GENDER-BASED VIOLENCE AMONGST WOMEN WITH DISABILITIES: A CASE STUDY OF MWENEZI DISTRICT, ZIMBABWE

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ABSTRACT

This article is based on a study of gender-based violence against women with disabilities. The study sought to examine the factors that make such women vulnerable, to investigate the community's responses to gender-based violence against women with disabilities, and to determine the impact of gender-based violence on the wellbeing and health of women with disabilities. The study adopted a qualitative research design so as to arrive at an in-depth understanding of the phenomenon under study. The study sample consisted of 48 disabled women living in marital or common law unions, selected using purposive sampling. Of the 48 women in the sample, 16 were visually impaired while the remaining 32 had other physical disabilities. Focus group discussions were used for data collection. The data were analysed using the thematic approach. The finding was that women with disabilities also experience gender-based violence. The study makes recommendations whose thrust is to change community perceptions on disability as the only guarantee towards eradicating gender-based violence against women with disabilities.

Keywords: disabilities, gender-based violence, sexual violence, women with disabilities

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INTRODUCTION AND BACKGROUND TO THE STUDY

Globally, the population of people living with disabilities is estimated at 15 per cent (WHO 2011). Worldwide, estimates are very high of violence against people with disabilities (INWWD 2010). As noted by Hightower and Smith (2003), over 55 per cent of people with disabilities are more likely to encounter abuse than non-disabled persons. Young, Nosek, Howland, Chanpong and Rintala (2009) also suggest disparities in terms of risks of abuse facing people with disabilities, compared to those without disabilities. The International Federation of Social Workers (IFSW 2012) estimates the percentage of people living with disabilities worldwide to be between 18 and 20, with more than half of them being female. Handicap International (2013) estimates that women with disabilities constitute 19.2 per cent of the global female population. While increasing research is being done on the abuse of women in general, there is a paucity of research on the abuse inflicted on women with disabilities (Naidu, Haffejee and Vetten et al. 2005; Plummer and Findley 2012). Some studies have shown that women with disabilities experience gender-based violence (Curry et al. 2001; Naidu et al. 2005). While violence against women with disabilities shares characteristics with violence against women in general, it has unique dimensions as well (INWWD 2010). The International Network of Women with Disabilities (INWWD) (2010) observes that being a woman and having a disability increase the likelihood of experiencing violence. According to Costella (2005), women with disabilities are two to ten times more likely to be abused, either physically or sexually, by a family member or caregiver. UNIFEM (2008) found that 22.3 per cent of disabled women between the ages of 15 and 49 in many rural districts of Zimbabwe have experienced gender-based violence.

In 2007, the government of Zimbabwe enacted the *Gender Violence Act*, which criminalises any act which can be defined as gender-based violence. Zimbabwe is also signatory to a number of regional and international treaties and conventions which seek to empower women in all spheres of life. These include the Southern Africa Development Community (SADC) Protocol of 2008, the OAU's African Charter on Human and People's Rights on the Rights of Women of 2003 and COMESA Gender Policy of 2002. Zimbabwe is also a signatory to the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW 1991), the Beijing Declaration on the Platform for Action of 1995, the International Convention on Civil and Political Rights (CCPR) of 1976, the International Labour Organisation's Equal Remuneration Convention of 1953, and the International Convention on Economic, and Social and Cultural Rights (ECOSOC) of 1976. Despite the presence of disability-related laws in Zimbabwe, not much seems to have been done to protect the rights of women with disabilities. As a result, the government has received a barrage of criticism for its complacency in dealing with the violation of the rights of women with disabilities (Astbury and Walji 2013). Jekayinfa (2004) argues that by remaining nonchalant while people's rights are being violated, the government of Zimbabwe appears to be complicit in the violation of these

rights. Despite the profound importance of understanding gender-based violence against women with disabilities, the issue is still under-researched in Zimbabwe.

PROBLEM STATEMENT

According to Karangwa and Kobusingye (2007), women with disabilities face a gender-based violence epidemic of monumental proportions in Zimbabwe. A dearth of literature on the experiences of abuse suffered by women with disabilities in the country has contributed to the lack of policy attention to the problem of gender-based violence against such women. Mtetwa (2001) observes that in Mwenezi, many seem to condone violence targeted at disabled women, who also tend to be treated as sick people in need of medical attention. Myths about disability often put the lives of disabled women in a precarious position (Mpofu, Kayisara and Mhaka et al. 2007): included here is the perception that women with disabilities are devoid of sexual feelings and therefore do not engage in sexual activities (Chikumbu 2014). Some media reports have it that certain local traditional healers and spiritualists recommend sexual intercourse with disabled people as a cure for HIV/AIDS to their clients (Mapimhidze 2014). It is against this background that the present study sought to investigate the experiences of gender-based violence by women with disabilities, using the Mwenezi District of Zimbabwe as a case study.

RESEARCH OBJECTIVES

The main aim of the study was to investigate gender-based violence against women with disabilities in Mwenezi District, Zimbabwe. More specifically, the study was guided by the following research objectives:

- To establish what factors put women with disabilities at risk of being victims of gender-based violence;
- To investigate the community's response to gender-based violence against women with disabilities;
- To determine the impact of gender-based violence on the wellbeing and health of women with disabilities.

LITERATURE REVIEW

There is no universally accepted definition of gender-based violence. The breadth of the concept is the main reason why it still lacks a unitary and widely accepted definition, with existing definitions varying in sense and application (Afaf 2006). Costella (2005) defines gender-based violence as any act or attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the survivor,

in any setting including (but not limited to) home and work. Hanass-Hancock (2008) defines gender-based violence as any harmful act that is perpetrated against a person's will, including acts that inflict mental, physical or sexual harm. Gender-based violence is also described by Karangwa and Kobusingye (2007) as violence involving women and men, in which women are usually the victims. This study adopts Hanass-Hancock's (2008) broad definition of gender-based violence as any harmful act that is perpetrated against a person's will, including acts that inflict mental, physical or sexual harm.

Newman, Christopher and Berry (2010) posit that there is evidence that people with developmental disabilities are at greater risk of violence. Developmental disabilities usually include life-long physical and/or mental disabilities that manifest in an individual before the age of 22. According to Lightfoot (2006, 53) these disabilities limit an individual's 'capacity to engage in major life activities such as independent living, mobility, language, learning, working, decision making and self-care'. Valenti-Hein and Schwartz's (2005) studies in Mexico revealed that more than three million crimes were committed against people with developmental disabilities, compared to 1.2 million child abuse cases and one million instances of elder abuse. Studies by Jacobson and Richardson (2007) also revealed that more than 90 per cent of people with developmental disabilities have experienced sexual abuse at some point in their lives. Similarly, studies on women in Toronto showed that 33 per cent of those with disabilities were physically abused, compared to 20 per cent of those without disabilities. Furthermore, Dickman and Roux (2005) found that women with physical disabilities experienced emotional, physical and sexual abuse. More than 16 per cent of women reported being abused in Kenya, while 59 per cent reported being abused in Ethiopia (Nosek et al. 2006).

The most common perpetrators of violence against women with disabilities are their male partners (Brownridge 2006). Findings by Groce and Trasi (2004) in Canada revealed that more than 56 per cent of women with disabilities reported their abusers to be their male partners. These findings are in line with those by the Disabled Women's Network of Canada, which showed that the most common perpetrators of gender-based violence against women with disabilities were their former or current intimate partners (Braun and Clarke 2006). When women with disabilities are sexually abused by their male partners, they are either ignored by families or sometimes perceived as not having the ability to give substantive evidence.

There is general agreement amongst scholars on the risk markers for violence against women with disabilities (Munyandamutsa and Mahoro 2009; Naidu et al. 2005; Nosek, Howland and Hughes 2011; World Bank 2009). According to Del Rio (2013), women with lower income and higher levels of physical dependence are more likely to be victims of gender-based violence than their counterparts. Munyandamutsa and Mahoro (2009) observe that many women with disabilities have low levels of educational attainment, which limits their employability and makes them dependent on their male counterparts for their day-to-day survival. This also makes them vulnerable to abuse by those on whom they are economically dependent. The more educated a woman with disabilities is, relative to her partner, the more power she has in the relationship and

the less likely she is to be abused (Collins 2006). The World Bank (2009) observes that women with disabilities are more likely to be illiterate, unemployed or just marginally employed, than those without disabilities. As observed by Nosek, Howland and Hughes (2011), low educational attainment by women with disabilities is a stumbling block to employment. Naidu and others (2005) state that while factors such as high levels of dependence on care-givers, social isolation, discrimination and lack of information make women with disabilities vulnerable to gender-based violence, the lack of economic independence has been widely cited as the key risk factor.

Becker (1997) postulates that myths surrounding disability increase the likelihood of victimisation for disabled women. The sexuality of women with disabilities is often denied or ignored, and there is pervasive stereotyping of disabled women as asexual (Nosek et al. 2007). Consequently, they are considered virgins and therefore more likely to experience virgin cleansing or virgin rape (Groce and Trasi 2004). In many developing countries, the body of a disabled woman is viewed as unable to reproduce (Becker 1997). Disabled women are thus prevented from fulfilling normative gender roles of reproduction and motherhood, resulting in increased difficulties for them to access reproductive healthcare services.

Women with disabilities are unlikely to receive sex education or information on reproductive health (Naidu et al. 2005). They are assumed to be ineligible for marriage, are deemed more likely to be divorced and are less likely to marry than women without disabilities (Gerschick 2000). As a result of the myths surrounding their asexuality and ineligibility for marriage, it is often assumed that women with disabilities do not have intimate partners and therefore do not need sex education. This stereotyping may be internalised by women, leading to their self-devaluation and poor self-esteem (Hassouneh-Phillips and McNeff 2005). The fear of being rejected and being alone may force them to stay in abusive relationships. Since they are perceived as 'other', women with disabilities are often objects of men's sexual fantasies (Naidu at al. 2005).

Gender-based violence against women with disabilities takes various forms: it can be psychological, physical, economic, emotional or sexual. It can be either active or passive (ibid.). Studies by Killen (2004) in Venezuela, for instance, revealed that more than 56 per cent of females with disabilities had been targets of wolf-whistling at least three times in their lives. Getting whistled at by men is a near universal experience for women in most African countries. This is usually accompanied by sexually explicit comments, groping, masturbating, and stalking (Choruma 2007). These behaviours are degrading, annoying and infuriating. As argued by Chiparaushe, Mapako and Makarau (2011), wolf-whistling is so common because many countries do not have proper legislation to battle street harassment against women in general, or those with disabilities in particular. There are forms of violence against women with disabilities that are not immediately visible as violence, because they are either legalised or accepted in society. Some women with disabilities have been subjected to forced sterilisation. As observed by Karangwa and Kobusingye (2007), forced sterilisation continues to be justified by

many governments, as well as legal and medical practitioners, as being in the 'best interests' of girls and women with disabilities. However, Hightower and Smith (2003) argue vehemently against this practice.

METHODOLOGY

The present study was carried out in Mwenezi District, which is part of Masvingo, one of the ten provinces of Zimbabwe. The district falls under Zimbabwe's agro-ecological Region Five, which is characterised by low and erratic rainfall. It shares borders with the Mberengwa and Zvishavane districts. According to the census of 2012, the district has a total population of 166 993.

This study was carried out using a qualitative research design, which involves an assortment of interpretative techniques, and seeks to describe, translate and come to terms with the meaning of phenomena. The study adopted this design because it sought to obtain in-depth information on gender-based violence, in order to understand its underlying causes and impacts. As explained by Leedy and Ormrod (2007), the main purpose of qualitative research is to understand an experience from the participant's point of view. It offers the chance to make meanings of both spoken and unspoken responses, and to understand first hand the experiences of the subjects of investigation. Furthermore, qualitative research offers flexible ways to carry out data collection, analysis, and the interpretation of collected data, and provides a holistic view of the phenomena under investigation (Matveev 2002). A qualitative research design also fosters a closer relationship between the researcher and the researched (Polit 2001).

Sampling procedure and sample size

Mwenezi District was purposively selected because of the presence of a non-governmental organisation (NGO) which runs awareness programmes on gender-based violence amongst women with disabilities. Four wards from the district were purposively selected for the study. The records of the NGO working on disability in the district were used to ascertain the availability of units of observation (people with disabilities) with the required characteristics (Mugenda and Mugenda 2003). Individual participants for the focus group discussions (FGDs) were selected through the snowballing technique. The chain referral process allowed the researcher to reach a population of disabled people that would have been difficult to sample using other sampling methods.

The sample consisted of 48 participants who were divided into four groups of 12 participants each. The composition of the groups was based on age, considering the sensitivity of the topic under discussion (Creswell 2009). FGD 1 was composed of those in the 16–20-year age group, group 2 of 21–30-year olds, group 3 of 31–40-year-olds, and group 4 of over 40s. Participants from the four wards were invited to meet at Mwenezi business centre, which was accessible to them all.

Data collection method

Data were collected using FGDs, which are a popular means of collecting data in the social sciences (Mason 1996). FDGs allow the researcher to obtain insight into the setting, context, environment and experiences of participants. An FGD yields a robust range of views and opinions on social perceptions (Yin 2011), and provides an opportunity for participants to probe each other's responses as well as the reasons why they hold certain views (Stewart, Shamdasani and Rook 2007). As Barr, McConkey and McConaghie (2003) state, focus groups have been used successfully in a number of studies on people with disabilities.

Data collection process

Before conducting the FGDs, the local authorities in Mwenezi were informed about the objectives and methodology of the study. Permission from the authorities was obtained prior to the commencement of the study, and participants were also informed about its nature, purpose, and use of the information they provided. Participant consent was obtained beforehand. Following Booth and Booth's (1996) advice, the study used direct questioning without abstract conceptual or time-oriented questions, working to develop a mutually trusting relationship and setting the agenda together. During the FGDs, participants were able to bring to the fore issues they deemed important and significant for them (Bryman 2001).

Linguistic barriers to participation in the FGDs were minimised by the use of first-language interviewers and through the provision of sign language interpreters for deaf participants. This was done because failing to consider the health and impairment-related circumstances of participants during an FGD can act as a barrier to its successful completion. We took particular care to be flexible during the discussions, allowing for multiple breaks in order to accommodate those participants who, due to their conditions, easily felt fatigued. All the FGDs were recorded using a tape recorder.

Data analysis

The data analysis from the FGDs followed a thematic analysis. These are the steps that were followed: familiarisation with the data, systematic reading, coding, searching, categorisation and generating of definitions, and interpretation.

Ethical issues

The study took into account the following ethical considerations: voluntary participation, confidentiality, anonymity and informed consent. The participants were informed that their participation was voluntary and that they were free to withdraw from the study at any time, without having to give reasons for their withdrawal and without incurring any

penalty (McMillan and Schumacher 2003). The objectives and process of the study were fully explained to the participants beforehand, leading to informed consent. Participants were also informed that the information they gave would not be disclosed to anyone but would be used solely for academic purposes. They were also assured that their identities would not be disclosed to anyone. Kaiser (2009) emphasises that confidentiality and anonymity should be guaranteed in qualitative research, so as to avoid harming the participants in any way.

FINDINGS

This section presents the findings of the study. These include the factors that put women with disabilities at risk of being victims of gender-based violence, the community's response to gender-based violence against women with disabilities, and the impact of gender-based violence on the wellbeing and health of women with disabilities. Participants in the four FGDs recounted their personal experiences of gender-based violence, mentioning this as the worst form of abuse they had ever experienced.

Factors that put women with disabilities at risk of gender-based violence

Nature and extent of disability

Many of the participants indicated that people with intellectual disabilities were the most vulnerable to gender-based violence, because intellectual disabilities limit an individual's ability to understand and remember what happens to them. Women with speech, hearing and visual impairments were also vulnerable to abuse, because these physical impairments limit their ability to escape violent situations:

> Persons with physical disabilities are vulnerable to sexual abuse because of their physical weaknesses .... blind women can be raped by their guides ... Those who are unable to talk are also vulnerable to rape because of their inability to shout for help when they are being attacked .... (participant, FGD 1)

> … my first sexual experience was rape ... I got to know sex when a young man who was staying with his father at our place raped me... (visually impaired participant, FGD 2)

The participant believes she was targeted because of her inability to see danger coming.

The speech-impaired, for example, are often victims of gender-based violence because they may not be able to shout for help when attacked. They may also be unable to communicate with other people or report the abuse. Visually impaired women were also said to be vulnerable because of their inability to identify the abuser. Men therefore tend to take advantage of these impairments to sexually abuse women with disabilities.

Low levels of education

The majority of participants were semi-literate, with some never having attended school at all, while others were primary or secondary school drop-outs. The participants generally believed that their low levels of educational attainment made them easy targets of sexual abuse. Most of those who had been victims stated that at the time they were abused they were not aware that their rights had been violated. Very few of them were aware that they had a right to report the abuse to the police, and that they could have access to health facilities after surviving sexual abuse. Education is crucial in dealing with gender-based violence, as it empowers the survivors to make informed decisions such as reporting the abuse to the police and seeking medical attention. A participant who had only completed primary school stated:

> … without education, it is difficult to know if some is violating your rights. Remember, is our culture we don't have thing such as gender-based violence. I only know it through radio that there is something called gender-based violence but I do not understand it.

A 23-year-old visually impaired participant stated:

> We are looked down upon because of our disability and lack of education. I only went up to Grade six and I can't speak English. I was afraid to go to the police because I thought they would ask me questions in English.

Poverty

Evidence from this study shows that poverty may result in some women with disabilities being forced into sexual acts, in exchange for money or gifts. A 20-year-old unemployed participant stated:

> I am not employed because I am not educated. I was not raped but I agreed to have sex with him after he gave me a dual SIM phone. It was out of desperation.

Women with disabilities in Mwenezi survive under harsh economic conditions. The government has stopped giving people with disabilities monthly disability grants, which used to cushion them economically. They have therefore been left at the mercy of the community. This exposes women with disabilities to sexual abuse, as some men take advantage of their desperation.

Community responses to gender-based violence against women with disabilities

Participants revealed that they were often sexually exploited by members of the community. Men often deceived them by promising to marry them when in reality all they wanted was to have sexual intercourse with them. Many of the women disclosed that they slept with men who had promised to marry them. However, most of the men

who promised them marriage turned out to be married themselves. Some, after sleeping with a woman several times, became ambivalent. One participant had this to say:

> He slept with me for years, promising to marry me then suddenly he wanted to dump me. He started telling me that his relatives were against the intended marriage.

Participants stated that they were stigmatised and discriminated against by the community:

> People with disabilities are not respected in Mwenezi … people can comment about your body structure anywhere, anytime …. (respondent, FGD 4)

> There is a problem with the mindsets of the community members. They see a person with a disability as a problem .... Some people in the community stereotype all people with disabilities as people who survive by begging. (respondent, FGD 3)

Participants expressed their views on how the community treats people with disabilities when they sought assistance or reported cases of gender-based violence:

> People with disabilities face a lot of risks of gender-based violence because the community does not take them seriously. If you have a disability nobody wants to listen to you because they think you are insane. (respondent, FGD 2)

A 27-year-old participant in FGD 1 echoed these sentiments:

> When a disabled person is raped, they keep quiet and try by all means to hide the evidence because they have no one to talk to.

This was corroborated by another participant from FGD 3, who stated that people with disabilities were never taken seriously by the community:

> ... members of the community used to laugh at me saying a deaf lady had been impregnated. The matter was not reported to any authority because I could not communicate as I did not have a sign language interpreter at the time.

Impact of gender-based violence on the wellbeing and health of women with disabilities

The existence of myths which propose having sex with a person with a disability to cure HIV/AIDS, often leads to the sexual abuse of women with disabilities. Participants revealed that some community members believe those with disabilities – especially deaf people – are free from HIV/AIDS. Such beliefs expose women with disabilities to HIV infection, as HIV-positive men are tempted to have sex with them, in the hope of being cured. A 24-year-old respondent explained:

> People in this community believe that when someone sleeps with a disabled lady they get cured of HIV/AIDS or get rich. There is also a belief that a lady with disabilities brings luck once

> raped. Some people also seem to believe that people with disabilities can never have HIV and AIDS.

Some participants claimed they were experiencing psychological trauma after surviving gender violence. This was exacerbated by the fact that most survivors of gender-based violence do not receive professional counselling. Coupled with stigmatisation, the lack of counselling left victims of gender-based violence traumatised, as is evident from the report of one such victim:

> Since that incident I have been experiencing severe headaches…. Every time I am alone I get panic attacks as I fear the worst. My heart would be pounding heavily … I am always stressed. There is no one who wants to listen to my story. All the people think that I started it. They all blame me. How can I survive when everyone is blaming me for something that is not my fault? (participant, FDG 1)

As a result of their experiences of gender-based violence, participants reported experiencing a lack of confidence and self-esteem. One unemployed participant narrated:

> I no longer feel like a human being. I feel as if all the people are talking about me. I can't participate in any event. I feel people will always accuse me of being a loose woman.

This was corroborated by single participants in other groups who pointed out:

> The experience leaves you in constant fear. Every time you feel useless. I feel it is better to die than to live with this experience. I can't contribute to any discussion in public for the fear of attracting attention. When people start whispering about what happened to you it is very depressing. You never know whether they sympathise with you or blame you for what happened.

DISCUSSION

Gender-based violence is a global phenomenon. Ulrich (2000) describes it as a 'global epidemic' which threatens and shapes every woman's life. There are, however, factors that make women with disabilities more vulnerable to gender-based violence than non-disabled women. According to the INWWD (2010), while violence against women with disabilities shares characteristics with violence against women in general, it has unique dimensions. Studies have shown that women with disabilities are more likely to be abused than their counterparts (Ballan and Freyer 2012; Del Rio et al. 2013; INWWD 2010). As observed by the INWWD (2010), being a woman and having a disability increases the likelihood of experiencing violence.

This study found that women with disabilities in Mwenezi District experience gender-based violence. The type and extent of their disability, and their level of educational attainment and of economic dependence were identified as factors affecting their vulnerability. A study by Del Rio et al. (2013) found that, among other things, abused disabled women had higher levels of physical dependence than non-victims.

Disabled women often fall victim to gender-based violence on the part of their caregivers. Perpetrators of gender-based violence against women are often known and close to the victim (Naidu et al. 2005). Physical impairment tends to impede women with disabilities from escaping violent situations (ibid.).

Education is a tool for personal empowerment. It facilitates economic self-sufficiency through formal or self-employment, and provides information for survival. This study confirms the World Bank's (2009) findings that women with disabilities are more likely to be illiterate, unemployed or just marginally employed than those without disabilities. Nosek, Howland and Hughes (2011) also assert that low educational attainment by women with disabilities is a stumbling block to employment. Gender-based violence is a crime and a human rights violation (INWWD 2010). However as the study shows, because of a lack of information, women with disabilities who experience gender-based violence may not be aware that their rights have been violated.

Poverty is an underlying factor in gender-based violence (WHO 2005). As found by Del Rio (2013), women with disabilities who are victims of gender-based violence are likely to have lower income than other women. Naidu et al. (2005) point out that a lack of economic independence amongst women with disabilities is acknowledged in international literature as a key risk factor in gender-based violence. Participants in this study reported experiences of abuse by men who took advantage of their poverty. The findings of this study are consistent with the risk factors identified by Curry et al. (2001) and the vulnerability factors noted by Hassouneh-Phillips (2005).

While the study found that gender-based violence is a reality among disabled women in the district under study, it did not establish the extent of the problem. As Naidu et al. (2005) point out, it is difficult to estimate the extent of gender-based violence against women with disabilities, because most of the violence goes unreported. Under-reporting is also found among non-disabled women; as Naidu and others state, certain factors prevent women with disabilities from reporting abuse, including a high level of dependency on caregivers who are often the perpetrators of the violence, social isolation, discrimination, lack of information and inadequate support services.

The way people think about or make sense of disability determines how they respond to those with disabilities. For example, some societies refuse to recognise that certain acts constitute violence (INWWD 2010). This study found that community perceptions of women with disabilities were generally negative. This supports the findings by Women with Disabilities Victoria (WWDV) (2014) that stereotypes of disability continue to inform societal practices that discriminate, devalue and marginalise. Regarding women with disabilities as 'other' makes them vulnerable to being treated as men's sexual fantasies.

The findings of this study also support those of Del Rio et al., that gender-based violence against women with disabilities is associated with women's lower levels of emotional wellbeing, psycho-social health and self-esteem. Participants who had experienced gender violence expressed feelings of constant fear, lack of confidence, low

self-esteem and depression as a result of the abuse. Although none of the participants disclosed having contracted HIV/AIDS as a result of gender-based violence, they expressed fears that the existing myths about the sexuality of women with disabilities expose them to infection.

CONCLUSION AND RECOMMENDATIONS

Women with disabilities are not spared gender-based violence. A number of factors make them more likely to experience such violence, including physical limitations which result in high levels of dependency on caregivers who are often the perpetrators of violence, low levels of education, and poverty. These are some of the factors that prevent women with disabilities from reporting the violence they experience. As a result, it is difficult to establish the extent of gender-based violence in Mwenezi. Community perceptions about disability to a very large degree determine the nature and extent of such violence against women with disabilities. As a result, any efforts to deal with gender-based violence against women with disabilities will have to aim, above all, at changing community perceptions. Without this change, gender-based violence against women with disabilities will continue to be trivialised. Based on the findings of this study, we make the following recommendations:

- Greater collaboration among the various stakeholders. Addressing gender-based violence among persons with disabilities requires a multi-sectoral approach. This requires collaboration among the various stakeholders, including government, politicians, NGOs, faith-based organisations (FBOs), traditional leaders and human rights groups. Together, they should come up with interventions to address issues of poverty, low levels of education, isolation and discrimination which women with disabilities face. Such efforts should be participatory and should include women with disabilities not just as beneficiaries or targets, but as partners;

- Community awareness campaigns. These should focus on the rights of people with disabilities in general and women with disabilities in particular. The campaigns should target local authorities, law enforcement agencies and health providers on how to handle cases involving women with disabilities;

- Provision of rights education for women with disabilities. This should focus on the women's rights over their bodies, their sexuality, and the right to justice;

- Encourage the formation of support groups for women with disabilities;

- The provision of disability-friendly health centres and police stations. This should include the provision of sign language interpreters in these establishments, the provision of information on braille and the establishment of toll-free helpline phone

numbers that women with disabilities can access in the event that they experience abuse;

- Ensuring access to inclusive sexual and reproductive health education by women with disabilities that is availed to people without disabilities, including HIV/AIDS education. Sexual health education should also be incorporated into programmes which seek to address the needs of people with disabilities, for example, rehabilitation services.

REFERENCES

Astbury, J. and J. Walji. 2013. *Triple jeopardy: Gender-based violence and human rights violations experienced by women with disabilities in Cambodia*. Phnom Penh: AusAID.

Ballan, M.S. and M.B. Freyer. 2012. Self-defence among women with disabilities: An unexplored domain in domestic violence cases. *Violence Against Women* 18(9): 1083–1107.

Barr, O., R. McConkey and J. MaConaghie. 2003. Views of people with learning difficulties about current and future accommodation: The use of focus groups to promote discussion. *Disability and Society* 18(5): 577–597.

Becker, G. 1997. *Disrupted lives: How people make meaning in a chaotic world*. Berkeley: University of California Press.

Booth, T. and W. Booth. 1996. Sounds of silence: Narrative research with inarticulate subjects. *Disability and Society* 11: 55–69.

Braun, V. and V. Clarke. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77–101.

Brownridge, D.A. 2006. Partner violence against women with disabilities: Prevalence, risk, and explanations. *Violence Against Women* 12: 805–822.

Bryman, A. 2001. *Social research methods*. Oxford: Oxford University Press.

Chikumbu, M. 2014. Challenges faced by disabled youth in sexual relationships. Unpublished thesis, Connect, Zimbabwe.

Chiparaushe B.T., O. Mapako and A. Makarau. 2011. *A survey of challenges, opportunities and threats faced by students with disabilities in the post-independent era in Zimbabwe.* Harare: Students Solidarity Trust.

Choruma, T. 2007. *The forgotten tribe: People with disabilities in Zimbabwe*. London: Progression.

Claude, R.P. 2006. The right to education and human rights. In *Human rights in the world community*: *Issues and actions*, ed. R.P. Claude and B.H. Weston. Pennsylvania: University of Pennsylvania Press.

COMESA (Common Market for Eastern and Southern Africa). 2002. *COMESA Gender Policy*. Addis Ababa: COMESA.

Costello, A.B. and J.W. Osborne. 2005. Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment Research & Evaluation* 10(7): 1–9.

Creswell, J.W. 2009. *Research design: Qualitative, quantitative, and mixed methods approaches*. Los Angeles: Sage.

Curry, J. 2011. Climate science and the uncertainty monster. *Bull. Amer. Meteor. Soc.* 92: 1667–1682. DOI: http://dx.doi.org/10.1175/2011BAMS3139.1

Curry M.A., D. Hassouneh-Phillips and A. Johnston-Silverberg. 2001. Abuse of women with disabilities: An ecological model and review. *Violence Against Women* 8: 1364–1389.

Del Rio, F.E., J.L. Mengias and F. Exposito. 2013. Gender-based violence against women with visual and physical disabilities. *Psicothema* 25(1): 67–72.

Dickman, B.J. and A.J. Roux. 2005. Complaints with learning disabilities in sexual abuse cases: A ten-year review of a psycho-legal project in Cape Town, South Africa. *British Journal of Learning Disabilities* 33(3): 138–144.

Enon, J.C. 1998. *Educational research, statistics and measurement*. Nairobi: Makerere University Press.

Gerschik, T. 2000. Towards a theory of disability and gender. *Signs* 25: 1263–1268.

Gilson, S.F., E.P. Cramer and E. DePoy. 2001. Redefining abuse of women with disabilities: A paradox of limitation and expansion. *Afflia: Journal of Women and Work* 16: 220–235.

Gooding, K. and A. Marriot. 2009. Including persons with disabilities in social cash transfer programmes in developing countries. *Journal of International Development* 21: 685–698. DOI: http://dx.doi.org/10.1002/jid.1597

Government of Zimbabwe (GOZ). 2007. *Gender and Violence Act*. Harare: GoZ.

Government of Zimbabwe. 2013. *Constitution of Zimbabwe (Amendment 20)*. Harare: GoZ.

Groce, E.N. and P. Bakshi. 2009. Illiteracy among adults with disabilities in developing world: An unexplored area of concern. Working Paper series No. 9. http://www.ac.ucl.uk/lc-ccr/centrepublications/workingpapers (accessed September 24, 2015).

Groce, N. and R. Trosi. 2004. Rape of individuals with disabilities: AIDS and the folk belief of virgin cleansing. *The Lancet* 363(9422): 1663–1664.

Hanass-Hancock, J. and S.A. Nixon. 2009. The fields of HIV and disability: Past, present and future. *Journal of the International AIDS Society* 2(1): 3.

Handicap International. 2013. *International Women's Day: Women with disabilities face double discrimination*. London: HI.

Hassouneh-Phillips, D. 2005. Understanding abuse of women with physical disabilities: An overview of the abuse pathways model. *Advances in Nursing Science* 28: 70–80.

Hightower, J. and G. Smith. 2003. Aging, disability and abuse. *AWARE: The Newsletter of the BC Institute Against family Violence* 10(1): 17–18.

International Federation of Social Workers (IFSW). 2012. *People with disabilities*. Berne: IFSW.

International Network of Women with Disabilities (INWWD). 2010. *Violence against women with disabilities*. Quebec: INWWD.

Jekayinfa, S.O. 2004. Modelling direct energy utilization in palm kernel oil industry in Osun and Oyo States, Nigeria. Unpublished PhD thesis, Department of Agricultural Engineering, University of Ibadan, Nigeria.

Kaiser, K. 2008. The meaning of the survivor identity for women with breast cancer. *Social Science and Medicine* 67: 79–87.

Karangwa, E. and M. Kobusingye. 2007. *Consultation report on education of the deaf in Rwanda*. Kigali: Ministry of Education.

Killen, E. 2004. *Social inequality and social injustice*. Hampshire: Palgrave Macmillan.

Lang, R. and G. Choruwa. 2007. *Scoping study: Disability in Zimbabwe*. London: Department for International Development.

Leedy, P.D. and J.E. Ormrod. 2005. *Practical research planning and design*. New Jersey: Pearson Merrill Prentice Hall.

Lightfoot, E. 2006. Older adults with developmental disabilities. In *Handbook of social work in health and aging*, ed. B. Berckman, 53–63. Oxford: Oxford University Press.

Mapimhidze, R. 2014. My sister and I are products of rape. *Newsday*, September 24.

Mason, J. 1996. *Qualitative researching*. London: Sage.

Matveev, A.V. 2002. The advantages of employing quantitative and qualitative methods in intercultural research. *Bulletin of Russian Communication Association* 1(1): 59–67.

McMillan, J.H. and S. Schumacher. 2003. *Research in education: A conceptual introduction.* New York: Longman.

Mpofu, E., J.M. Kayisara, M.M Mhaka, R. Chireshe and L. Maunganidze. 2007. *Inclusive education in Zimbabwe.* Pretoria: Van Schaik.

Mtetwa, E. 2011. Understanding the plight of persons with disabilities in Zimbabwe and policy implications: A literature review and analysis. *International Journal of Humanities* 2(3): 115–123.

Mugenda, A.D. and O.M. Mugenda. 2003. *Research methods.* Nairobi: Acts Press.

Munyandamutsa, N. and P. Mahoro Nkubamugisha. 2012. Mental and physical health in Rwanda 14 years after the genocide. *Social Psychiatry and Psychiatric Epidemiology* 47(11): 1753–1761.

Naidu, E., S. Haffejee, L. Vetten and S. Hargreaves. 2005. On the margins: Violence against women with disabilities. *CSVR* (free access).

Newman, C. and D.S. Berry. 2010. Lying words: Predicting deception from linguistic styles. *Journal of Language and Social Psychology* 29(5): 665–675.

Nosek, B.A. 2007. Understanding the individual implicitly and explicitly. *International Journal of Psychology* 42(3): 184–188.

Nosek, B.A., J. Graham and C. Hawkins. 2010. Implicit political cognition. In *Handbook of implicit social cognition: Measurement, theory, and applications*, ed. B. Gawronski and B.K. Payne, 548–564. New York: Guilford Press.

Nosek, M.A., C. Clubb, R.B. Hughes and C.A. Howland. 2001. Vulnerabilities for abuse among women with disabilities. *Sexuality and Disability* 19: 177–189.

Nosek, M.A., R.B. Hughes, H.B. Taylor and P. Taylor. 2006. Disability, psychosocial and demographic characteristics of abused women with physical disabilities. *Violence Against Women* 12: 838–850.

Organisation for African Unity (OAU). 2003. *African Charter on Human and People's Rights*. Maputo: OAU.

Plummer, S.B. and P.A. Findley. 2012. Women with disabilities' experience with physical and sexual abuse: A review of literature and implications for the field. *Trauma, Violence and Abuse* 13(10): 15–29.

Polit, D.F., C. Beck and B.P. Hungler. 2001. *Essentials of nursing research: Methods, appraisal and utilization.* Philadelphia: Lippincott.

Puri, M., G. Misra and S. Hawkes. 2015. Hidden voices: Prevalence and risk factors for violence against women with disabilities in Nepal. BMC, *Public Health* 15(1): 261–271.

Rugoho, T. and B. Siziba. 2014. Rejected people: Beggars with disabilities in the city of Harare, Zimbabwe. *Developing Country Studies* 4(26): 51–56.

South African Development Community (SADC). 2008. *SADC Protocol on Gender and Development*. Johannesburg: SADC.

Stewart, D.W., P.N. Shamdasani and D.W. Rook. 2007. *Focus groups: Theory and practice*. London: Sage.

Ulrich, J.L. 2000. Confronting gender-based violence with international instruments: Is a solution to the pandemic within reach*? Indiana Journal of Global Legal Studies* 7(2): 629–654.

United Nations (UN). 1976. *International Convention on Civil and Political Rights*. Geneva: UN.

United Nations. 1976. *International Convention on Economic, Social and Cultural Rights.* New York: UN.

United Nations. 1991. *United Nations Convention for the Elimination of all Forms of Discrimination Against Women (General Amendment 16)*. New York: UN.

United Nations. 1995. *Beijing Platform for Action*. Beijing: UN.

Unifem (United Nations Development Fund for Women). 2008. *Progress of the world's women: Who answers to women?* New York: Unifem.

Valenti-Hein, D. and L. Schwartz. 2005. *The sexual abuse interview for those with developmental disabilities.* Santa Barbara: James Stanfield Company.

Women with Disabilities Victoria. 2014. *Voices against violence: Current issues in understanding and responding to violence against women with disabilities.* Melbourne: WWDV.

World Bank. 2009. Violence against Women: Health sector responses. Sector Operational Guide for the World Bank Gender and Development Group.

World Health Organisation (WHO). 2011. *International classification of functioning, disability and health (ICF)*. Geneva: WHO.

World Health Organisation and The World Bank. 2011. *World report on disability*. Geneva: WHO.

Yin, R.K. 2011. *Qualitative research from start to finish*. New York: The Guilford Press.

Young, M.E., M.A. Nosek, C. Howland, G. Chanpong and D.H. Rintala. 1997. Prevalence of abuse in women with physical disabilities. *Archives of Medicine and Rehabilitation* 78(12) (suppl 5): 534–538.

Zulu, W.K. 2011. I had polio. I also have sex. *New York Times*, June 18, p. 10. http://www.nytimes.com/2011/06/19/opinion/19zulu.html