevention; accessibility; service provision

### Points of interest

- Worldwide women with disabilities experience higher levels of gender-based violence than women without disabilities.
- Women with disabilities have rights to equal and quality service provision and rights to freedom from gender-based violence.
- For a country with one of the highest levels of gender-based violence in the world, the struggle for accessible and inclusive gender-based violence service provision in South Africa and its after-effects remains a concern.
- Poor coordination of disability-related support services and gender-based violence services mean a general lack of understanding and

accommodation of women's disability-related risks of victimisation and needs. Thus, majority women with disabilities receive inadequate support and care.

- Addressing unique barriers at service levels to ensure inclusivity and protection from gender-based violence must be prioritized.
- Understanding the nature of violence against women with disabilities is an essential first step in developing effective and inclusive gender-based violence prevention and support services.

## Background

Globally, women with disabilities experience higher levels of gender-based violence (GBV), including intimate partner violence (IPV) than non-disabled women (Khalifeh et al. 2015; Du Mont and Forte 2014; Schröttle and Glammeier 2013). Women with disabilities face discrimination and stigma based on both their gender and disability, that increases their risk of victimisation (United Nations 2017; Mays 2006; Abu Habib 1995). Data further show that women with disabilities may fear retribution from perpetrators, lack credibility when reporting, or experience dismissive attitudes from service providers, thwarting their personal help-seeking behaviours (Barrett and Pierre 2011; Milberger et al. 2003). Structural barriers and economic and physical dependence on perpetrators further hamper their ability to end violent relationships (Plummer and Findley 2012; Hassouneh-Phillips and McNeff 2005; Hassouneh-Phillips et al. 2005). Dependence on others may expose women to disability-specific violence on top of GBV, which often remains undetected and untreated (Curry et al. 2009; Brownridge 2006; Saxton et al. 2001). Their increased vulnerability to violence means the rights and needs of women with disabilities must be integrated into health care and GBV services.

Both the social and psycho-emotional dimensions of disability are important to consider when understanding women with disabilities' vulnerability to GBV and their access to post-violence care and support (Thomas 2004; Reeve 2002). Structural barriers, invalidation and social exclusion as a woman *and* as a person with a disability may contribute to a lack of self-esteem, making tolerance of and exposure to GBV more likely for women with disabilities (Astbury 2012; Saxton et al. 2001). Research shows how experiences of ongoing and multiple forms of discrimination and violence impact on an individual's psychological well-being, and that women with disabilities experience higher levels of anxiety and depression compared to men and women without disabilities (Dembo, Mitra, and McKee 2018). All these factors can undermine the reporting of violence and limit help seeking behaviours.

Among the general female population in South Africa, the prevalence of GBV is staggeringly high. Estimates reveal that up to 40% of women have experienced sexual and/or physical intimate partner violence (IPV) during their lifetime, and between 12% and 28% of women ever report being raped (Jewkes et al. 2010; Jewkes et al. 2009; Dunkle et al. 2004; Jewkes 2002). However, the prevalence of violence against women in South Africa is undermined by under-reporting. Women are reluctant to report because of lack of confidence in justice outcomes, service provider apathy, stigma and shame, and fear of retributive violence from perpetrators (Mazars et al. 2013). Furthermore, existing GBV programmes and services in South Africa are under-resourced, under-utilised and lack robust evidence-based interventions (Centre for the Study of Violence and Reconciliation [CSVR] 2016).

Globally, women with disabilities face numerous barriers to health service provision and show higher rates of not receiving health services compared to people without disabilities (Stockburger and Omar 2015; Gibson and Mykitiuk 2012; Thiara, Hague, and Mullender 2011; World Health Organisation/World Bank 2011; Barrett, O'Day, Roche, and Carlson 2009; Coker, Smith, and Fadden 2005). In low-middle income countries (LMICs), barriers to health care are exacerbated. Studies from the Global South, including South Africa, reveal that services are largely unavailable because resources for alternative communication, augmentative devices and accessible facilities are inadequate. Furthermore, help-seeking is hampered by myths and stigmatization of disabled sexuality in Africa, health-provider ignorance and negative attitudes, and the costs of using services (Rugoho and Maphosa 2017; Mavuso and Maharaj 2015; Kritzinger et al. 2014; Mall and Swartz 2012; Swartz et al. 2009; Mgwili and Watermeyer 2006). Similarly, in the Philippines, service providers show little understanding of human rights for women, regardless of disability status, have insufficient training in relation to disability, and have limited access to resources to enable disability-inclusive services. Additionally, service providers lack awareness of violence and abuse among disabled clients, preventing screening for IPV and access to care (Lee et al. 2015).

Violence against women with disabilities may be higher in South Africa than countries in the Global North, because there are greater stigmas associated with having a disability, fewer resources and limited accessibility to infrastructure and health services (Mavuso and Maharaj 2015; Kritzinger et al. 2014; Mall and Swartz 2012; Hanass-Hancock 2009). While accessing and utilising services is a challenge for GBV survivors overall in South Africa (CSVR (Centre for the Study of Violence and Reconciliation) 2016), women with disabilities can expect exacerbated difficulties in accessing GBV services given their impairments, marginalisation and the unique nature of the violence

they encounter. Acknowledging that women with disabilities have equal rights to quality service provision and rights to freedom from GBV (United Nations 2006), this paper documents some of the challenges to GBV support for women with physical and sensory disabilities in South Africa, and includes recommendations for accessible pathways to disability-inclusive GBV care and support.

### ***Study context and terminology***

South Africa's entrenched segregation by race during Apartheid has left an indelible culture of poverty and marginalisation among the majority of black African and Coloured populations living in informal communities in the Western Cape (Moodley and Graham 2015; Moodley and Ross 2015; Loeb et al. 2008). These informal communities are characterised by high levels of crime – including high rates of GBV, low levels of employment, poor infrastructure and limited resources (Gibbs et al. 2018; Jewkes 2002). People with disabilities living in such communities have greater restrictions to employment, basic sanitation, transportation and greater exposure to harsh weather, health problems and verbal, physical and sexual abuse than people without disabilities (Watermeyer 2013).

In recent years, GBV and its negative consequences on society have been prioritized by the South African government and civil society organisations. A Victim Empowerment programme was established (National Department of Health 2007), various laws on sexual assault and violence against children passed, post rape services and access to legal aid coordinated, and awareness campaigns around GBV and changing damaging masculine norms intensified. Despite these efforts, IPV still remains an endemic problem (Gordon 2016). In November 2018, the government committed to develop a national strategy to fight GBV and ensure adequate resourcing of post-rape care centres, sexual offences courts and domestic violence shelters “that respond to the needs of all people including people with disabilities and lesbian, gay, bisexual, trans, queer, intersex and asexual persons (LGBTQIA -+)” (South African Government 2019). It is in this context that this paper serves to identify barriers to GBV service provision for women with disabilities to guide future efforts towards improving services for *all* women living in South Africa.

In this paper we use the term ‘disabled women’ or ‘disabled people’ interchangeably with the term ‘women [or people] with disabilities’ because of the lack of consensus on the preferred terminology. Global North literature favours people-first terminology while some disability activists argue the phrase ‘disabled people’ has advantages in that it implies a marginalised, identifiable social category in binary opposition to able-bodiedness (United

Nations 2006). The term 'people with disabilities' may also be rejected as it implies that disability rests within the individual person rather than with society (Abberley 1987). While we acknowledge that the journal may have language policies on preferred terminology, in this paper we do not favour one terminological orientation over another.

### ***Methodology***

The findings in this paper are part of a broader qualitative project aimed to understand the violence experiences of women with physical and sensory disabilities living in Cape Town. Between 2013 and 2015, data was collected from two groups of participants; service providers in the disability and GBV sectors, and women living with physical and sensory disabilities. It is envisioned that including perspectives from both users and providers allowed for a holistic account of the barriers and constraints to GBV services.

### ***Service providers***

Disabled Peoples Organisations (DPOs) working with people with a range of disabilities in informal communities in Cape Town were contacted by email or telephonically and invited to participate in the study. DPOs provided disability awareness and advocacy, rehabilitation services, residential care facilities, counselling, individual case management and referrals. Some provided social development services for assistance in accessing disability grants and housing, and provided life skills and job training through internships and protective workshops. DPOs did not specifically cater for GBV support, but referrals to GBV services could be facilitated.

GBV service providers included those from rape crisis centres, domestic violence shelters and Thuthuzela Care Centres (TCCs). Thuthuzela Care Centres are one-stop facilities, located within hospitals, providing post rape care with the aim to reduce secondary victimisation and improve conviction rates. Services included post-rape medical care and forensics, referrals to criminal justice systems and procedural assistance in reporting violence, 24-hour hotline services for victims, suicide prevention hotline services, and counselling for survivors of sexual assault and domestic violence.

Service provider representatives interviewed included senior managers, counsellors and social workers. Nineteen representatives from seven DPOs and three GBV services agreed to participate. With informed consent, seven individual interviews and three focus group discussions were conducted in private venues and lasted between one and two hours. Service providers were offered refreshments after discussions. Questions asked by the interviewer included perceptions of the magnitude of the problem of GBV against

women with disabilities, sources of support, perceptions of services' effectiveness, and recommendations for responding to and preventing GBV against women with disabilities.

### ***Women with disabilities***

In this paper we follow the definition of persons with disabilities as per Article 1 of the Convention on the Rights of Persons as those with long-term or reoccurring physical, intellectual, psychosocial or sensory impairments, which in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others (United Nations 2006). Women with disabilities were purposively recruited from protective workshops and residential care facilities in the Cape Town metropole. Women with severe cognitive impairments were excluded from the study, and their exclusion is recognised as a limitation to the study's representivity. Another limitation is that, because participants were selected through DPOs, they may have been better able to access services, ignoring other women with disabilities who may be more isolated and likely more vulnerable to GBV.

Participants were aged between 19 and 54 years. Participants were majority black African ( $n=21$ ) and Coloured women ( $n=9$ ) residing in urban-based informal settlements on the outskirts of Cape Town. It is acknowledged that the racial make-up of participants means the data may not be reflective of the experiences of white, upper class South African women with disabilities.

Physical disabilities were congenital (for example, participants born with cerebral palsy or spina bifida) or conditions acquired in childhood, or later in life through illness or injury (including impairments caused by violence). Some participants were wheelchair-users, others used alternative assistive mobility devices or moved independently. Sensory (hearing and visual) disabilities were either genetic, congenital or resulted from trauma, autoimmune conditions, cataracts, glaucoma, or chronic conditions associated with albinism or diabetes. To avoid medicalising disability, the specifics of participants' impairments are not included in the findings. In this way, participants' anonymity and confidentiality are protected.

Women with disabilities were invited to participate in initial and follow up in-depth interviews until data saturation was achieved. Interviews were audio-recorded with participants' consent, and notes were taken. Interviews were conducted in accessible private spaces and lasted between one and two hours. Questions posed to women with disabilities aimed to understand participants' experiences of GBV and experiences of support and redress post-violence.

Ethics approval for the study was acquired from the South African Medical Research Council and the University of Cape Town. Ethical and safety recommendations for research on violence against women published by the World Health Organisation (WHO) served as guidelines for the study (Ellsberg and Heise 2005), as well as other publications on sensitive research strategies with people with disabilities (Van der Heijden, Harries, and Abrahams 2018; Northway, Howarth, and Evans 2015; Nind 2008; Harris and Roberts 2003). Informed consent and research methodologies embraced the principle of reasonable accommodation which refers to any action, behaviour or modification to everyday tasks or environments to eliminate barriers or increase employment, access, participation or advancement of a person with a disability, or other categorically disadvantaged group (Republic of South Africa 1998). We aimed to facilitate participants accommodation needs to ensure they were (physically) comfortable, able to communicate effectively, and protected from adverse events precipitated by their participation in a study on GBV (Van der Heijden, Harries, and Abrahams 2018). Informed consent procedures were made accessible in both written and oral formats, available in the preferred language of the participant, and included an option to give written or verbal consent – taking in to account restrictions in literacy, dexterity, vision or hearing. All participants were assured of confidentiality and informed that their names or names of organisations would not be used in published data. Interviews were discontinued if participants grew tired, distressed or no longer wished to continue. If participants expressed distress, the interviewer provided a pamphlet of several local resources for support.

The first author conducted interviews in English and Afrikaans, and a research assistant translated for participants who spoke *isiXhosa* (the predominant African language spoken in Cape Town). Hearing-impaired participants were encouraged to nominate their own sign language assistant with whom they had an established rapport. All assistants signed a confidentiality agreement. Transport reimbursements, refreshments and monetary compensation of USD13 were given to participants for time spent participating in the study.

Interviews and focus groups were translated and transcribed verbatim and cross-checked against audio recordings. Thematic analysis was conducted on the transcribed data. Using ATLAS.Ti 7.5.6, the first author initially coded data deductively drawing on main themes in the study's scope of inquiry. Subsequent themes were identified through inductive analysis of emerging issues, ideas and patterns. To enhance the trustworthiness of the study, participant quotes are used to reflect their experiences and perspectives. Combined viewpoints from both service providers and women with disabilities further help to validate the data.



## **Findings**

The findings demonstrate that women with disabilities do seek out GBV services and support. Nonetheless, various restrictions curb their help-seeking and service utilisation. The identified barriers include disability-related factors, inadequate information and awareness, lack of training, limited resources and limited funding.

### **Disability-related factors**

The consensus of both groups of participants was that women with disabilities are at higher risk of experiencing violence, particularly because of existing high levels of GBV in the country, which when compounded by various environmental barriers and disability-discrimination, may increase their vulnerability and thwart help-seeking. Disability-related factors included functional barriers (physical access and communication barriers), disability-related stigma, dependence on perpetrators, and personal factors.

### **Functional barriers**

Women with mobility impairments were affected by general physical inaccessibility to services. Co-morbid conditions of pain and fatigue associated with their physical impairments further restricted their help-seeking: “I am so tired, and I have pain everywhere. I lack the will to get into the [wheel]chair to go anywhere, let alone to the clinic” (Female with physical disability, 37 years old). Service providers reported that shelters may not have ground-floor bedrooms, and that constructing entrance ramps or converting bathrooms to make the facilities accessible was constrained by lack of funding. Women with disabilities needing personal-care assistants or assistance dogs were also unlikely to be accommodated at shelters. Service providers described a lack of specialised aids for hearing- or visually-impaired clients. Communication barriers further hindered help-seeking and potentially re-traumatised survivors with disabilities:

By being a victim of abuse, they face more abuse whether it's going to the police or to the clinic because [...] when somebody's been through violence and they are a 'hearing person', they got a lot of anger inside. They are frustrated, and maybe they going to shout, and raise their voice. Deaf people communicate with their hands and their face. You don't understand me, so you come across looking at me like something is wrong mentally, so [Deaf people] face more discrimination. People start to think something is wrong, and they subject you to more abuse when trying to get the necessary help for the abuse that is already there, so there is just more victimisation (Service provider, DPO manager).

Another service provider commented on how communication barriers were not always anticipated in GBV services:

A hotline is of little help to a woman that is Deaf. When a person with a speech impediment calls in, the person taking the call may not understand her, or think she is drunk, so they do not take her seriously (Service provider, rape crisis hotline operator).

In some cases, communication obstacles compromised credibility and confidentiality. A participant recounted an incident where a woman with a hearing impairment came in to report intimate partner abuse:

She didn't have a hearing aid and it was extremely difficult. We had to get another family member to come in to assist her. That is a sticky situation, as it compromises her privacy. If this family member is complicit in the abuse, there is a very big issue with full and truthful disclosure (Service provider, Thuthuzela Care Centre social worker).

Functional barriers were compounded by poverty, isolation, costs of specialised transport and minimal family or caregiver support. Additionally, participants with different types and severity of impairments had different challenges when accessing services.

### **Disability-related stigma**

Disability-related stigma functioned as a central hindrance when seeking out services or reporting GBV. Service providers acknowledged that, in general, people hold assumptions that women with disabilities are not sexually active or partnered. Non-sexuality was closely linked to the infantilisation of women with disabilities when reporting assault, which may create a hostile environment that re-traumatises survivors with disabilities:

Even though I was the one who was raped, the police spoke only to my mother. I was there, and she was there, but they did not even look at me, it was as if I was a child that could not speak for myself (Female with physical disability, 27 years old).

Both women with disabilities and service providers claimed that due to the particular nature of IPV against women with disabilities – such as psychological and verbal abuse, or financial exploitation, where partners pocketed their disability grant monies – service providers may not consider these violations to be as serious as other forms of IPV that leave visible injuries. A participant explained: “There is no use in discussing these things that happen to us because they are only going to help when you can prove you have been beaten or raped” (Female with physical disability, 24 years old). A service provider agreed: “They assume the abuse is not real abuse” (Service provider, DPO social worker). Lack of awareness of the unique forms of violence experienced by women with disabilities also meant that women with disabilities were reluctant to disclose disability-related forms of abuse, hampering their help-seeking and care:

How can a counsellor who does not live with a disability know exactly what I am going through? How can she know that he neglects me, and calls me names, and tells me I am stupid? That is why I do not go to speak to them (Female with physical disability, 32 years old).

Some participants who sought post-violence support claimed that the attitudes of service providers towards them were worse than what women without disabilities may experience:

The police don't know what the protocol is when they come across a victim with a disability (Service provider, DPO manager).

Regardless of the fact that they treat *any* woman who has experienced violence disrespectfully, they treat women with disabilities even worse (Female with hearing disability, 28 years old).

With regard to negative attitudes, a participant claimed: "The system questions a disabled women's credibility more when reporting a violence-related crime" (Service provider, Thuthuzela manager). Another participant affirmed how impairment and lack of credibility undermined help-seeking and support:

I was abused as a child several times at home and as an adult, and now I get abused by the staff [at the care facility]. I couldn't do anything about it. They think they can do it and nothing will happen [...] and because I couldn't get away. I tried to tell people, but nobody believed me that I had been raped (Female with physical disability, 34 years old).

## Dependency

Women with disabilities' dependency on partners and caregivers for impairment-related needs did not assure quality care or assistance. Generally, participants with disabilities reported receiving poor assistance at home and residential care facilities, that may have limited their ability to leave abusive scenarios:

I can't even leave the house, so how will I find another place to go? If I leave him where will I go, who else will take care of me? I rely on him to help me get out of bed in the morning (Female with physical disability, 30 years old).

## Personal factors

Disability-related factors curbing access to GBV services included the psychological impact of having a disability and experiencing violence. Women with disabilities may not seek services when they blame themselves for violence or for burdening their caregivers: "They believe they are worthless and a problem, so they put up with abuse" (Service provider, residential care facility social worker). Depression, uncertainty, and lacking options left some women with disabilities without knowing who to talk to or where to go:

“The abuse disturbed my mind and I could not think of what to do or how do stop it” (Female with physical disability, 39 years old,). Overall, participants with disabilities reported how anxious they felt about disclosing violence because they anticipated apathetic responses.

### ***Inadequate information and awareness***

Overall, participants with disabilities received little to no information on how to prevent abuse, and where to go afterwards, or whether existing GBV services could accommodate their disability-specific needs. After disclosing multiple acts of IPV to the interviewer, one participant retorted: “I don’t know if the shelter is even accessible to me?” (Female with physical disability, 32 years old). The absence of information on the inclusivity of amenities for the immediate safety of women with disabilities was an important barrier that one service provider acknowledged:

We need prevention education and awareness and options for these women within mainstream services. They have no information about their rights, that they have a right to feel safe and a right not to be abused like that (Service provider, protective workshop manager).

Some participants with disabilities felt protective workshops were unstimulating and segregated women with disabilities from mainstream services and resources:

Women are invisible in this community, they remain voiceless and aren’t seen around. They are kept at the [protective] workshops all day, and are doing craft work that is suitable for children, not getting skills that can help better their lives. We are given no information on how to protect ourselves, or how to empower ourselves. I think they are abusing us by keeping us here with no information or options (Female with visual disability, 32 years old).

Overall, GBV service providers claimed they did not come across many women with disabilities, so neither structural provisions nor disability-specific training or resources had been allocated. When asking whether they had offered services to woman with disabilities in recent years, most could only recall a few instances. Furthermore, service providers generally felt ill-equipped to handle disability-related cases: “We don’t hear about it, so how can we be ready to deal with it?” (Service provider, domestic-abuse shelter counsellor).

### ***Lack of staff training, resources, and funding***

Importantly, some DPO participants reported having facilitated GBV-specific assistance to a range of disabled women. This included advocating for court access for a woman with a hearing impairment, facilitating counselling

services for a rape victim with hearing and mental impairment, and referrals to social workers for ongoing case management. However, service providers admitted that there was negligible follow-up of such cases, and that making provisions for women's disability-specific needs was a challenge:

We have women from all the communities coming here, with their children. We had a woman here in a wheelchair. We made sure she could feel safe here, but the room and bathrooms were inadequate for her needs. And in any case, we do not have funding to upgrade the shelter to make it accessible to women who cannot walk or wash themselves... We need to make shelter services and other first points of care accessible to women with disabilities. Staff need education on disability and to learn sign language (Service provider, domestic abuse shelter social worker).

Seemingly, GBV service providers were able to coordinate assistance with DPOs: "We organised an interpreter that would be available every time she needed to go to the doctor or to court" (Service provider, rape crisis social worker). However, other GBV providers admitted having to make alternative arrangements for survivors with disabilities due to lack of trained staff:

We don't like to turn any survivor away, we do what we can for them, but with little capacity staff-wise and not knowing what their needs are, or how to help them feel safe again, its problematic (Service provider, domestic abuse shelter manager).

DPO participants agreed that GBV services are not always inclusive or disability appropriate: "I am talking from experience that clients who use GBV services are not properly counselled. They are given advice on leaving, but get no assistance to leave, or help arranging alternative safer living arrangements" (Service provider, DPO social worker).

Overall, both groups of service providers said lack of funding made it difficult to ensure adequate staffing, disability training or GBV training for staff, and difficult to make structural changes in shelters or other points of care:

There is no budget provision towards prevention and services for GBV in our organisation, so we are at a loss on how to initiate proper training, responses and violence support programmes (Service provider, DPO manager).

### ***Strengthening pathways to care***

When asked to share what provisions were required to facilitate access to care after victimisation, participants' responses recognised that access to service provision was about more than mere functional accommodations. They recommended challenging disability-stigma, decreasing dependency, and providing relevant psychological assistance to women with disabilities. A further recommendation was to network with both sectors to increase inclusivity of services within the existing GBV provision context:

Because violence against women is prolific in the country, violence responses from the highest level to grassroots should make space for disability. Disability increases risk and restricts support. It is in the interest of GBV services to include and accommodate all women (Service provider, DPO manager).

Service providers mentioned that IPV screening of women with disabilities could be facilitated by trained social workers. Identifying GBV cases from police or medical records where survivors are women with disabilities could promote help-seeking and referrals to appropriate services. It was agreed that disability-sensitive training in GBV sectors may facilitate better access and appropriate assistance for women with disabilities. Other proposals included mobile outreach services to reach women with disabilities who are isolated at home, or unable to travel, to ensure early identification of neglect or violence. Participants with disabilities and service providers agreed that outreach can facilitate information dissemination, identification of neglect or abuse, and promote help-seeking.

Several service providers commented on the importance of cross-referrals between different services and organisations, and the need for trained GBV advocates to serve on boards of DPOs. Resources and funding allocation and partnering with local GBV and DPO services could facilitate training in both sectors and complement coordinated and accessible service provision:

What would help is to have a trained person who can understand disability issues and assist in communication and sensitivity relating to disability in police stations, shelters and Thuthuzelas (Service provider, DPO social worker)

Working with legal and justice services to remove perpetrators from disabled women's homes was proposed: "I think the department of justice can play a part in that. Because if you look at us, we are removing these victims from places, instead of removing perpetrators" (Service provider, DPO Social worker).

Survivors of IPV in South Africa are encouraged to leave abusive situations and relocate to a safe house or domestic violence shelter, or to take out a protection order against the perpetrator to prevent him from accessing the survivor. However, a cited response to prevent further victimisation of women with disabilities was their relocation to residential care facilities or day protective workshops. Domestic abuse shelters were often not considered appropriate for rehabilitative care of women with disabilities and the decisions to move them were most often made by family members and not the women themselves. A participant who was assaulted by a stranger in her house recounted: "After the incident, the only option to protect me from the people in the community, who may take advantage of my situation, was to move me" (Female with visual disability, 32 years old). Another participant described her relocation into residential-care living after she was raped a year ago: "[The family] can't be there all day to help or keep me safe. They

must work” (Female with physical disability, 24 years old). It was recommended that safer and independent living be established as an alternative to residential care: “It means that we need to ensure accessible and secure housing, that accommodates their needs, without them having to rely on others” (Service provider, DPO manager).

While one participant was highly critical of the protective workshop as a place of abuse and disempowerment, another participant claimed that protective workshops provided protection from violence at home and in the community:

I came [to the workshop] to get away from home ... to spend time away from home, where I’m ignored and abused anyway. The thugs can always get to me there. At least here I can be safe ... (Female with physical disability, 43 years old).

Overall, the findings reveal that while women with disabilities may attempt to seek help and use GBV services, few participants reported positive or adequate experiences.

## Discussion

This is the first known qualitative study to explore access to GBV services for women with physical and sensory disabilities in South Africa. Service provision for women with disabilities who are survivors of GBV is significant: it can either be a source of support – with information, empathy, support and redress – or where they may feel further victimised by blame, stigma or indifference. The findings show that women with disabilities have needs that may differ from their non-disabled counterparts; that there may be differences in the experiences of women according to the range of impairments; and that women with disabilities are not a uniform group.

The biopsychosocial model of disability places emphasis on impairment, the personal experiences of impairments, as well as the economic, environmental, and social barriers persons with impairments encounter (WHO 2001). It is not only society’s lack of awareness of people with disabilities, or multiple environmental and attitudinal barriers that limit service provision and utilisation. An individual’s behaviours, attitudes, and personal experience of impairment, pain, depression, humiliation, fear, poverty, minimal support and isolation may further restrict their ability to leave violent situations and access GBV services. Thus, attention needs to be given to addressing the psychological effects of disability-stigma and structural barriers for GBV survivors with disabilities.

The psycho-emotional construction of disability relates to how persons react to their experiences of barriers and stigma (Reeve 2002). Women’s personal internalisation of stigma and their perceptions of blame and being

burdensome play a role in limiting their help-seeking behaviour. Self-blame, inferiority, and depression among women with disabilities can act as both a risk for and consequence of victimisation and can hamper safety and support (Dembo, Mitra, and McKee 2018; Khalifeh et al. 2015; Astbury 2012). Globally, women who endure physical IPV say that the psychological abuse and degradation are even more difficult to endure than the physical abuse (Heise, Ellsberg, and Gottmoeller 2002). Knowing that women with disabilities are more likely to suffer subsequent ill health, and to disclose exclusively to health professionals (Khalifeh et al. 2015), there is a need for mainstream health providers to include items about victimisation and mental health during screenings and assessments, and to refer women with disabilities to accessible and relevant mental health counselling.

Furthermore, instead of the survivor or her impairment being perceived as problematic, a biopsychosocial approach would remove perpetrators, remove barriers within and outside the home, and ensure access to safety, care and psychological support. A biopsychosocial approach and human rights lens would herald the embodied experiences of disability and victimisation, the social processes that increase the vulnerability of women with disabilities, and reinforce the rights of all women to live free of violence and have access to health care, regardless of their disability status.

Like other research in South Africa, perceptions of non-sexuality barred participants with disabilities from receiving adequate post-violence care (Meer and Combrinck 2015, 2017). Thus, service provision can be improved by acknowledging the sexual experiences and sexual health needs of women with physical and sensory disabilities – related to both consensual and non-consensual sex. Guidelines and training for service providers and police on the sexual and reproductive health rights of women with disabilities, and how to communicate and approach survivors with different impairments, may help to alleviate mistreatment and disbelief of women with disabilities, and ensure pathways to care and justice. DPO services like protective workshops should integrate GBV awareness and safety information into their day programmes and facilitate accessible transport and communication strategies for appropriate GBV service provision.

It is well known that South African women stay in abusive relationships because of the normalisation of IPV. Belief that the abuse will stop; being pregnant or having children by a partner; having an emotional or economic attachment to a partner; or fear of retribution for leaving are often reasons why women remain with abusive partners (Hatcher et al. 2019; Shamu et al. 2011). While participants with disabilities reported similar reasons for staying in abusive relationships as non-disabled women, disability-related dependency on partners and lack of independence or mobility further restricts their help and safety-seeking.



In lieu of these findings, women with physical and sensory disabilities are not receiving the benefits of GBV services in South Africa. Further research is required to establish the extent of GBV against women with disabilities, and there are important studies which need to be done on hospital and police data, which may provide further data on service utilisation and follow-up.

Awareness of disability-specific needs and barriers can help tailor inclusive violence response and prevention strategies. Increased disability awareness and training can facilitate disability-relevant accommodations and referrals, help to inform appropriate mental health interventions, and increase access to justice, support services and GBV prevention strategies. Adaption of existing GBV services should not only address accessibility barriers, but include stigma-alleviation and changes in social norms. That said, integrating services to include disability-friendly strategies may be an extremely complex task given the already over-burdened and under-funded GBV services in the country, and the spectrum and types of impairments that exist.

Targeted GBV services may be required to serve women with disabilities and address their disability-specific risks and experiences of violence. Existing or proposed prevention programmes should consult disability experts and women living with disabilities in conceptualising and designing targeted services. Further research to assess whether there is benefit in mainstreaming GBV services, or in developing targeted interventions is necessary – particularly in LMICs like South Africa where GBV levels are high, and where women with disabilities experience increased isolation, limited resources and inaccessible services. Robust evidence on what works in GBV service delivery and prevention programmes to alleviate the exclusion of women with disabilities is urgently required in order to attract funding for inclusive violence prevention programming and intervention.

## **Conclusion**

The study contributes to the dearth of literature on the inclusivity and accessibility of GBV services for women with a range of disabilities. In a country with one of the highest levels of GBV in the world, the lack of accessible and inclusive service-provision for GBV and its after-effects in South Africa presents an ongoing concern. Women with disabilities have rights to equal and quality service provision and rights to freedom from all forms of violence. Understanding the nature of the violence to which women with disabilities are exposed is an essential first step in developing effective and inclusive GBV prevention and support services. Addressing their additional and unique barriers to services requires a collaborative effort by both GBV and disability sectors. Inclusive GBV services that address both the social and

psycho-emotional dimensions of women with disabilities' vulnerability to violence will ensure better services for all women.

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