On the Margins:
Violence Against Women with Disabilities

by

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Section 1: Introduction

Close to one in three women experiences violence at the hands of their intimate partners (Jewkes et al, 1999). When emotional and economic abuse is included within an understanding of domestic violence, this number rises to one in two (ibid). National figures for intimate femicide (men's killing of their intimate female partners) suggest that this most lethal form of domestic violence is prevalent in South Africa. In 1999 8.8 per 100 000 of the female population aged 14 years and older died at the hands of their partners - the highest rate ever reported in research anywhere in the world (Mathews et al, 2004). The number of rapes reported to the police has been increasing since at least 1994, rising in that year from 44 751 to 52 733 in 2003/2004 (SAPS, undated). Given the extent to which rape is under-reported, even these totals represent but a fraction of the actual number of rapes perpetrated.[1] To what extent do these statistics capture violence against women with disabilities? In addition, does the nature of the violence they are subjected to differ in any way from that experienced by non-disabled women? Are disabled women able to access the legal rights and assistance available to some, but not all, non-disabled women?

In an effort to answer some of these questions, and in so doing begin to address the marginalisation of women with disabilities, the Centre for the Study of Violence and Reconciliation (CSVR) undertook a small-scale exploratory research project on gender-

based violence and disabled women. We aimed to make visible the nature and forms of violence against women with disabilities, their particular vulnerabilities to violence, and the barriers they confront accessing assistance. The study focused on women with physical, visual and hearing disabilities. Women with developmental (or mental) disabilities, as well as learning or psychiatric impairments, were not included in the ambit of the study. Being a small, exploratory study, it also did not aim to derive statistics on the prevalence of gender-based violence affecting disabled women.

The next section provides some background to the study, outlines the objectives of the research and the methodology we used to gather information, and also describes some of the limitations of our research project. In Section 3 we present our survey of the national and international literature, policy documents and research findings on women with disabilities and gender-based violence. Section 4 details the findings of our small-scale survey of non-governmental organisations (NGOs) and specialist units of the South African Police Services (SAPS) tasked with providing services to survivors of gender-based violence. The report concludes with recommendations aimed at increasing disabled women's access to justice and other key support services.

Section 2: Background to the Study

2.1 Background

In 2001 the Gender-based Violence Programme of the CSVR conducted a series of provincial workshops at the request of the Disabled Women's Development Programme of Disabled People of South Africa (DPSA). The purpose of these workshops was to increase women with disabilities' access to justice by providing participants with information on violence against women and those legal rights that can be claimed through the criminal justice system. These workshops raised a number of key questions and problems, which we aimed to further explore through in-depth interviews.

2.2 Objectives

On the basis of the issues identified through the provincial workshops, CSVR designed a small-scale, exploratory research project that aimed to:

- Make visible the nature and forms of violence experienced by women with disabilities;
- Investigate women with disabilities' access to justice (including support services); and
- Formulate recommendations aimed at reducing the exclusion of abused women with disabilities from access to justice and key services for survivors of gender-based violence.

2.3 Methodology

An in-depth *review of relevant international literature, national research, policies and other documents* considered pertinent to the research focus was undertaken and informed the design of the field research. The results of the literature review are presented in Section 2 of this report, and provide important context to the findings of our small survey.

Two in-depth interviews were also conducted with women with disabilities to understand both the violence they had been subjected to as well as their experience of seeking help to combat the violence. The interviews also explored the impact of the violence on their lives. To further illustrate the devastating relationship between violence and disability, we also drew on two set of inquest records, retrieved during the course of a study on intimate femicide in Gauteng.

Twelve in-depth interviews were undertaken with staff of six non-governmental organisations (NGO) and four specialist units of the South African Police Service (SAPS). The NGOs included People Opposing Women Abuse (POWA) (three offices in total), Nisaa Institute for Women's Development, FAMSA, Disabled People of South Africa (DPSA), Teddy Bear Clinic for Abused Children and Lungelo. The majority of NGOs provide counselling, advice, information and training services in the field of gender-based violence. The Teddy Bear Clinic deals more specifically with abused children, while the DPSA focuses specifically on disability. These organisations are based, or have satellite offices, in Johannesburg, Soweto and Sebokeng.

Respondents from the following police units were interviewed: Protea Area Community Services; Braamfontein Family Violence, Child Protection and Sexual Offences (FCS) Unit; Vaal Child Protection Unit; and the Victim Empowerment Unit of the Central Johannesburg police station. The four police units are principally tasked with the enforcement of the Domestic Violence Act (DVA) and/or child protection.

All ten service providers were selected on the basis of the nature of the services they provide, our assumption being that they were likely to encounter abused women with disabilities on a more or less frequent basis.

A structured interview schedule was used to elicit general information about the organisation and its services, and assess the 'accessibility' of the organisation's services, drawing on Anello's (1998) five components of access:

- *Physical:* indicators to measure the extent of physical accessibility included the existence of washrooms for people with disabilities; appropriately designed ramps, doorways and floor surfaces; elevators; and the location of the service relative to major public transport routes.
- *Procedural:* access was measured by the adaptation of regular procedures followed by service providers to accommodate the needs of people with disabilities.
- *Communication:* indicators included the availability and accessibility of information in alternative formats such as Braille, audiotapes and other communication aids.
- *Attitudinal:* access was measured on the basis of the sensitivity of service providers to the needs of women with disabilities. A key indicator here was whether the organisation had engaged in any training or strategic discussions on the issue of disability and gender-based violence.
- *Financial:* this dimension of access was measured on the basis of the cost of services, and the general accessibility of these services to clients using public transport.

Interviewees were asked to discuss the types of cases involving women with disabilities

that they had dealt with; their experience of providing services to women with disabilities; as well as their policies, programmes and initiatives to improve service delivery to abused women with disabilities. All information elicited was of a qualitative nature.

In addition to the above-mentioned interviews, which also included site inspections, we undertook *site-only inspection visits* to the Johannesburg Family Court; Protea Magistrate's Court (in Soweto); and the Sebokeng Magistrate's Court. A checklist, containing criteria for measuring the physical accessibility of the site to people with different physical disabilities, was developed and guided the site inspections.

2.4 Limitations

Disability remains a largely 'invisible' issue in South Africa and, as a result, there is a limited pool of research from which to draw. As mentioned earlier in this report, we have not been able to locate any local research on violence against women with disabilities. We have, therefore, relied almost exclusively on international research studies, mainly undertaken in the North American context, which have only in recent years begun to address the profound silence on violence affecting women with disabilities (Chenoweth and Cook, 2001). While we have been able to draw useful analysis and lessons from these country experiences, their applicability and relevance to the South African context remains somewhat limited. Canada and the United States of America are wealthy countries, characterised by a broader range of services and provisions for people with disabilities. Moreover, comparatively speaking, governments and NGOs in North America have access to more resources to address the developmental challenges associated with disability.

While many of the international studies have pointed to overwhelming levels of abuse of women with developmental (mental), learning and psychiatric disabilities, this falls outside the scope of our study. The CSVR research has focused quite specifically on women with physical, visual and hearing disabilities. Research on other non-physical/sensory disabilities would have expanded the scope of our small study, and introduced capacity requirements not immediately available to the CSVR. This remains a gap in the focus of our work, which we hope could be remedied with time by other organisations with relevant capacity.

The field research was undertaken in Gauteng Province only, and was limited to assessing the range, type and content of services provided by a small sample of governmental and non-governmental service providers. We cannot generalise the findings beyond Gauteng or the sample of organisations reached.

The research did not seek to derive estimates of the extent of violence against women with different types of disabilities, but rather aimed to make 'visible' the particular social, economic and physical vulnerabilities of disabled women to gender-based violence, and the constraints to them accessing the assistance that is available to some, but not all, non-disabled women. The research has flagged a number of major challenges related to the forma, nature and accessibility of services provided, and posed a number of important questions for discussion and further investigation in the field. These outcomes satisfy the objectives we set for ourselves in terms of this small, exploratory study.

Our experience correlates closely with an identified limitation of the Office on the Status of Disabled People's (OSDP) commissioned survey of national government departments

(OSDP, 2000). We too found ignorance of disability issues, violence against women, and departmental initiatives to address disability amongst some of the SAPS staff we surveyed. As a result we have not been able to make use of the interview material of three of the four interviews undertaken with members of the SAPS.

2.5 Definitions

This report applies the definitions for disability and impairment established by the Disability Rights Movement (see Section 3.1 on Conceptualising Disability). For a description of forms of impairment see Section 3.2 below.

Definitions on the different forms of violence experienced by women with and without disabilities, as well as those particular to women with disabilities are presented in Section 3.5.1 of this report.

Section 3: Disability and Violence against Women

This section of the report reviews and analyses some of our key findings of the review of the national and international literature on disability and violence against women. The first part of this section focuses on the diverse ways of thinking about disability that frame policy and programmatic responses of government and service providers. Here we also clarify some of the key terms and concepts used in this report. In the second part, we discuss the prevalence, forms and causes of disability in the South African context. In the third part of this section, we discuss and analyse the South African government's post-1994 policy and programmatic responses to disability. In part four, we present an analytical framework for thinking about women and disability, which emphasises the intersectionality of race, class, gender and disability in determining women's socio-economic location, experiences and options for recourse when confronting violence. In the fifth part of this section, we discuss disability and violence against women, focusing on the unique forms such violence may take, as well as highlighting disabled women's specific vulnerabilities to gender- based violence. This section concludes with a discussion on the particular barriers disabled women confront accessing their legal rights and assistance to escape the violence. Case studies drawn from the literature review, some court records and raw data from previous CSVR research initiatives are included in Section 3.5 of this report to illustrate certain aspects of the analysis.

3.1 Conceptualising disability

Disability, its causes and remedies, are understood in a variety of ways. The conceptual framework applied by law and policy-makers, as well as programme designers, influences the way they frame and address the needs of people with disabilities. Similarly, the ways in which ordinary people think about or make sense of disability determines how they respond to disabled people.

For some, disability has religious or moral significance in that people become disabled either as punishment for sin, or as a means of inspiring or redeeming others (Gill, 1999). Others see people with disabilities as needy and dependent, unable to make life choices and therefore unable to participate as worthy citizens. This approach typically results in the establishment by non–disabled people of welfare–based institutions which attempt to create

a 'caring environment', as an alternative to persons with disabilities having to beg or hide away. While a welcome corrective to the view that disabled persons are to be feared and hidden away, it does perpetuate the notion that they are in need of constant care (INDS, 1997; Philpot and McClaren, 1997).

Still others see disability primarily as a medical malfunction needing to be corrected. From this perspective, disability is:

- Always a problem or measurable defect (rather than a way of being in the world) located in the individual (rather than the environment);
- Seen to diminish the quality of life in some way (rather than merely changing the lifestyle);
- In need of cure or alleviation (rather than social accommodation); and
- To be addressed by medical experts (rather than other experts).

Drawing on this medical conceptualisation, the World Health Organisation (WHO) distinguishes between impairment and disability:

- Impairment is defined as any loss or abnormality of psychological, physiological, or anatomical structure or function.
- Disability is defined as any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being.

Impairment is thus defined objectively in terms of observable function, while disability is defined in relation to what is considered 'normal' for an individual (UN, 2002: 3).

The medical model has promoted a sense of dependency, with health workers seen as central to the decision-making process of people with disabilities (Philpot and McClaren, 1997). While this perspective conceives of disability as a medical 'problem' rather than as atonement for sin (or a motivating inspiration to others), it has resulted in the neglect of disabled persons' wider social, economic and political needs and has translated into a more isolated existence for many people with disabilities (Gill, 1999).

More recently, in much the same way as gender and race have come to be understood as socially constructed categories rather than biological givens, disability has also come to be seen as a social construction in response to biological variations (Gill, 1999).

The social model views disability as a human rights issue. It emphasises that the barriers disabled people face are the consequence of the psychological and social responses of communities and the socio–political structure of societies, rather than individuals' particular physical, mental or emotional impairments. According to Philpot and McClaren (1997) and Saxton and Howe (1984), this paradigm shift focuses on the 'disabling world' where people with disabilities are unnecessarily segregated, ostracised and mistreated. The social model calls for the removal of barriers that marginalize people with disabilities and instead challenges the disabling world. In this perspective, disability:

- Is part of the variety of human difference (and therefore does not need eradication

because the individual's difference is not the primary problem);
- Derives its meanings from society's responses to individuals who deviate from cultural standards (and is not inherent in the individual);
- Depends on the quality of the arrangement between the individual and society (and not on the severity of the disability); and
- Can be addressed through a range of options, involving many experts, because problems of disability arise from a complex interaction between the individual and society, and are not attributable to the individual alone (Philpot and McClaren, 1997; and Saxton and Howe, 1984).

Thus the *Disability Rights Movement* argues that problems of disability arise not so much from individuals' impairments, but from the way that society is organised and perceives disability. According to this movement:

- Disability refers to the disadvantage or restriction of activity caused by the way society is organised which takes little account of people who have physical, sensory or mental impairments. This results in people with disabilities being excluded and prevented from participating fully and equally in mainstream society; and
- Impairment refers to a part of the body which is impaired in some way and results in limitations in its functioning (Philpot and McClaren, 1997).

This definition serves to shift the focus away from the disabled individual to the disabling society; disability is "a product of the built environment which is reinforced by social values and beliefs" (Bagilhole 1997: 430). The social model is preferred because it seeks to develop, empower and integrate disabled persons into society. This model of thinking about disability has been adopted by the South African government in its endeavour to more adequately cater to the needs of people with disabilities.

3.2 Disability in South Africa – its Prevalence and Causes

Information on the nature and prevalence of disability within South Africa is limited and estimates of its prevalence vary. According to the 1996 South African Population Census, there are 3 037 351 people with disabilities, constituting 6.7% of the total population. The 1995 October Household Survey, implemented by Statistics South Africa, reported a prevalence rate of 5%, while the Department of Welfare has estimated that people with disabilities constitute 12.7% of the population (OSDP, 2000).

According to the 1996 Population Census, 41% of people living with disabilities experience some form of visual impairment, 21% physical disabilities, 7% mental disabilities, 6% multiple disabilities, 5% hearing disabilities, and a further 10% live with unspecified forms of disability. The same Census also finds that the prevalence of disability is 7.1% amongst females and 6.4% amongst males (OSDP, 2000). African women make up the bulk of disabled persons as compared with African men, or men and women from other race groups. Men have a slightly higher incidence of developmental impairments, and physical disabilities that relate to accidents, particularly in the mining industry. Women, on the other hand, have more disabilities related to motherhood, osteoporosis and old age (Census, 1996).

There is a high correlation between the incidence of disability and poverty (measured on

the basis of education, employment and level of earning). The 1996 Census found that disability is most common amongst people who have never been to school (a 10.9% prevalence rate), and least common amongst people with post-matric qualifications (a 3.9% prevalence rate). This indicates that people with disabilities have historically not enjoyed the right to education. Disability prevalence is also lowest amongst people who are employed (5.1%) and highest amongst people who are not working (11.5%). Disability is also found to be most prevalent (16.5%) amongst people in the lowest monthly income category (R1 000 - R1 500), as compared with a prevalence rate of 2.6% in the monthly income category of R11 000+. People with disabilities are thus greatly discriminated against in relation to their access to education and work training, and also confront numerous barriers obtaining employment, leading to high levels of unemployment and low income-earning.

Six general types of disability have been identified (Anello, 1998):

- Physical disabilities – which take the form of limitations in mobility and may result from neurological conditions (such as Cerebral Palsy, Spina Bifida, Multiple Sclerosis), orthopaedic conditions (associated with polio, arthritis, Muscular Dystrophy) or spinal cord injuries;
- Developmental (or intellectual) disabilities – usually associated with delayed or limited development in learning that affect a person's ability to understand, remember or differentiate;
- Mental health or psychiatric disabilities – a range of conditions or disorders fall under this general category, including Major Depressive Disorder, Schizophrenia and Bipolar Disorder;
- Learning disabilities – these disabilities usually relate to a neurological dysfunction which affects the brain's ability to process information, and may include dyslexia;
- Hearing disabilities – can range from partial hearing loss to deafness; and
- Visual disabilities – can range in degree from poor vision to blindness.

Common causes of disability include:

Diseases
In developing countries like South Africa, large numbers of people have long-lasting or recurrent disability resulting from bacterial or parasitic diseases, cancer and HIV infection (Helander, 1999).

Poverty
Disabilities are caused and increased by overcrowding, poor living conditions, poor sanitation, lack of access to information and inadequate diets (Schneider, in Simon-Meyer, 1999). McClain, in the South African Human Rights Commission (SAHRC) Report on Disability, states that "poverty causes disability and disability causes poverty" (2002: 18).

Inadequate medical services
Disability is increased by the inadequacy of primary health care and genetic counselling services; weak organizational links between social services; inadequate treatment of the injured when accidents occur; and the incorrect use of medication (INDS, 1997). Examples of this failure include the poor management of chronic illnesses like diabetes and poor medical services for pregnant women in rural areas, resulting in pre- and peri-natal

problems (Simon-Meyer, 1999).

Violence and accidents

Some trauma or disability is also caused by violence. Violence often results in severe injuries and/or loss of consciousness, with disabling and lifelong physical and mental consequences. Transport accidents, as well as those occurring in the industrial and agricultural sectors, also increase disability (INDS, 1997; Helander, 1999). Violence against women results in disability (see case studies in Section 3.5 of this report), but the scale of this problem has yet to be estimated.

3.3 Legislative and Policy Responses to Disability in South Africa

Since 1994, concrete steps have been taken to address the human rights of people with disabilities. The Bill of Rights contained in Chapter 2 of the Constitution of South Africa (Act No. 108 of 1996) guarantees fundamental rights to all citizens, including the right to freedom from discrimination on the basis of disability.

The South African government is a signatory to the 1993 United Nations Standard Rules on the Equalization of Opportunities for People with Disabilities which stipulates that "girls, boys, women and men with disabilities, as members of their societies, may exercise the same rights and obligations as others" (McClain, 2002: 25). These international rules are enshrined in the International Bill of Human Rights and represent the most significant international agreement on the rights of people with disabilities, and the obligations of governments to advance these rights through their policies and programmes. To this end, the UN rules establish a set of clear guidelines for actions to be taken by government regarding disability integration (OSDP, 2000).

They also informed the development of the White Paper on an Integrated National Disability Strategy (INDS), adopted by the South African government in 1997. The INDS offers a progressive policy framework, and set of guidelines, to inform the development of government policies, strategies, plans and programmes to address the social, economic and political inequities that marginalise people with disabilities (McClain, 2002).

The objectives of the INDS (1997) include:

- Facilitating the integration of disability issues into government plans and programmes;
- Developing an integrated management system to coordinate disability programmes at all levels of government;
- Developing a capacity building strategy to ensure that the recommendations of the INDS are implemented at all governmental levels; and
- Implementing national public education and awareness programmes to combat discriminatory attitudes towards people with disabilities.

Key areas targeted for policy development by the INDS include: the prevention of disabilities; raising public awareness; ensuring adequate health care; prevention and rehabilitation; barrier-free access to services, including transport; appropriate communications; research and information to inform policy development, programmes and evaluation; inclusive education; access to employment; human resource development; and

social welfare and community development (INDS, 1997).

The OSDP, a statutory body located in the Presidency, holds responsibility for setting government's agenda on disability and monitoring the implementation of the INDS by government departments. Amongst other strategic objectives of the OSDP, it must facilitate the integration of disability issues into government developmental strategies, plans and programmes; develop capacity at all levels of government to implement recommendations of the INDS; and implement a programme of public education and awareness-raising to challenge the prejudices of members of our society towards people with disabilities (OSDP, 2000).

The implementation of the INDS has been disappointing, with a number of research initiatives pointing to discrepancies between government's stated objective of mainstreaming disability into government policies, legislation and programmes, and the actual practice of government departments.

In 2000 the OSDP commissioned a national situation analysis that aimed to assess the extent to which eighteen national government departments were integrating disability issues, and implementing the recommendations of the INDS. The study made the following key findings:

- Most of the policies developed in the post-1994 period do not address the needs of people with disabilities. Even those policies that do integrate a disability perspective do not translate into strategies and programmes able to integrate people with disabilities into mainstream society.
- Most departments do not have disability integration strategies that would ensure the mainstreaming of disability into policies and programmes, form the basis for public awareness campaigns, or build the capacity of staff to integrate disability into their work.
- Budgetary allocations are generally inadequate and are poorly targeted to ensure the integration of people with disabilities into the mainstream.
- There is a paucity of research and information on disability to inform policy formulation, programme implementation and evaluation.
- About half of the government departments surveyed have less than 1% of their staff profile filled by people with disabilities, significantly lower than the 2% target stipulated for the public service. Moreover, people with disabilities occupy low-level non-management positions.
- Most national government department buildings were found to be physically inaccessible to people with disabilities.

In 2002, the Institute for Democratic Alternatives in South Africa (IDASA) undertook a critical review of government department budgets to establish the relationship between plans for the inclusion of people with disabilities into governmental programmes and the actual budgets set aside for the implementation of these activities. While IDASA found that some departments, notably the Departments of Education, Health, Labour and Social Development, were adopting an inclusive approach to people with disabilities, on the whole they found that there was little progress towards meeting the objectives set by the INDS. Government departments (with the exception of those listed above) had substantially failed to set empirical targets for the inclusion of disabled persons in their programmes, and were

not meeting the statutory requirement of the Employment Equity Act to employ a minimum of 2% of people with disabilities in its workforce. The study was unable to fully quantify government expenditure on people with disabilities because beneficiary groups were not disaggregated and nor were items related specifically to interventions around disability included in the budgets (Mbanjwa and Neeson, 2002).

IDASA concludes that while the INDS may call for the decrease of disability-specific programmes and the mainstreaming of disability into the core programmes of government, the needs of people with disabilities should still be separately stated in programme goals and strategies, and budgeted for separately, so as to effectively measure progress against objectives set by the INDS (Mbanjwa and Neeson, 2002).

Assistive devices (such as hearing aids, wheelchairs and prostheses) may assist people with disabilities to participate as equal members of society. However, Philpott and McClaren's study (1997) in KwaZulu-Natal found a number of barriers to the provision of an ideal assistive devices service, including the high cost of such devices; the centralisation of assistive devices and related services (with only 17 out of the 59 hospitals in the province providing a minimal assistive devices service); lack of knowledge regarding available services; and inappropriate attitudes of service providers. The benefits for government of providing an adequate service, they argue, include disabled people's increased independence for work and study, their decreased hospitalisation and a decrease in the provision of care required from family and other caregivers.

For critical analysis related to people, and especially women with disabilities', barriers to access to the criminal justice system (CJS), see Section 3.6 of this report.

In conclusion, despite government initiatives to build an enabling policy framework for disabled people through the INDS, and various attempts since 1994 to eliminate legislation discriminatory to disabled persons, incongruities still exist between law, policy and practice.

3.4 Disability and Women – the intersection between multiple forms of discrimination

In a paper focused on identity politics and violence against women, Crenshaw (1994) suggests distinct intersections between class, race and gender that shape the structural and political aspects of violence against black women in a patriarchal society. She argues that gender and class oppression, coupled to racial discrimination, contribute significantly to Black women constituting the majority of people that are socially and politically marginalized, and live in conditions of poverty. She concludes that for many Black women who have experienced violence, the justice system and related services are inaccessible due to social, economic and cultural barriers.

Glenn (2002), writing of the experiences of African-American women with disabilities, refers to the impact of race, gender and disability as the 'triple jeopardy syndrome', in terms of which African-American disabled women suffer a triple oppression due to their race/ethnicity, gender and disability.

Snyder (1999) theorises the links between gender, disability and poverty. She argues that women in general have to strive much harder than men to earn their livelihoods, and that in

most developing countries people with disabilities are disproportionately poor. Poor, disabled women in developing countries thus must contend with the discrimination and disadvantage that arises from being a woman, of their experience of poverty as a woman, and the marginalisation ('the third strike') that arises from their disability.

Following on from Driedger (1996), who notes that women with disabilities experience discrimination on the basis of their disability and gender, and that this discrimination may be further compounded by poverty, race and socio-economic disadvantage, we can advance the argument that African women with disabilities, as a specific group, are one of the most marginalized and vulnerable groupings in our society. The 1996 census statistics cited earlier in this report show that African women with disabilities constitute the greatest proportion of disabled persons in South Africa, as compared with men and women from other racial groups.

Since African women as a whole constitute the majority of the poor in South Africa, disabled women in their ranks are the most likely to be poor and destitute, malnourished and illiterate (INDS, 1997). Unemployment figures show that African women are over-represented in the ranks of the unemployed and underemployed. In 2002, just 40.4% of the female economically active population participated in the labour market, compared to 71.05% of men (UNDP, 2003). The poverty rate of female-headed households is twice that of male-headed households (Fish 2003:405).

Disability is statistically shown to reduce opportunities for education, work training and employment; limit access to medical and welfare services; and place women at greater risk of sexual violence. African women with disabilities, therefore, experience multiple and reinforcing layers of discrimination, disadvantage and social marginalisation that are lethal and deeply oppressive. For this reason, the White Paper on Social Welfare (1997) and the INDS (1997) identify women, especially African women, as an especially vulnerable group and deserving of concerted policy attention.

3.4.2 Poverty and disability

In his address at the 2001 International Day for Disabled Persons, former Deputy President Zuma stated that poverty amongst disabled people remains one of the key challenges for government to address. The cycle of poverty and disability has been fairly well documented (see INDS, 1997; Mbanjwa and Neeson, 2002; Philpott and McClaren, 1997; and Census, 1996). Local and international studies have shown that poor nutrition, inadequate health care and the general absence of basic services and information in rural areas, have rendered poor people in rural areas more at risk of impairment (INDS, 1997; Philpott and McClaren, 1997; and Iglesias et al, 1998). Moreover, the incidence of disability within the family unit may compound the effects of poverty, or create impoverishment. Disability has been shown to impact negatively on family morale and the economic status of the family. Women who bear children with disabilities often find themselves isolated from economic or social activities due to the absence of support services or facilities (INDS, 1997).

The South African Schools Act of 1996 requires that government-funded schools admit all learners and provide for the special educational needs of learners with disabilities (McClain, 2002). However, it is estimated that at least 70% of children with disabilities do not receive formal education and those that are admitted into the education system face a

range of barriers to learning, including an inadequate skills base of teaching staff, discriminatory attitudes, as well as an inaccessible physical environment (Frances Kinghorn, "Disabled demand empowerment," Mail and Guardian, November 30, 2001). Further, a gender study focused on education in the SADC region, found that the education system throughout most of the SADC region was still biased against girls, and that disabled girls, despite their special education needs, experienced double discrimination due to their sex and their disability (SADC Gender Monitor, 1999).

The inability of the education department to effectively consider how to address disability in public schooling and educational or vocational programmes, has resulted in a systematic exclusion of disabled people from educational opportunity leading to low skills levels and high illiteracy rates amongst the disabled. This reality, coupled to discriminatory attitudes on the part of employers, and generally inaccessible physical and vocational environments, results in high levels of unemployment amongst disabled people. It is estimated that approximately 99% of disabled people are excluded from the open labour market (INDS, 1997).

The high level of unemployment amongst women with disabilities is directly linked to the barriers to education. International studies have shown that the few women with disabilities that do obtain employment are exploited and underpaid, receiving on average 56% of what men with disabilities earn. Furthermore, men with disabilities are twice as likely to find employment as compared to women with disabilities. These numerous barriers to obtaining employment result in women with disabilities being disproportionately poor as compared with the rest of the population (Iglesias et al, 1998; and Traustadottir, 2002).

In South Africa the 1998 Employment Equity Act prohibits discrimination on the basis of disability. However, statistics show that disability equity remains a neglected area in most institutions. Eight percent of work seekers are people with disabilities, yet 99% of people with disabilities remain unemployed. The 2000 OSDP survey of eighteen national government departments found that only four departments had met the public service disability equity target of 2%. A 2001 report on employment equity in the private sector established that people with disabilities made up 0,93% of the total workforce (Frances Kinghorn, "Disabled demand empowerment," *Mail and Guardian*, November 30, 2001).

Self-help programmes run by various private and public welfare organisations have generally been unable to sustain people with disabilities and their dependents (INDS, 1997). State-funded disability grants (DGs) which, in 2004, stood at a maximum monthly grant of R740, represent an important supplementary source of income for people with disabilities and their dependents. IDASA, however, estimated that only 56% of potential beneficiaries were receiving the grant in 2002. They attribute poor take-up of the grant amongst qualifying persons to problems of accessibility, related both to poor infrastructure (a problem mainly in rural areas), and lack of information about the grants (Mbanjwa and Neeson, 2002).

3.4.3 Social roles, sexuality and motherhood

People with disabilities, and women with disabilities in particular, are subjected to the mystification of their sexuality (Iglesias et al, 1998). They are either viewed as non-sexual beings with no sexual urges or needs or, at the other extreme, as people with rampant,

uncontrollable sexual urges (Department of Health Sciences, 2002; and Iglesias et al, 1998). These distorted and negative views may contribute to low self-esteem, and in the case of disabled women, place them at risk of gender-based violence (which we discuss in greater detail in 3.5.2.)

Another factor that contributes to low self-esteem amongst women with disabilities is the 'medicalising' of their bodies (Iglesias et al., 1998). As a result of society's view that disability is an undesirable medical problem, many women with disabilities find themselves the subject of medical experiments and tutorials, often without their consent. For women with disabilities, the constant exposure since childhood of their bodies to members of the medical profession (most often male) or their care-givers confirms the pervasive societal myth that their bodies are undesirable and only capable of raising curiosity in medical magazines or medical training sessions. This objectification of the 'disabled' body, as well as the domination of the body by members of the medical profession, may result in women with disabilities seeking to modify or transform the 'undesirable' body through self-inflicted social isolation, cosmetic surgery and self-mutilation (Iglesias et al., 1998). The 'medicalisation' of the bodies of women who are disabled confirms their socialised negative body image, further reinforcing low self-esteem and confidence. As a consequence, many women with disabilities may be unable to experience themselves as sexual beings.

Not only is disabled women's sexuality barely acknowledged at best, and distorted at worst, but they are also often deprived of opportunities to marry (or form intimate relationships), raise their own children or adopt. International studies have shown that women with disabilities, as compared with women without disabilities and men with disabilities, are more likely to be unmarried, married later or divorced earlier (Traustadottir, 2002). While restrictions on the formation of intimate relationships and on biological reproduction are directly proportional to the nature and degree of disability, there is a widely held view that women with disabilities should not be married or allowed to have children. Because women with disabilities are often perceived as dependent, helpless, child-like and in need of constant care, communities often determine that they are incapable of mothering and nurturing children, so depriving them of a key dimension of women's identity (Traustadottir, 2002).

Despite medical evidence that most disabilities are not hereditary, common fears and perceptions still persist within society that women with disabilities will produce disabled children. Brady's (2001) empirical research on eighteen sterilisation applications made to the Family Court of Australia between 1992 and 1999 finds that, despite a new discourse that emphasises the rights of individuals and the Courts acting in the 'best interests' of the girl or woman subject, the dominant approach to sterilisation in the Courts is deeply oppressive and reminiscent of the prejudice and violation characterising the eugenics policy of the first half of the twentieth century. Brady asserts that sterilisation applications cannot be reduced to a medical problem – the dominant approach to the issue of sterilisation in the Courts – but should rather be conceived as a question that bears on the fundamental human right of people to maintain bodily integrity and bear children. The dominant medical approach sanitises and presents as impartial and objective the arguments for sterilisation that are founded on discriminatory and prejudicial social values and beliefs about girls and women with intellectual disabilities.

Given societal restrictions on the social roles women with disabilities may perform in life,

it is unsurprising that disabled women come to view their disability as negative. For many women, their disability is the key factor that renders them unable to perform certain pre-determined and valued social roles – intimate partner, lover, mother and nurturer - thus imposing upon them an 'invisible social status.' The contradiction for women with disabilities then, is that despite being precluded from performing many traditional gendered roles as a result of society's perception that they are not full, capable and whole human and sexual beings, it is these very women that are at great risk of finding themselves victims of sexual violence (Iglesias et al, 1998; Nosek and Howland, 1998; and Traustadottir, 2002).

3.5 Disability and Violence against Women

Violence and abuse is a reality in the lives of many women with disabilities (Anello, 1986; Sobsey, 2002; Chenoweth, 1999; and Chenoweth and Cook, 2001). It is, however, difficult to fully estimate the extent of the problem because acts that women with disabilities may experience as violent generally go unreported. While underreporting of violence is also common amongst non-disabled women, there are additional complicating factors that may inhibit or prevent women with disabilities reporting abuse. These include high levels of dependency on caregivers, who often are the perpetrators of the violence; social isolation and discrimination against women with disabilities; and a lack of information and inadequate support services (see Section 3.5.2). Moreover, as we have noted earlier in this report, there is a general paucity of research on violence against women with disabilities that has only recently started being addressed, and then mainly within a North American context.

Recent international studies have concluded that women with disabilities suffered an equal, or up to three times greater, risk of rape by a stranger or acquaintance, than their non-disabled peers (Groce, 1999; Saxton et al, 2001; and Groce, 2004). In a 1995 US survey of violence against women with and without disabilities, it was found that the incidence of abuse amongst both groups of women was similar, with 62% reporting some type of abuse in their lifetime (Nosek and Howland, 1998). Half of both groups had experienced physical or sexual abuse, with the most common perpetrators of physical or emotional abuse being husbands or live-in partners. The researchers, however, found two key differences between the two groups of women in their experience of gender-based violence: firstly, women with disabilities were more likely to experience abuse by care givers and health care providers; and secondly, the duration of abuse for women with disabilities was typically longer than for women without disabilities (3.9 years versus 2.5 years). Because of society's negative perceptions about disability, and the resultant ostracism and marginalisation of people with disabilities, many women with disabilities remain trapped in abusive relationships because they find themselves solely dependent on the abuser for affection, communication, financial assistance and physical support.

A Canadian study involving 245 women found that 40% of women with disabilities had experienced some form of abuse and 12% had been raped. Spouses and ex-spouses were most often cited as the perpetrators, followed by strangers, parents, service providers and dating partners. This study also revealed that less than half of these women reported the abuse because of their dependency on the abuser and/or their fear of recrimination (Riddington, 1989 in Nosek and Howland, 1998). The study found that the perpetrators of violence were usually people known to or close to the victim (*ibid*).

Nosek and Howland (1998), however, warn that statistics on the prevalence of violence against women with disabilities should be treated with caution. Due to the difficulty in defining variables and the vague parameters used to conceptualise disability, data are often not comparable. Some statistics suggest that violence against women with disabilities is greater than that against non-disabled women, whilst others find that it is equal in prevalence. Furthermore, in failing to distinguish between the different forms disability takes, some research has the unwitting effect of homogenising the experiences of disabled women, thereby occluding real differences in life circumstances, and resultant experience and need.

Violence causes Disability

Violence against women causes disability. While this short study has not aimed to explore this particular dimension of gender-based violence and disability, the stories we came across in the course of our research were so powerful we felt they should be highlighted in this report. The stories of the four women that are presented below expose the tremendous social costs – the physical pain, the emotional trauma and, in two instances, the subsequent loss of life - to the individual women concerned, their families, communities and society as a whole. They also highlight the economic costs to society of violence against women. Many of the women whose stories are told below spent months in hospital receiving treatment for the injuries they sustained. Many subsequently relied quite heavily on the public health system for ongoing treatment related to their disabilities, and associated complications. Their disabilities arising from the abuse rendered them incapable of earning an income and adequately caring for themselves and their children. For example, a woman blinded by her abusive husband was forced to relinquish her university studies, and the important contributions she could have made to society as a teacher. Her daughter, also blinded by the abusive father, has to attend a special school for the blind, which incurs high financial costs to the family and government, through its subsidisation of the child's educational needs. The stories also illustrate the failures of the criminal justice system (CJS), a theme taken up later in this report.

* Names have been changed to protect people's identities.

Thandi*, a 29-year old mother of two children, was stabbed in the neck by her abusive boyfriend when she was just 17 years old. It was New Years Eve, 1990 and Thandi's boyfriend wanted her to travel with him to Durban. She declined, preferring instead to spend the evening with her friends. Thandi's boyfriend camped outside her home waiting for her to return. He reported to her mother and father that he was planning to stab her. As her mother left for Church the following morning, Thandi's boyfriend forced his way into the house and "came running to me. I got out of the house, but I was too late. He stabbed me and I fell down. They took me to the hospital. I was in hospital for nine months." Thandi has since spent her life in a wheelchair.

Rose* and her daughter, Nokwazi*, were both blinded by the constant physical abuse they endured at the hands of Rose's husband, and Nokwazi's father, Phineas. "…He used to pull my hair, push my head into the wall, kick me on the head, hit me with fists on the head …That is what he used to do continuously when he was fighting me. I don't think the

blindness was caused by one incident, … I think slowly I was getting damaged. It was on the 8th March 1991, I still remember that was on a Friday that was the day I lost my sight." At the time Rose lost her eyesight she was completing her third year of education studies at University and was forced to abandon her studies. Rose's daughter, Nokwazi, is also blind. "I would say that he [the father] was a loving father, that was the way we used to know him, but we really don't know what went wrong because there was this day in July 1990 that he hit Nokwazi and then [she] became blind. Nokwazi was quiet all along and she [later] said "it's because the father said that if you tell I will kill you."" Nokwazi attends a school for the blind at some distance from the family home. She boards and commutes home when the family can afford it. The only source of income to Rose, Nokwazi and another child is Rose's disability grant. The family endures great financial hardship.

Patricia's* story was retrieved amongst inquest records held at the Johannesburg Magistrates Court. On the 25th of January 1991, Patricia's boyfriend attacked her and stabbed her in the neck. At the time they were staying at the Dube men's hostel and Patricia was unemployed. Patricia was taken to hospital and hospitalized for 3 months. She sustained a spinal cord injury because of the attack, resulting in paraplegia. She was discharged sometime in April 1991 and continued to receive treatment at the hospital as an outpatient. Patricia died on the 28th June 1991, six months after the stabbing incident. The police were called to the hostel at the time of her death and only then did they start to investigate the case of assault. The cause of death was recorded as "pyelonephritis following [a] penetrating incised wound of the neck". The injuries recorded on the post-mortem included large, deep, septic bed-sores over the sacrum, the left hip region and another one running laterally over the right thigh, infested with maggots. The deceased was found with a catheter on her. The bedsores indicated that she had been terribly neglected. The police record states that there was no documentation to help them trace the accused, reported to have absconded to KwaZulu-Natal, but investigations were continuing.

The story of **Judith*** was found in the inquest records at the Johannesburg Magistrate's Court. In 1982, when Judith was nineteen years of age, she was stabbed by John her boyfriend. John was living at the Marafe Men's Hostel in Soweto at the time of the incident. Judith was hospitalised after she had been stabbed and stayed in hospital for six months. She became a paraplegic as a result of the injury. In the eight years to follow, Judith was hospitalised numerous times until she died in February 1990. On the day she was taken to the hospital for the last time, she was shivering and complained of being cold. She had developed bedsores on both her right and left hips. A letter written by the doctor who attended to her states thus: "…the patient's demise was due to complications resulting from paraplegia which in turn resulted from an injury to the back." The police later traced the reported case of assault, which stated that the deceased had been stabbed by her boyfriend in August 1982. The inquest found that Judith's death stemmed from this stabbing incident. The assault case against John was subsequently closed because the police could not trace him. He had disappeared, together with the couple's three-year old child.

3.5.1 Forms of Violence against Women with Disabilities

Violence against women with disabilities, like violence against women without disabilities, varies in manifestation. The form that violence against disabled and non-disabled women takes is usually diverse and includes psychological, physical, economic, emotional and

sexual abuse. Women with disabilities may, however, experience forms of abuse that are particular to their specific disability.

Iglesias et al (1998) posit that violence in the context of disability can be divided into the categories of active and passive violence.

- **Active violence** includes physical, emotional, sexual and economic abuse.
- **Passive violence** includes physical and emotional neglect, as well as discriminatory actions that may result in further physical or psychological harm to the victim.

A new term 'disability-related abuse' has been coined to describe forms of abuse that are particular to women with disabilities, often related directly to the vulnerabilities associated with the form of disability (Center for Research on Women with Disabilities, no date). Disability-related abuse may be found in the categories of both active and passive violence, described by Iglesias. Many of these forms of abuse originate in the care-giving relationship, which so many women with disabilities depend upon. This is discussed in more depth later in this section.

Under the broad category of *active violence*, women with and without disabilities may share vulnerabilities to and experiences of different forms of violence.

- *Physical violence* may be defined as any direct or indirect action that can damage the life, welfare or health of women, provoking pain or unnecessary suffering. It manifests in aggression to different parts of the body (applicable to women with and without disabilities), *the unjustified administration of drugs (tranquillising the woman to 'shut her up') or withdrawal of drugs, and restrictions in mobility (for example, taking away an assistive device required for communication or social interaction, or refusing to help a woman leave her home for social activities).*

- *Emotional abuse* may be defined as behaviour that results in damage to the welfare and emotional balance of the woman. It manifests in controlling behaviours that restrict access to family and friends and result in isolation; verbal threats and cruelty; intimidation; and emotional blackmail. While women with and without disabilities experience emotional abuse, women with disabilities may experience particular forms of emotional abuse related to their disabilities. *For example, women with disabilities may be subject to threats from a caregiver to leave without feeding or assisting her with the toilet; threats to leave and take the children; threats to institutionalise her; threats to stop taking care of her etc. Other examples of emotional abuse peculiar to women with disabilities include not allowing a woman with limited verbal skills to express herself, or speaking to a woman with an intellectual disability in a complex or confusing way.*

- *Sexual abuse* is defined as sexually aggressive actions towards a woman, which can produce physical or emotional harm. Sexual abuse manifests in rape, sexual harassment and sexually explicit actions that result in feelings of humiliation or degradation on the part of the victim. Once again, these forms of abuse can be inflicted upon women with and without disabilities. However, in the context of a care giving relationship the following particular forms of sexual abuse may arise: a

caregiver engaging in sexual touching during bathing and toilet routines; leaving the bathroom door open or coming into the room while a woman is dressing, bathing or using the toilet; and using explicit sexual language or making crude sexual jokes.

- *Economic abuse* may be defined as actions and omissions that result in the loss of a woman's control over or rights to the means for survival (including property, money and/or employment). This is manifested in restrictions on her finding and/or sustaining employment, confiscating her earnings and/or limiting her spending. Women with disabilities may experience the following particular forms of economic abuse: confiscating or misusing her disability grant; defrauding her by making unauthorised withdrawals of money from her account (common in the case of women who are visually impaired or physically immobile, and who are therefore reliant on others making financial transactions on their behalf); and petty theft (for example, a blind or visually impaired person being short-changed).

Passive violence refers to that which is not done rather than actions that are done. This form of violence is often idiosyncratic to women with disabilities (or women with severe disabilities) because of their reliance on caregivers, which may include intimate partners, family members or paid/voluntary staff.

- *Physical neglect* is defined as the denial or privation of the basic care required for maintaining the safety and health of the person with disability. This form of violence manifests in *negligence in feeding (for example, denying her food and fluids), personal carelessness, neglect of basic hygiene measures and inadequate supervision. It may include withholding essential assistance with personal tasks, such as dressing or getting the woman out of bed, leaving her in soiled or wet clothes or bed sheets, and/or leaving her on the toilet or in the bath for extended periods of time.*

- *Emotional neglect* is defined as actions that deny attention, consideration and respect towards the woman. It may take the form of ignoring the woman, making her feel ashamed and not valuing her opinion (Iglesias, 1998).

Two South African women with disabilities: their stories of abuse

(1) A 39-year old woman, blinded by her abusive husband

"…after I became blind - it was still in the year 1991 – it was on a Tuesday. I took off all the [dirty linen from the bed] and put on the clean ones… what my husband did that day he took the thorns [from the cactus fruit] and spread them on the sheets. I said my prayers and opened up the duvet… and I had to sleep in all of this. There were so many thorns in my flesh…"

"…in December 1991, a friend of mine discovered that I was cooking… the maize meal with worms in it. My husband [would pretend] … as if he had finished his porridge [I had cooked]. Meanwhile, he would throw it in the bin without me knowing… and take the

bread… It means that I was eating the worms."

(2) A 29-year old woman with physical disability

"He'd take my wheelchair and put it in a box. When I wake up, I would scream and ask 'where are you?' And I would realize that he did take the wheel chair because he doesn't want me to go [out]. I'd stay on the bed until he comes back…he just wanted to punish me to stay in the house."

"My husband would force me [to have sex] all the time. When I tell him that I am tired today he would… force me. I would just sleep even though he would be on top of me. It was painful. It happened all the time."

"In 2001 when he was punching me, he twisted [my hand]. I didn't know how to push my wheelchair [for nine months]. I'd use one hand because my hand was sore, even now it's sore."

The 'Power and Control' wheel reproduced below captures the different forms of violence experienced by women with and without disabilities, as well as those forms of abuse that are peculiar to women with disabilities, and which arise from the particular vulnerabilities associated with their specific disability. This wheel was developed by women survivors of abuse to describe their experiences of violence.
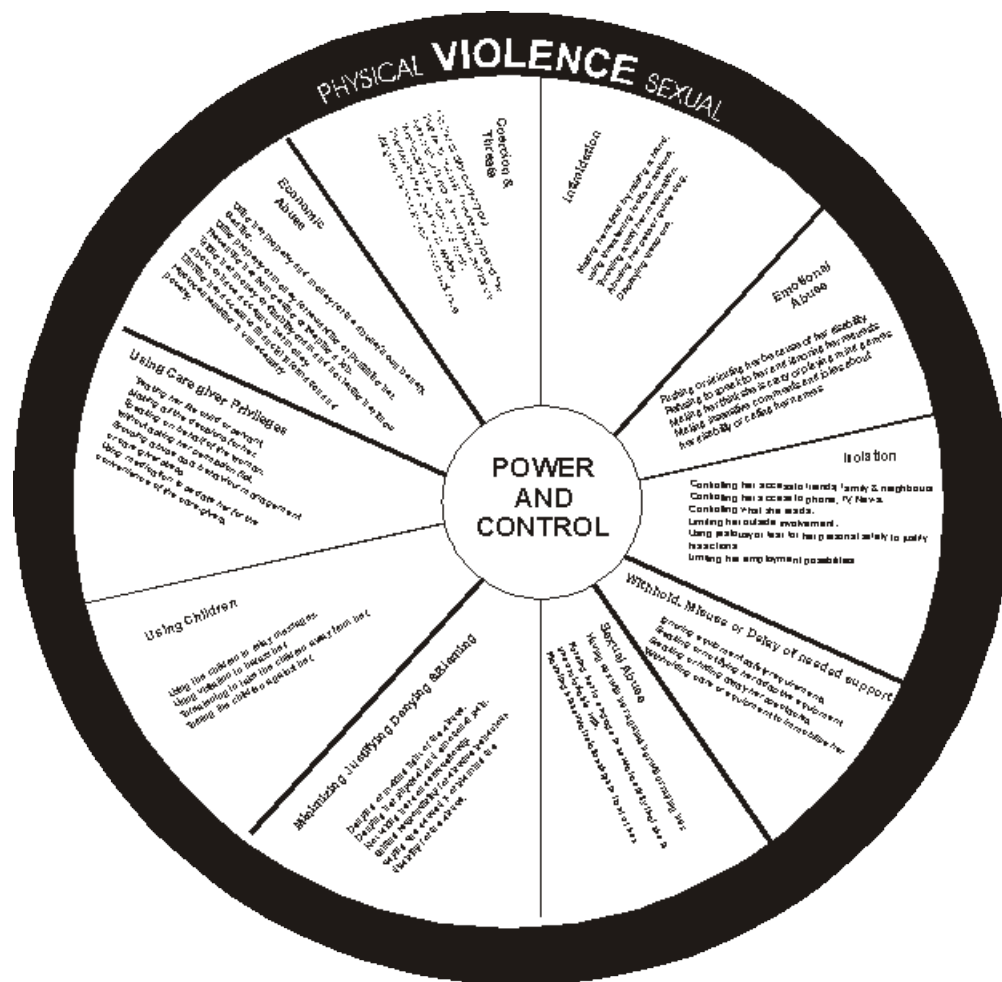
Source: Domestic Abuse Intervention Centre, Duluth, Minnesota

International studies have identified the abuse of women with disabilities by personal assistance providers (PAS)[2] as a significant problem. A study by Sobsey and Doe (1991) found in 44% of reported cases of sexual abuse affecting adults and children with developmental disabilities in North America, the abuser had a relationship with the victim that was specifically related to the person's disability. Nearly 28% of these included disability service providers, such as personal care assistants, psychiatrists and residential care staff. The remaining abusers included transportation providers, foster parents and other individuals with disabilities.

Saxton et al (2001), in their qualitative study that sought to explore perceptions and experiences of abuse by personal service providers to 72 women with disabilities, found diverse forms of abuse to feature in these relationships, ranging from physical harm or threat of harm, forced sexual contact, emotional abuse, and financial abuse. While these forms of abuse are experienced by women without disabilities, the highly dependent nature of the relationship between women with disabilities and their caregivers, and the often extreme imbalances of power that arise in this relationship, results in women with disabilities experiencing the abuse differently, and imposes particular barriers on women seeking help to escape the abuse. Moreover, for women with disabilities, dealing with the dual socialising effects of being a woman and hence instructed in compliance, sacrifice and

accommodation to others (usually men), and being disabled resulting in personal devaluation and low self-esteem. This greatly exacerbates the imbalance of power in the PAS relationship.

Saxton et al note that the uneven balance of power may be further exacerbated for women with disabilities when they are reliant upon family members and/or husbands/life partners for their personal care. A woman's reliance on her spouse for not only her financial and/or emotional needs, but also for the most basic needs of mobility and physical access, can "reinforce the classic cycle of domestic abuse" (2001: 403).

Another key issue identified by this particular study was the difficulty of women with disabilities recognising, defining and describing abuse, especially in relationships which typically involve the care provider undertaking tasks which blur personal and physical boundaries, such as washing the person, assisting them to use the toilet, and helping them dress. The participants in their study noted that boundary confusion was particularly notable when matters of personal touch arose. "The line between appropriate touching as an essential part of the job of providers and inappropriate touching, which could lead to unwanted or ambiguous sexual contact was not always definable" (Saxton et al 2001: 401).

The role of the medical profession in perpetrating abuse against women with disabilities is also highlighted by the same study. They found that health care providers, including nurses, physicians, occupational and physical therapists were also abusive. Participants to their study described health care providers "pushing them beyond their limits", such as forcing them to stand for long periods of time or to "do things that were painful" (Saxton et al 2001: 405).

Women with developmental disabilities, as compared with their male counterparts, are over-represented in the most controversial and restrictive emergency interventions for managing violent or threatening behaviour, such as seclusion, restraint or rapid tranquillisation in institutions of psychiatric care (Rangecroft et al, 1997 and Sequeira et al, 1997 cited in Sequeria and Halstead, 2001). In a later study by Sequeria and Halstead (2001) they find that people with developmental disabilities find these interventions to be physically painful, and mentally and emotionally distressing. Much of the discomfort of patients arises from their perception that the nursing staff employed the interventions to punish or control them. They find that rapid tranquillisation is the method of choice for managing violent or aggressive behaviour amongst female patients with developmental disabilities. They contend that the use of this intervention suggests gender-bias, stemming from a "discomfort or wish to deny aggressive or violent behaviour, in females" (Sequeria and Halstead, 2001: 470). Tranquillisation, as opposed to seclusion, promotes passive and dependent behaviour via the administration of a sedative drug, which is controlled by another.

The issue of abuse and violence in medical settings and by medical professionals is complex and difficult to define. While some acts can quite explicitly be labelled abusive, others such as physical touch, the use of restraints, or forcing a patient to stand when she is clearly in intense pain are not easily categorised and defined as abusive. There is clearly need for further research and consideration of the issue in the establishment of guidelines and standards for medical practice involving people with disabilities.

Since the majority of women with disabilities are reliant on others – usually friends, family members, spouses and sometimes paid caregivers - for basic survival and reproduction, this creates unique vulnerabilities to, and possibilities for different forms of violence and abuse that may not be experienced by women without disabilities. Disabled women may require substantial assistance with personal care, equipment, medication and finances. The withdrawal of, or restrictions in access, to these often life-depending resources may constitute abuse, and place women with disabilities at increased risk of abuse by their caregivers and members of the medical profession. Where there is a high level of dependency for basic reproduction, a woman with a disability may perceive that abuse is the price she must pay for survival. Saxton et al (2001), therefore, call for expanding current definitions of gender-based violence to accommodate the unique and particular experiences of women with different types of disabilities.

3.5.2 Increased Vulnerability to Gender-Based Violence

As Nosek et al (2001) cogently point out the dynamics of abuse are shaped by the extent and form of the disability, and the vulnerabilities that present with different disabilities. So, the vulnerabilities for a woman with a physical disability that prevent her physically escaping a violent situation are different as compared to a woman with a hearing disability, who might be able to physically escape the abusive situation, but then finds herself facing communication barriers in relation to institutions that are supposed to serve battered women. It is important to note that having more than one disability can increase a woman's vulnerability to abuse (Anello, 1998). There are a number of vulnerability factors that are, however, shared by the majority of women with different disabilities such as economic dependence, low self-esteem and confidence, and social isolation.

According to Traustadottir (2002) perpetrators of violence look for and use vulnerability to create opportunities for violence, and many women with disabilities are physically, socially, economically and psychologically vulnerable. Women with disabilities are often taken advantage of economically, with partners and other family members taking control of their disability grants and other financial resources. The lack of economic independence of women with disabilities is cited throughout the international literature as a key risk factor to gender-based violence.

Researchers argue that women with disabilities may be more psychologically vulnerable than non-disabled women. Because women with disabilities are presented as the 'other' and their sexuality misrepresented as either absent or exaggerated, they can and often do become the subject of men's sexual fantasies. Non-disabled men may wish to sleep with disabled women to see if they will present a different sexual experience (Simon-Meyer, 1999). This may place women with disabilities at greater risk of sexual violence.

The social myths around the 'asexuality' of disabled women and the resultant lack of sex education or life skills, also presents further opportunities for victimization. The 'lack of sexuality' becomes a means to sexual exploitation and emotional abuse. This may be exacerbated by societal beliefs that women with disabilities are passive and unaware and therefore constitute 'easy prey' (Nosek et al, 2001). For abusive husbands and partners the myth of asexuality becomes a means for the abuser to justify his abusive actions as an expression of love, and reflect himself as a social martyr (Iglesias et al., 1998).

Because of the sexual constraints and inhibitions which society places on women with disabilities, they have fewer opportunities to explore their sexual likes and dislikes and set sexual boundaries. Women with disabilities may not have had opportunity to date, go to parties, or engage in age-appropriate sexual activity. They may come to believe that the only options available to them are celibacy, or violent sexual encounters because of the internalised belief that they are unattractive and no loving person would want them. Some women may believe that their situation is determined by fate, and that any feelings (even if bad) are better than no feelings at all (Womendez et al, 1991 cited in Nosek et al, 2001).

Emotional abuse, particularly by husbands and partners, may be perpetuated by myths around disability. The belief that a woman with disability is dependent and child–like becomes a means of exerting control over her and excluding her from decision–making. The lack of self-esteem and confidence of a disabled woman, as a result of society's negative beliefs, allows her partner to increase the cycle of dependency, making her believe that she is incompetent and not capable of living without him (Impact, 2002; Odette and Ronaldi, 2000). In addition, abusive partners may threaten to use the woman's disability to discredit her story if she discloses the abuse.

For women with disabilities, the continual crossing of personal frontiers by the medical profession, family and caregivers, may make it difficult for her to perceive sexual abuse as a violation. Womandez et al (1991, cited in Nosek et al, 2001) argue that because of the constant infringements on the body by members of the medical profession and caregivers, women with disabilities may disassociate the self from the body where there is pain, where privacy is denied, where nakedness is the norm and where women feel that they are not treated as fully human.

The perpetrators of violence against women with and without disabilities are often people that are known and close to the victim. This has a direct impact on disabled women's vulnerability to violence because of the many caregivers on whom they are dependent. The concept of family for disabled women often does not only include immediate relatives, but also neighbours, friends and paid or voluntary caregivers. The reliance on these various people to fulfil daily tasks for survival, as well as the intimate physical and emotional contact involved in care giving, increases the risk of abuse (Iglesias et al., 1998). For women with disabilities, who are socially isolated and overly dependent on their caregivers, these relationships of dependency, power and control hold greater potential for abuse (Mandeville and Hanson, 2002). Many women with disabilities find themselves trapped in abusive relationships because they are solely dependent on the abuser for affection, communication, financial assistance and physical support.

In a study aimed at understanding the vulnerability of women with disabilities to abuse, Sobsey identified five myths around disability that increase the likelihood of disabled women's victimization (Sobsey, 1990 in Iglesias et al, 1998: 12):

- *Dehumanization:* people with disabilities are considered less human and inferior to the rest of society. The perpetrator and indeed society as a whole may, therefore, not see the abuse as a crime of the same magnitude as compared with a victim who is not disabled.
- *Damaged Merchandise:* a disabled person is considered defective, whose life has less value and may not be considered worth living. Arguments for euthanasia and

medical experimentation have drawn on this myth.

- **_Feeling no pain:_** many women with disabilities, especially developmental disabilities, are considered incapable of experiencing emotional and physical pain or pleasure. This argument is the basis for forced abortions and sterilisation.

- **_Disabled menace:_** people with disabilities are viewed as dangerous social threats. Perpetrators of violence rationalize their behaviour by blaming the victim for provoking the attack.
- **_Helplessness:_** people, and especially women, with disabilities are often considered vulnerable, helpless, naive and, hence, easy prey.

Andrews and Veronen (1993, in Nosek, Howland and Hughes, 2001: 480) and Anello (1998) have identified the following as factors that increase the vulnerability of disabled women to violence and abuse and constitute a cogent and useful summary of many of the arguments already presented in this report:

- Poverty;
- Negative public attitudes towards and fears about disability;
- Women with disabilities are generally not believed when reporting or disclosing abuse;
- Social isolation and increased risk of manipulation;
- Lack of support for caregivers;
- Limited or no education about appropriate and inappropriate sexuality;
- Physical helplessness and vulnerability in public places;
- Lack of safe, affordable, and reliable alternatives in terms of shelter, services and care;
- Lack of access to information about protective legislation and options for redress in the case of abuse;
- Denial of human rights, resulting in perceptions of powerlessness, internalised oppressive beliefs and socialisation to be compliant;
- Fear of losing their children;
- Fear of being ostracised from their community/family;
- Distrust of and lack of confidence in the police;
- High dependency on others, often the perpetrator/s of the abuse, for care and basic survival; and
- Perpetrators' perceptions that there is less likelihood of their behaviour being exposed.

A qualitative research study conducted by the Center for Research on Women with Disabilities in Canada noted the following as additional disability-related vulnerability factors: the absence of adaptive equipment (usually linked to inadequate finances); and the increased risks that come with institutionalisation and frequent exposure to the medical profession (cited in Nosek et al, 2001). In the absence of adaptive equipment, a reality for the majority of women in South Africa, women with disabilities are trapped in immobility, and extremely dependent on abusers.

Many of the vulnerabilities to violence and abuse experienced by women with disabilities in other parts of the world relate to the failures of the criminal justice system, the inaccessibility of services for treatment, and inadequate provisions in the gender-violence

sector to accommodate the particular needs of women with disabilities.

3.6 Access to Justice and Support Services

International studies have pointed to the numerous barriers women with disabilities confront responding to abuse. In the Saxton et al (2001) study described earlier, research participants pointed to the important links between how a society that devalues and discriminates against both disabled people and women, then fosters abuse and neglect of disabled people (and women with disabilities in particular); and the failure of society and its institutions to offer adequate support to abused women with disabilities. One of their research participants powerfully concluded:

> People that are devalued as cripples and burdens and inferior and defective will be abused. If you like somebody, respect somebody, you're not going to kick them. You're not going to leave them in bed and not get them up… You're not going to not give them the meds that they need or give them too many to tranquillise them and shut them up… (Saxton et al, 2001: 408).

If society does not value people, and especially women, with disabilities as worthy citizens, then violence will continue to be perpetrated and cases of abuse in which the victim is a person with disability might seem "less worthy of criminal prosecution." (Saxton et al, 2001: 409)

Some of the international studies point to the problems women with disabilities have identifying, naming and responding to abuse by care providers given the blurring of personal boundaries and the high levels of dependency, and associated imbalances of power that come into the care giving relationship, especially where friends or family members are involved. Low levels of self-esteem and confidence, associated with the socialisation of people, and especially women with disabilities in a 'disabling world', lead to the internalisation of 'oppressive assumptions'. This inhibits the identification of abuse (especially in societies where the particular forms of abuse women with disabilities are subjected to are not named and publicly exposed), and may lead to self-blame for the abuse (Saxton et al, 2001). These internalised negative beliefs act as a major impediment to women with disabilities seeking help (Center for Research on Women with Disabilities, no date).

High levels of dependency on caregivers, especially where they involve the unpaid labour of friends and family members, also lead to women with disabilities weighing the pros and cons of responding to a relationship that has turned abusive. Important here are women's fears of being financially abandoned, losing access to shelter, relinquishing access to the most basic care and support needed to survive, fear of losing custody over children and so on. In the context of these real material and emotional dependencies on others, so central to the survival and reproduction of women with disabilities, options for dealing with an abusive relationship are deeply constrained.

The Disabled Women's Network of Canada survey of 245 women with disabilities, which found that 40% had experienced abuse, also finds that less than half of these experiences were reported due mostly to fear of retaliation and/or dependency on the perpetrator (Nosek and Howland, 1998).

A number of other international studies highlight the general problem of abused women with disabilities generally not receiving or accessing treatment and support for abuse. In the Disabled Women's Network of Canada survey of 245 women with disabilities, only 10% of the abused women had used shelters or other services, 15% reported that no services were available, and a further 55% had not tried to obtain services. The Sobsey and Doe (1991) study of 166 abuse cases handled by the University of Alberta's Sexual Abuse and Disability Project found that treatment services were either inadequate or not offered in 73% of the cases. Saxton et al (2001), find that none of the 72 participants that participated in their study reported having called a counselling service or crisis facility, or a shelter for abused women. The participants, moreover, could not cite any examples of other disabled women having pursued these avenues for recourse.

International researchers conclude that women with disabilities may not be aware of services available to women confronting gender-based violence, or feel entitled to call on the resources and support that are available.

Moreover, much of the international literature points to problems in the police services, with police staff often being unaware of and untrained on issues related to disability, particularly as this pertains to abuse in care-giving relationships. Houchins (2002) highlights the problem of police officials subscribing to the social mythology that people with disabilities cannot be victims of crime so long as they are in the 'safety' of institutions or their families, and therefore, doubting the veracity of the claims of abuse brought by a person with disability. Chenoweth (1999) mentions that police officers are often reluctant to investigate allegations of abuse brought by women with developmental disabilities, in particular. Chenoweth attributes this to inadequate training of police officials on disability issues, as well as capacity and resource constraints. If police officials think a case is unlikely to be prosecuted successfully, they are not inclined to prioritise the case and investigate further.

Morgan's (2001) study on Deaf people's access to the justice system in South Africa concludes that there are significant communication barriers that undermine their right to justice. The barriers identified by this study include police taking down statements without a professional sign language interpreter and problems of court interpreters not being proficient in the dialect or system of sign language used by the Deaf person. In the case of the latter, court officials are generally found to be reluctant to swear in relay interpreters, who are in a position to translate the dialect used by the Deaf person to the court interpreter and visa versa. Morgan notes that relay interpreters are essential to ensure that Deaf people understand their rights and have an opportunity to participate in the proceedings of the court. So long as the courts fail to recognise the importance of relay interpreters and are prepared to swear them in as interpreters, communication barriers will persist which represent a serious infringement on the rights of Deaf witnesses. Morgan also identifies the communication challenge that may arise especially in gender sensitive cases, such as divorce or rape, where the gender and culture of the witness and the interpreter are not matched.

Barriers to access to justice and support: case examples from South Africa

"…that social worker didn't help me… I never even bother going to any other social worker… You go to this person and [they] don't even care about the situation. You feel very bitter… When you go to another social worker in another area they refer you back to the very… person you are running away from."

39-year old woman, blinded by her abusive husband

"I went to the police all of the time. Maybe I have eight case records. I wanted them to talk to [my husband]. Maybe they can lock him up and throw the keys away, or take him to jail for many years. They did do that, but it didn't work. When I went to them again because he hit me, I asked them to lock him up. They didn't lock him again. They said you are disabled, we don't want to discuss disabled matters. You must go to the social workers."

29-year old physically disabled woman abused by her husband

"[When I went to Court after he burnt my clothes], the prosecutor said he must be discharged. They came to my mother's house. It was a Sunday and they had pump action guns. They shot at the sky… after that they shot at my room. I was so frightened. The police came and took three cartridges. The Meadowlands police did not arrest him. Another day he came here… two guys were coming. They said take her, take her… [Men came] and ran after those guys. They called the police. I told them I suspect this person. They said they will go to his place, but they never went. All these cases are still open."

29-year old physically disabled woman abused by her husband

"I went for protection order many times. I used monies there. Because I started to go to the Protea Court, they said I must go to Roodepoort. I went to Roodepoort and they said I must go to Dobsonville Police Station. I hired a maxi taxi to Roodepoort, then to Protea. I took my friend to Meadowlands. She said I must buy her food… I used a lot of money… roughly it can make R500" (This was one of three protection orders the respondent tried to obtain over a period of time).

29-year old physically disabled woman abused by her husband

Nosek and Howland (1998) note that there are virtually no studies that examine the existence or feasibility of interventions aimed at abused women with disabilities. They note that, in both the disability rights movement and the battered women's movement in Canada, it is generally acknowledged that programmes to assist abused women are "often architecturally inaccessible, lack interpreter services for deaf women, and are not able to accommodate women who need assistance with daily self-care or medications (Nosek and Howland, 1998: 3).

In an effort to address the paucity of information on the relevance and accessibility of support services to abused women with disabilities, the CSVR undertook a small-scale survey of governmental and non-governmental organisations, working in the field of disability and gender-based violence, in the Gauteng Province. The results of this survey are presented in the section that follows.

Section 4: Findings of the Survey of Gauteng Service Organisations

4.1 Cases Involving Women with Disabilities

Table 1: Cases dealt with

Cases of Violence Against Women with Disabilities in the Past Two Years	NGOs	SAPS
Once	-	
Seldom (< than 5 times)	3	1
A few times (> than 10 times < than 20)	1	
Often (more than 20 times)	3	
Never	1	3
Total	8	4

The survey of the ten service organisations (and two outreach offices of one NGO) found that few organisations had assisted women with disabilities, who had been victims of violence, in the past two years. Four offices (three of which were service organisations of the SAPS) had not provided a service to a woman with disability, confronting gender-based violence, over the past two years. Only three organisations/outreach offices had encountered abused women with disabilities more than twenty times in the past two years.

There are two conclusions that can be drawn from these findings: women with disabilities either do not suffer abuse, or women with disabilities are unable to access services. Most informants reached through the survey concluded that there is little doubt that women with disabilities are vulnerable to victimization, a tentative confirmation of the findings from our survey of the literature, but confront barriers accessing assistance. Some of the challenges identified include the stigma attached to women with disabilities i.e. that they cannot be raped because they are asexual or undesirable; communication problems; secondary victimisation by insensitive service providers; and physical barriers to reaching police stations and the courts.

Although a few of the organisations interviewed had encountered women with mixed disabilities, the majority of women presenting for assistance were women with physical disabilities, mainly women in wheel-chairs, and blind women. None of the service providers could recall having assisted Deaf women, the probable explanation being that not one of the organisations (and their outreach offices) employed staff capable of communicating in sign language.

Those informants that were in a position to report on the forms of violence they had encountered in the course of their support work, indicated that the main forms of abuse that women with physical disabilities seemed to experience were physical violence, and economic and emotional abuse, with the key manifestation here being restrictions on their physical mobility. In the case of paraplegic and quadriplegic women, informants mentioned that intimate partners would either damage or hide the wheelchairs to prevent them leaving

the home.

Consistent with our findings of the survey of the international literature, the perpetrators of the abuse include intimate partners, parents, siblings and adult children. In cases of abuse of young women by older siblings or parents, they were subjected to social isolation, their mobility was restricted and family members prevented them applying for disability grants. Physical abuse was used to force compliance to 'rules'. One service provider mentioned their organisation having serviced disabled parents whose children had been abused. Perpetrators took advantage of the vulnerability of the parents' disability to abuse their children.

Many informants dwelt on the economic abuse of women with disabilities. They mentioned that non-disabled men often enter into relationships with women with disabilities so they can access their disability grants. They had come across instances of a husband or partner forcibly confiscating the disability grant from women, claiming that they had no need for the money, stealing the money, or using the money under false pretexts.

Three of the NGO informants' interviewed believed that women with developmental and psychiatric disabilities were more likely to suffer sexual abuse.

The findings of our small survey confirm those of international studies, which argue that while women with disabilities, like all women in general, are likely to be victims of abuse, their disability does render them more vulnerable than other women because of their dependency on care givers and because they are more physically vulnerable and less able to defend themselves. Our findings also confirm that violence against women with disabilities is not homogenous and the faces of violence change according to the specific disability.

4.2 Physical Accessibility of Services

Of the ten organisations (and two outreach offices of one organisation) that were surveyed, staff of eight of the organisations/offices believed that their services were physically accessible. However, the criteria they applied to determine physical accessibility clearly encompassed women with physical disabilities only. In discussing physical access, informants cited the existence of ramps and wide passages and doorways, which could accommodate women using wheelchairs. Other indicators for accessibility, including voice-activated or Braille numbered elevators and large-lettered or illustrated direction boards, were not mentioned. Consciousness of the particular limitations that women with visual or hearing disabilities might confront were therefore, absent amongst many of the informants reached.

Our observations, in the course of our visits to the ten organisations (and two outreach offices) were that many of the buildings were physically inaccessible to women with disabilities (see Table 2 below).

Table 2: Measuring physical accessibility

Physical Accessibility Criteria	NGOs	SAPS

Ramps	2	3
Balustrades	2	3
Wide doorways and Passages	5	4
Elevators (not necessarily with Braille or voice activated)	2	2
Bathrooms designed for people with disabilities	1	-
Reserved parking	-	-
Other	-	-
Total	8	4

Informants from three NGOs mentioned the difficulty they encounter offering an effective service to women with disabilities because of the physical inaccessibility of their office space. One organisation, which does not have an elevator in the building, had previously used the offices of another organization on the ground floor to counsel a physically disabled woman. The situation was far from ideal with the counseling being undertaken in the presence of other people. In the case of the second organization, a woman in a wheelchair was unable to enter the building as there were no ramps. The counseling was undertaken in the garden, an option that could not be feasibly pursued in poor weather conditions. The third organization is based on the first floor, and there are no elevators in the building. Counselors have to provide services on the ground floor.

When asked if offices would be made more physically accessible in the near future, organisations indicated that financial constraints prevented them considering a physical relocation or the remodelling of offices. One of the organisations indicated that they were considering the feasibility of moving to alternative offices, so as to better accommodate the needs of women with disabilities.

Site inspections were also undertaken at the Johannesburg Family Court, Protea Magistrate's Court (in Soweto) and Sebokeng Magistrate's Court. A checklist, containing criteria for measuring the physical accessibility of the site to people with different physical disabilities, was developed and guided the site inspections. The results of these site inspections are presented below as Table 3. We also include the results of our physical survey of the four SAPS units.

In regard to the physical accessibility of police stations and courts, while some attempts had been made to make buildings and office space more accessible, mainly through the introduction of ramps, we noted problems with their design. Ramps were either too steep or too narrow to accommodate wheelchairs, suggesting limited knowledge of the circumstances and needs of potential users of these facilities.

Table 3: Results of physical survey for accessibility of services – courts and police stations

	Victim Empowerment	Johannesburg Family	Protea Police	Sebokeng Police	Johannesburg Family Court	Protea Magistrate	Sebok Magi

	Unit at Johannesburg Central Police Station	Violence, Child Protection and Sexual Offences Unit	Station	Station		Court	Cour
Entrance/ Ramps	Side of Building. 2 ramps	No separate entrance. 2 ramps – but angle unusable	No separate entrance. 1 ramp, but too narrow	Dust, gravel road. Obstructive entrance. No ramps	Offices spread across building. No ramps	Revolving door, limits access. 1 ramp, angle too steep	Grave road. 1 ram
Elevators	Voice activated with Braille	X	No need for elevators – office on ground floor	X	Do have elevators – 3 out of order	X	X
Bathroom	X	X	X	X	Located on the first floor	X	-
Passages	Wide enough	Wide enough	Wide enough	Wide enough	Wide enough	Wide enough	-
Parking	X	X	X	X	X	X	-

4.3 Programmatic (including Communications) and Attitudinal Accessibility

Table 4: Disability-related programmes/organisational interventions

Programmes/Interventions Related Specifically to Disability	NGOs	SAPS
Disability–related staff training	2	-
Coordinated programmes with other service- providers	3	-
Advocacy and awareness around violence against women with disabilities	2	-
Total	8	4

Of the twelve service providers reached through this small survey, seven felt there was sufficient competency in their organisations to deal with issues of disability and violence against women. Most were of the opinion that if women with disabilities were to access their services they would be treated sensitively and fairly, and that the few clients seen did not reflect poorly on the appropriateness or quality of their services.

While some of the informants believed that women with disabilities were highly vulnerable to gender-based violence, they rationalised that women with disabilities were choosing not

to seek help and gave this as the main reason why few women with disabilities were presenting at their organisation for assistance. This is, however, contradicted by the findings of this small survey which point to a correlation between those organisations actively working to include disability in their activities and communications strategy, and the number of abused women with disabilities seeking assistance from their organisation.

Hence, those organisations that were making themselves accessible were seeing more abused women with disabilities, while those organisations that were not accessible were not seeing women with disabilities. This indicates an important attitudinal blockage to organisational transformation that would need to be vigorously addressed if abused women with disabilities are to enjoy adequate and accessible support services.

Training and awareness-raising is a key organisational intervention to build knowledge and understanding about disability, challenge misconceptions and biases on the part of service providers, and enable an organisation to introduce programmes and interventions that are appropriate and relevant to abused women with disabilities. Only two organisations (both NGOs) had undertaken training of staff on disability-related issues. None of the SAPS informants interviewed had participated in training or awareness programmes around disability, or had knowledge of the SAPS having undertaken such training. While the majority of the respondents interviewed were of the opinion that focused training on disability and gender issues was required to enable them to improve their delivery of services, most of the organisations did not have such training built into their present business or strategic plans, neither did they have such commitments for the future. Some respondents cited budgetary constraints as the major challenge to training.

In the absence of knowledge and understanding about the circumstances, experiences and needs of women with disabilities that are confronting gender-based violence, an organisation and its staff are not positioned to offer appropriate services.

Most organisations do not have specific guidelines or protocols for managing cases involving women with disabilities. Informants reported that staff members are required to be flexible and adapt existing guidelines to the needs of the client at hand. According to informants from organisations that are specifically dealing with issues of gender-based violence, they 'offer the same services to women with and without disabilities.' However, one of the NGOs that more regularly services abused women with disabilities had noted that women with disabilities experience problems accessing services and also experience secondary victimisation by service providers. In acknowledging the special circumstances and needs of women with disabilities, their organisation had resolved to develop a 'one stop' service for women with disabilities. At the time the research was undertaken, some of their immediate plans included relocating one of their offices to a physical space accessible to people with disabilities, as well as orienting their annual strategic planning session to focus on disability. Finally, the organization was planning to undertake a survey of abused women with disabilities to better understand their experiences of abuse and the barriers they confront accessing support services, with a view to informing the reorientation of their organisational services.

Services offered to women with disabilities, across all service organisations, include the following:

- Advice and information on legal rights and options, including assisting women lodge assault cases and/or apply for protection orders against abusive partners;
- Counselling of women with disabilities;
- Mediation between women with disabilities and their partners (reported by two organisations);
- Assistance with applications for disability grants; and
- Facilitating access to emergency shelters for victims of abuse.

Informants pointed to a number of barriers they confront providing services to women with disabilities. Firstly, informants noted that there are no shelters for women with developmental, psychiatric and learning disabilities. A shelter manager from one of the service organisations thought that the incorporation of women with such disabilities into existent shelters would not be feasible. In her perception, women with non-physical disabilities require constant supervision and care. Shelters seek to promote independence, self-care and mutual assistance between the residents. She felt that women with developmental, psychiatric and learning disabilities may not be able to contribute to communal tasks, and could become a source of frustration to other women in a shelter. The accuracy of this perception has yet to be tested in practice. But until such time as shelters take up the challenge to investigate what is feasible and what not in accommodating the particular needs of women with non-physical disabilities, this remains a shortfall in service provision.

A second major barrier to service provision to women with non-physical disabilities is that of credibility. Informants indicated that police officers usually disbelieve reports of abuse from women with psychiatric or developmental disabilities and such cases are usually not investigated. Even if the case reaches the courts, women with mental and developmental disabilities are usually regarded as incompetent witnesses to their own abuse.

A third barrier mentioned by three service organisations was the difficulty of women with mental or developmental disabilities accessing services independently. Their experience was that these women were deeply dependent on others, and required the assistance of family or friends to report cases of gender-based violence, and gain access to emergency shelters.

Only a minority of the organisations reached in this survey undertook coordinated programmes with other service providers. Most informants from NGOs indicated that their organisations prefer to refer abused women with disabilities to other service providers that are better able to assist them. The implication here is that women with disabilities, who are poor and experience mobility constraints, may sometimes experience one or more referrals before they are assisted. It is unclear what impact the referral approach may have on women with disabilities' efforts to seek assistance.

Most of the organisations had not led on or participated in advocacy campaigns related to disability and gender-based violence, with one informant mentioning the high costs involved in campaigning work. One NGO mentioned their efforts to lobby local ward councillors on the issue of violence against women with disabilities, with a view to having local government play a more active role in this arena.

In terms of their communication and information strategies targeting women with

disabilities, only two organisations actively advertise their services to disabled women and children, and they are two of the three organisations that report the highest number of cases involving abused women with disabilities. This finding clearly suggests that an appropriate information strategy is a key factor in effective service provision for women with disabilities. None of the organisations reached, however, has developed information materials appropriate to women with hearing and visual disabilities. Most informants indicated that their organisations do not have the funds necessary to produce material in Braille, on audiocassettes or in storyboard form.

Two of the organisations reached through this survey indicated that their organisation would be better positioned to offer support to Deaf women if they could employ or recruit in women who were proficient in sign language.

4.4 Financial Accessibility

None of the organisations surveyed charge fees for services rendered and are hence accessible to women with and without disabilities. However, many of the organisations cited financial constraints as a barrier to expanding and sophisticating their services to make them more accessible to women with disabilities. Specific mention was made of the costs of organisational training on disability and gender based violence, the production of alternative information materials and targeted campaigns. Some informants noted that there are limited financial resources available for work in the field of disability more generally.

The majority of the informants mentioned that women with disabilities confront considerable economic hardship, as compared with non-disabled women. The transport costs associated with a visit to a service organisation, and subsequent follow-up visits to follow through on decisions, place a tremendous financial burden on women with disabilities.

Informants recommended that government implement life and vocational skills training programmes to equip women with disabilities with the capacity required to become more economically independent. Some commented that the disability grant is inadequate to cater for the needs of women with disabilities, and their dependents, and that a more sustainable approach should be pursued by government.

4.5 Conclusions of Survey

While many of the informants from service organisations reached through this survey were aware of and concerned about violence against women with disabilities, their organisations were, in the main, failing to address the needs of this specific, and very neglected, constituency.

The survey sought to measure, drawing on Anello's five components of access, the accessibility of services along the following axes: physical, procedural, communication, attitudinal and financial. The survey has found that the services of the organisations reached are, with a few exceptions, generally not accessible or appropriate to the needs of women with disabilities.

In terms of *physical accessibility*, some informants and their organisations were aware of

the need to make their organisations physically accessible. Whether by coincidence or design, the major innovation to ensure physical accessibility is the introduction of ramps, found in seven of the twelve offices. We found that most organisations (nine of the twelve offices) had wide passages, an important accommodation to people in wheelchairs.

In the main, we found that service providers had a limited notion of physical accessibility, which restricted innovation to people with disabilities that relate to restrictions in mobility. Specific provisions for people with visual or hearing disabilities – such as voice-activated or Braille-numbered elevators and large-lettered or illustrated direction boards - were largely absent. This limited understanding of the needs of women with different disabilities results in Deaf and blind women being particularly neglected from services as their needs vary considerably from quadriplegic and paraplegic women, with communication access taking precedence over physical access.

In terms of *procedural, attitudinal and communication accessibility* – aspects that are closely interrelated – the majority of service organisations, at the time the research was conducted, were not faring very well. Only two of the ten organisations had undertaken any internal organisational disability related training. None had introduced specific programmes dealing with women with disabilities, or modified their internal organisational procedures and guidelines to accommodate the particular needs of abused women with disabilities. Most of the organisations were not undertaking any campaigning or lobbying on the issue of women with disabilities and gender-based violence. Only two organisations were actively advertising their services to disabled women and children, and they were two of the three organisations that reported the highest number of cases involving abused women with disabilities. At the time of the research, none of the organisations reached had developed information materials - in Braille, on audiocassettes or in storyboard form - appropriate to women with hearing and visual disabilities, and none had employed or recruited in support workers that were able to communicate in sign language. No shelters exist to accommodate women with mental, learning or developmental disabilities. While many informants – especially from the NGOs reached through the survey – acknowledged the shortfalls in their organisational programmes and services, they highlighted financial constraints as the major barrier to addressing communication, training and support gaps.

The majority of informants from organisations that have a specific focus on domestic violence were of the opinion that their services were relevant and appropriate to all women, disabled and non-disabled. However, given the very limited interaction organizations have had with disabled women and, as a consequence, the limited feedback they have probably received around the appropriateness of their services, this position is open to challenge. Research indicates that violence perpetrated against women with disabilities is often idiosyncratic to the disability and does not necessarily follow the same patterns as those found in non-disabled groups. While the majority of organisations are providing invaluable services to women confronting gender-based violence, and doing so with limited financial resources and capacity, the failure to accommodate the particular needs of women with different disabilities results in their continued marginalisation and neglect.

In terms of *financial accessibility*, the survey found that none of the organisations charge for the services they render to the public. However, some informants did note that women with disabilities, as compared with non-disabled women, confront particular financial constraints, which impinge on their ability to access services. Specific mention was made

of transport costs. The irony here is that while informants note transport as a particular constraint to access to services for women with disabilities, they indicate that their organisations often refer women with disabilities on to other service providers, which results in these women incurring further cost. Since we did survey women with disabilities we cannot conclude whether transport costs are a major barrier, and the effects of onward referral on women with disabilities' efforts to seek assistance.

Our study also suggests that women with disabilities may confront difficulties in accessing information and appropriate support. The SAPS informants demonstrated a particularly limited understanding of issues related to disability generally, and gender-based violence against women with disabilities in particular (hence our discarding of most of their interviews). Amongst the balance of the informants, however, while we found some sympathy and concern for the needs of abused women with disabilities this did not necessarily translate into a solid and informed understanding of what this would mean for the transformation of organisational services to accommodate the particular needs of women with disabilities. While our survey findings confirm that disability indeed remains a largely 'invisible' issue, we believe that the research process, which opened opportunity for service providers to reflect on the orientation of their services, and the accessibility of these to abused women with disabilities has opened space for critical reflection and may trigger organisational transformation efforts to make services more accessible to a significantly neglected and marginalized grouping of women.

Section 5: Recommendations and Conclusions

This exploratory research study on violence against women with disabilities strongly indicates that women with disabilities are extremely vulnerable to gender-based violence, that the violence and abuse they confront is shaped by the nature and form of their particular disability, and that they are especially disadvantaged in their access to the criminal justice system and gender-based violence support services, as compared to women without disabilities.

5.1 Recommendations

As previously discussed, there is a paucity of research on the problem of violence against women with disabilities, which only recently has begun to be addressed mainly in the North American context. While the survey of the international literature enriches our understanding of the problem, and highlights possible areas for intervention, the context is different and therefore places limitations on the application of these research findings. In the absence of a body of research on violence against women with disabilities in the South African, or comparable, context we do not feel confident to propose wide-ranging, long-term recommendations. We have elected to draw on the INDS policy framework, the findings emerging from our small survey, complemented by some of the key issues emerging from the international literature, to formulate recommendations that could feasibly be implemented, in the short to medium term, to reduce the numerous vulnerabilities of especially poor, black women with disabilities to gender-based violence, and increase their access to the criminal justice system and appropriate support services.

5.1.1 Advocacy and Awareness

In spite of government's vision and commitment to promote 'unity in diversity,' people with disabilities are amongst the most marginalized, 'invisible' members of our society. They are particularly disadvantaged in their access to education and employment opportunities, which results in extremes of economic marginalisation and impoverishment for people with disabilities and their families. As a result of South Africa's racially discriminatory history, black people with disabilities confront particular socio-economic disadvantage. Women with disabilities, like their non-disabled counterparts, are subjected to gender discrimination, which proscribe and limit their roles, behaviour and contributions in family and society. Women with disabilities, however, experience particular forms of discrimination and prejudice related directly to their gender and disability, which may further limit their participation in and enjoyment of a full life in family and society.

This exploratory study has constructed an analysis that intersects the social factors of race, class, gender and disability, arguing that the social and economic location of different groups of people, and especially women, with disabilities determines their lived reality, the discriminations and disadvantage they confront, and following on from this, their particular needs in terms of governmental and non-governmental intervention for redress.

The various myths and negative perceptions held about different groups of people, especially women, with disabilities must be debunked and, to this end, the INDS has proposed an integrated awareness campaign targeting all levels of government and society, which has yet to be implemented. While there is need for general campaigning for the rights of people with disabilities, there is need to ensure a clear gender perspective to this work. In particular, the problematic of violence against women with disabilities, with emphasis on the specific vulnerabilities that arise from different disabilities, and the myths associated with these, should come into the purview of campaigns undertaken by both government and the NGO sector. Ongoing campaigning on gender-based violence, undertaken by government and NGOs, should also attend to the issue of violence against women with disabilities.

5.1.2 Networking and Collaboration

This exploratory study has revealed that most organizations work in silos with limited interaction and collaboration across line function departments, NGOs, and between government departments and NGOs engaged in sectoral work on disability and violence against women. While the INDS has sought to foster the creation of intra-and inter-government department working forums on disability, this strategy has, to date, not yielded much success. Our survey of organisations working in the field of disability and violence against women, has pointed to the importance of cross-sectoral collaboration in fostering programmes that are better positioned to respond to the particular needs and problems confronting abused women with disabilities.

Collaborative and coordinated programmes between NGOs, and between line function departments in government, as well as joint programmes across the two sectors could lead to more accessible, appropriate and cost-effective services for abused women with disabilities.

5.1.3 Promoting Accessible Services

Our small survey of non-governmental and governmental organisations that have a role to play in supporting abused women with disabilities indicates a low level of awareness of the multiple layers of vulnerability confronting different groups of women with disabilities, the particular constraints they confront gaining access to the criminal justice system, and their needs of support organisations. There is a general failure to acknowledge differences that arise from disability, and to mould policies, programmes and protocols for the provision of service to accommodate abused women with disabilities. This confirms a key tenet of the social model of disability, which is that discrimination and marginalisation confronted by people with disabilities arises from the failure of the 'disabling' world to acknowledge difference, and organise appropriate responses that accommodate differences in experience, social location and need.

There is need for disability-awareness and integration training across all governmental and non-governmental organisations that have a role to play in dealing with the socio-economic needs of people with disabilities, and also of abused women with disabilities. The INDS has identified disability-integration training as a key strategy for advancing the rights of people with disabilities, which commitment has been partially addressed by the OSDP through the training of representatives from various national government departments to integrate disability into all mainstream departmental programmes. The OSDP is challenged to consider how to facilitate such training, which must be gender-sensitive, at other levels of government, with particular emphasis on those departments – principally safety and security, justice, health, and social services – which represent the points at which abused women with disabilities will make first contact with the governmental system for assistance.

Non-governmental service providers are also challenged to build greater awareness on issues of disability and violence against women, and evolve new or reorient existing programmes and services to the needs of abused women with disabilities.

None of the services providers surveyed have internal capacity to communicate with clients in sign language, an aspect which requires attention in any effort to reorient services to accommodate the needs of women with extreme hearing disabilities.

Access to services hinges, to a greater extent, on target beneficiaries being informed about their rights, understanding what constitutes violence and abuse, and their knowledge of the range of services that are available. This report suggests that many women with disabilities, especially those of a developmental nature, are unable to recognise their experiences of abuse as a violation requiring redress, and in addition cannot obtain information about available support services.

This study has found that there is currently no material on gender-based violence available in Braille, on audiotape or in large font format. It is unclear how many service providers have been able to publicise information, including their services, through the medium of radio, particularly appropriate to women with visual disabilities. While financial constraints have been identified as a key factor inhibiting the development of information strategies that are capable of reaching different groups of women with disability, initiatives involving collaboration across government, and victim and disability service providers could result in

the cost-effective production of such materials.

One of the key findings of this survey of service providers, which confirms the international experience, is that there are no dedicated shelters for women with disabilities. Women with disabilities, especially of a developmental nature, will require shelters with special physical design provisions and a higher level of care than may ordinarily be required in shelters catering for non-disabled women. Government and NGOs are, therefore, challenged to consider how best to respond to this extremely important, but as yet, unmet need.

It has been noted previously that women with disabilities often suffer low self-esteem, primarily due to their social isolation and the absence of appropriate role models. The practice for many organizations dealing with gender-based violence has been to recruit volunteers and staff who are survivors of violence, and women passionate about such issues. By consciously recruiting women with disabilities as volunteers or paid staff, organizations would be positioned to gain first-hand knowledge of the experiences and needs of women with disabilities, which perspective can inform the reorientation of or introduction of new support services and methods for working with abused women with disabilities. Women with disabilities, serving in a volunteer or paid capacity within organisations, could also serve as mentors or role models for women with disabilities. The facilitation of support and discussion groups to help build the self-esteem and confidence of women with disabilities should also be considered.

The OSDP-commissioned survey of 18 national government departments, and our small-scale survey of service providers, has pointed to the numerous physical barriers to services that exist for people with different disabilities. Barriers that have been identified include physically inaccessible entrances and ablution facilities, the absence of lifts, Braille and large print signage. To ensure that women with disabilities who have been victims of violence are not discriminated against in accessing the same services as non-disabled women seeking help, it is essential that courts, police stations, shelters, counselling centres and local service points for health care and social services are physically accessible to people with disabilities.

While cost constraints have been cited as a factor impinging upon the ability of organisations to offer accessible services, it is worth noting that when the criterion of accessibility is built into the original design of a built environment, the additional costs usually lie in the range of 0.2% of the overall cost of development (INDS, 1997). For organisations already located in office space that is physically inaccessible, every effort should be made to improve accessibility within existing financial means, and ensure that the criterion of accessibility guides any future leasing or purchase arrangements for offices and shelters.

The survey of the international and (limited) national research points to the exclusion of women with particular disabilities from access to justice. Abused women with hearing difficulties face particular exclusion from the courts, as the 2001 Morgan study indicates. The various obstacles to women with disabilities' access to justice requires further investigation, but a minimum immediate intervention that is required is the introduction of certified court interpreters for women who are hard of hearing or Deaf.

5.1.4 Policy, Monitoring and Research

While there is an existing policy framework, the INDS, that outlines key recommendations and strategies to guide the formulation of policies, laws and programmes of government, the OSDP and other stakeholders working in the field of disability have noted the difficulty of operationalising its vision, strategies and recommendations. And while the OSDP has been tasked with responsibility for supporting government departments integrate disability issues into mainstream work, and monitoring the implementation thereof, the OSDP lacks the capacity required for this mammoth task, as well as its wider agenda of promoting and advocating the rights of people with disabilities throughout government and society as a whole.

The OSDP review of 18 national government departments and other complimentary studies, point to the disjuncture between the INDS, which is founded on the social model of disability, and the continual pursuit of a welfare approach and practice throughout the public sector. People with disabilities remain on the fringe of mainstream policies and programmes, which fail to recognise and accommodate their needs for shelter, employment, education and training and basic social services. The pursuit of the principle of integration, so central to the social model approach, has led to the abandonment of even dedicated programmes, and the failure to allocate sufficient budgets to meet government commitments to address the needs of people with disabilities. In the absence of political will, and the associated commitment of human capacity and finances, to address the human rights of people with disabilities, the social, economic and political inequities that marginalize people, and especially poor black women, with disabilities will remain firmly in place.

As has been noted previously, the issue of disability and especially violence against women with disabilities has been neglected as an area for research. Research is needed to develop greater understanding of the issue with a view to informing law, policy and programmes, and also with a view to evaluating the impact of these. A key challenge to research on violence against women with disabilities is conceptual, that is traditional conceptualisations and definitions of gender-based violence are generally exclusive of the experiences of women with disabilities. Organisations working in the field of violence against women are challenged to reframe their thinking of violence against women to consider the particularities of violence against women with disabilities. This establishes part of the immediate research agenda and that is to uncover the particular vulnerabilities that different groups of women with disabilities experience, the forms that gender-based violence against women with disabilities takes, the peculiar constraints that women with different disabilities confront escaping abusive situations and obtaining access to support services.

5.2 Conclusion

Violence against women with disabilities arises in the context of a society that is both patriarchal and discriminates against people with disabilities. For black African women that are disabled, they confront an additional layer of discrimination and disadvantage that originates in a history of institutionalised racism, the effects of which remain with us today. Until this discrimination is weeded out, and until people with disabilities, and especially black African women, have obtained their rightful status as human beings, able to claim and exercise the various rights to which they are entitled, violence against women, and

particularly black women with disabilities, will continue to ravage its way through our society.

The words of "Rose" a black South African woman, blinded by her abusive husband, and at the time of the interview an activist for the rights of people with disabilities and for survivors of violence against women, are significant here:

> If only the society can be made aware of these things [violence against women], be educated about these things. That we shouldn't be quiet about the situation happening in front of our very eyes… What is being done about these cases that are being reported… Nobody cares… You have to sit and shut up. I'm trying to practice advocacy for disabled people. The abuse that is [suffered] by disabled people [both male and female] is not acceptable at all.

Women with disabilities, like their non-disabled counterparts, are subject to gender-based violence and abuse. Both groups of women are subjected to secondary victimisation by a society that undermines the severity of the problem and its consequences for affected women, their families, their communities and wider society. This exploratory research has pointed to the particular economic, social and psychological vulnerabilities to abuse which women with disabilities confront.

Women with disabilities are not only more vulnerable, but experience very particular forms of abuse, not yet fully understood and encapsulated in conventional definitions of gender-based violence, and which directly link to the specific type of disability. Because of the stigmatisation of disability, and the resultant social isolation, women with disabilities may endure violence for longer periods of time than their non-disabled counterparts. Women with disabilities, depending on their severity, may be extremely dependent on caregivers - a dependency which itself creates opportunity for the perpetration of violence and abuse and which limits their options for escaping an abusive relationship.

Service providers, government and non-government, do not have an adequate understanding of the experiences and needs of women with disabilities. As a result information often does not reach these women, and the orientation and content of services is often inappropriate and inadequate. The international research, and our own small survey of service providers, suggests that services may be inaccessible and inappropriate on a number of levels: physical, attitudinal, procedural and in terms of communication. While government has established a disability policy framework, the INDS, this has to date substantively failed to ensure the integration of disability issues and concerns into mainstream government programmes, and fails to attend to the gender dimensions of disability, particularly gender-based violence.

While this study has only focused on access to services for abused women with disabilities in the urban context, the situation for women in rural areas, characterised by poor infrastructure, low access to basic services, and higher poverty levels, will be far worse. This represents an important focus for further research on violence against women with disabilities.

Government and NGOs are challenged to conceive of women with disabilities as citizens

with rights and entitlements, rather than dependents in need of charity and special care. Seeing disabled women as citizens with rights places a duty on both government and civil society to contribute to the realization of those rights. Seen in this way, addressing the intersections between disability, gender and violence becomes less an act of charitable kindness than a social imperative.

Notes:

[1] The 'Victims of Crime Survey' conducted by Statistics South Africa found that approximately half of all women who admitted to having been raped reported the matter to the police (Hirschowitz, Worku and Orkin, 2000) while the Medical Research Council's report on violence against women in three provinces found that one quarter of women raped in the year prior to the study reported the matter to the police (Jewkes et al, 1999).

[2] Defined as one or more people that assist another person with tasks that they would typically do if they did not have a disability. PAS may be paid or unpaid family members and/or friends, or paid personnel.

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