Understanding support pathways for women with disabilities who experience or are at risk of gender-based violence

In partnership with

MSI REPRODUCTIVE CHOICES

Leonard Cheshire

Contents

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Introduction

Violence against women is a significant issue globally, with a third of women aged 15 and older thought to have experienced intimate partner violence [IPV] or non-partner sexual violence at least once (World Health Organisation, 2021). Violence can take direct forms, such as physical, psychological & economic violence perpetrated by individuals, as well as more indirect forms which are characterised by harmful norms, attitudes and stereotypes around gender that operate within the broader societal milieu. (ADD, 2016). Gender shapes vulnerability to violence (Meyer et al., 2022) and the majority of violence that women experience is gender-based. In other words, it is targeted to women because of their gender. (ADD, 2016). Moreover, disability is known to be a significant risk factor for violence and evidence shows that women with disabilities experience higher rates of violence compared to both men with disabilities and women without disabilities (UNFPA, 2018). Accordingly, gender-based violence toward women with disabilities is normally rooted in discrimination towards women with disabilities on the basis of both their disability and gender (ADD, 2016).

Estimates of the prevalence of gender-based violence toward women with disabilities differ across contexts but the majority are consistent in identifying increased risk (Meyer et al., 2022), with one Australian study finding that 62% of women with disabilities aged between 15 and 50 have experienced some form of violence and had been subjected to sexual violence at three times the rate as those without disabilities (UNFPA, 2018). Demographic characteristics such as impairment type can increase the risk of violence, with women with intellectual disabilities particularly vulnerable to violence (UNFPA, 2018) due to (for example) perpetrators assuming that they will not be able to report instances of violence (Rohleder, Braathen & Carew, 2018).

One review of the available evidence emphasised that forms of gender-based violence such as sexual violence are complex events that require the involvement of multidisciplinary services such as health, social care and legal support. In relation, Olson et al. (2020) identified that challenges faced by healthcare services to providing support for gender-based violence to the general population in low- and middle-income countries include harmful staff attitudes, lack of availability of services, lack of community awareness and steep out of pocket costs for users or other financial constraints. Despite the epidemic of gender-based violence against women with disabilities globally, evidence on what works to prevent and support disabled women who have experienced violence is sparse (Lambert & Mactaggart, 2021). Such evidence is urgently needed, particularly since women with disabilities also face a disparity of access to healthcare services, including sexual and reproductive services globally (e.g., Carew et al., 2017; Ganle et al., 2020; Rohleder et al., 2018).

In the Western African nation of Sierra Leone, gender-based violence is a particularly pressing concern. The Sierra Leone Demographic and Health Survey (Stats SL and ICF, 2020) found that 61% of married women say they have experienced physical, sexual, or emotional violence from their spouse. At the same time there is a cultural hesitation about reporting occurrences of GBV because of fear of stigma, shame or economic concerns (M'Cormack-Hale & Twum, 2022). Due to a lack of good quality disability data, exact rates of gender-based violence among women with disabilities are unknown. Recent research conducted as part of the Women's Integrated Sexual Health [WISH] programme has however highlighted gender-based violence as a significant issue. In that research (Carew et al.in prep), women with disabilities

highlighted the dangers of “night-husbands”. These individuals are men who are using women with disabilities as sex partners but who will not be seen openly with women with disabilities by the community (i.e. in the day) and who have no desire for long-term commitment (Bangura, Njelesani & Njelesani, 2021). Some women shared instances of violence associated with “night-husbands”, as well as broader occurrences of violence against women with disabilities:

> **“Sexual violence is also high as men come around at night and give these girls a small amount, have sex with these girls, impregnate them, and abandoned them. Some girls take to prostitution and we even lost one who was abducted and killed.”**
> Women with physical disability

As this example shows, it is critically important to address gender-based violence affecting women with disabilities, as well as women in general, in Sierra Leone.

To help address an evidentiary gap, this study looks at:

How women with disabilities at risk of experiencing gender-based violence can be supported by sexual and reproductive health services in Sierra Leone.

To achieve this aim, the study also examines how responsive policies in Sierra Leone are towards the needs of women with disabilities experiencing GBV, and the existing evidence base on women with disabilities and GBV in Sierra Leone as well as the wider continent. Suggestions of support for women with disabilities are contextualised amongst their lived experience as women with disabilities in Sierra Leone, as derived from qualitative research.

Country & study context

The West African country of Sierra Leone has a population of approximately 8 million of whom 1.3% are estimated to be people with disabilities (Statistics Sierra Leone, 2017) although this is considered to be an underestimate due to lack of a good quality disability status measure (Ossul- Vermehren et al., 2022). Moreover, Sierra Leone is one of the poorest countries in the world, with approximately two-thirds of the population estimated as living with multi-dimensional poverty. (Statistics Sierra Leone, Oxford Poverty and Human Development Initiative, & United Nations Development Programme, 2019). Within Sierra Leone, many people with disabilities live together in separate small communities, of which many originated as refugee camps for injured victims of the Sierra Leonean Civil War (Conteh & Berghs, 2004).

This study was funded by the Foreign and Commonwealth Development Office, UK via the Women's Integrated Sexual Health project [WISH], awarded to MSI Reproductive Choices [MSI]. In Sierra Leone, the organisation is known as Marie Stopes Sierra Leone [MSSL]. The services MSSL offer include contraception and family-planning, HIV & STI testing, cervical cancer screening and post-abortion care. In terms of specific GBV support, MSSL offer first line response to victims and survivors of violence, and maintains a toll-free hotline where women can anonymously report gender-based violence. More broadly, it carries out sensitisation and training on gender-based violence at the community level, as well as via broader advocacy campaigns. MSSL also has partnerships with institutions such as the Ministry of Gender and Children's Affairs and the NGO Rainbo Initiative which enables the onwards referral of victims and survivors of GBV for further targeted support. Both the Ministry and Rainbo initiative have set up GBV centres that offer a comprehensive package of services including medical treatment, legal services and psychosocial support.[1]

Leonard Cheshire, MSI and MSSL have been working together since 2018 under the WISH programme in order to deliver disability-inclusive sexual and reproductive healthcare services to women with disabilities in Sierra Leone. As part of their approach under WISH, MSSL also delivers mobile outreach sexual and reproductive health services specifically to vulnerable communities, including communities with a high proportion of residents with disabilities who cannot easily access brick and mortar health facilities. Research conducted on the WISH programme suggests that outreach services through WISH have been critical in supporting women with disabilities in Sierra Leone to access convenient, low-cost, and dignified sexual and reproductive healthcare (Leonard Cheshire, 2022).

Methodology

Policy review

A predetermined set of inclusion and exclusion criteria (below) were developed and used to identify relevant Sierra Leone policies that relate to gender, disability rights, and gender-based violence, as well other national laws and policies concerning overall governance of the country. (e.g., local governance act, National Health Action Plan, Mental Health Policy).

The inclusion and exclusion criteria for the policy review were:

Inclusion criteria:

- Main/core legislation/policies of Sierra Leone provisioned to address law and order of the country including the governance at the city level. This included Constitution of Sierra Leone and Local Government Act mandates to address gender-based violence, as well as National Action Plans.
- Acts or Policies specifically focusing on gender, gender-based violence or disability.
- Supporting policies from other sectors if referenced in any policies or research on gender-based violence and disability rights.

Exclusion criteria:

- Policies published in language other than English

For the analysis, policies were rated using two scoring matrixes. The primary scoring matrix was adapted from Humanity & Inclusion (2020) and looks at how well policies are addressing gender-based violence against women with disabilities (Annex 1). For additional context, policies were also rated on the extent that they include disability issues more generally, using an established approach from Lang et al., (2019), which is summarised narratively in the Findings section.[2]

Policies were rated by one team member and a proportion of the scores co-rated by a second team member to ensure reliability and accuracy of scoring. Scoring is intended to provide an initial overview of how well policies consider the issue of gender-based violence toward women with disabilities. The subsequent analytical narrative provided in the Findings section is intended as equally valuable to establishing which policy elements need strengthening.

Literature review

To inform the other research components within this study, a review of existing peer-reviewed and grey literature was conducted, which focused specifically on studies conducted on gender-based violence among women with disabilities in Africa. Searches were limited to the English language and on sources published between 2010 and 2022 to ensure the evidence-base was recent.

Initial searches revealed a non-peer-reviewed study on the same topic had been recently conducted in 2021. Findings for the present literature review draw heavily on this source.

Primary qualitative research

A total of 51 participants took part in the study. Participant groups comprised women with disabilities from Freetown who both were and were not currently in receipt of services from Marie Stopes Sierra Leone, as well as local community leaders, representatives of Organisations of Persons with Disabilities and NGOs working in areas related to gender-based violence. Policymakers were also targeted, specifically institutions working on gender and the protection of women including provision of services of vulnerable groups. Representatives from the Ministry of Gender, Ministry of Social Welfare, the Disability Commission and the Human Rights Commission were interviewed for this research.

Table 1 shows the profile and numbers of study participants.

Table 1. Profile and numbers of study participants

Profile	N
Disabled women living in communities where MSSL have recently provided healthcare services.	11
Disabled women who do not currently receive MSSL healthcare services	15
Government representatives/employees in Ministries/Departments relevant to GBV	4
Organisations of Persons with Disabilities [OPDs] including women focused OPDs	10
Representatives of NGOs that provide healthcare services or GBV support services, as well as traditional and community healers	11

Note. Total N = 51

Women with disabilities were identified through a selection of MSSL's community outreach sites and a comparable group of non-outreach sites. Of the women with disabilities, most had a single impairment (81%, N = 21) and the remainder had multiple impairments (19%, N = 5). Most women (85%, N = 22), had physical impairments, while four (15%, N = 4) had visual or speech impairment respectively. Additionally, two respondents (7%, N = 2) had a hearing impairment. The women who took part in the study were all of childbearing age (aged 26 to 51 years). The respondents' children's age ranged from 0 to 7 years. Twelve respondents cohabitate, four are married, six are single, one is separated, and three are widows. Detailed demographic information is shown in the Appendix.

Four researchers (one female and three males) from Institute for Development conducted the key informant interviews. The female researcher interviewed all women with disabilities to minimize the risk of discomfort to participants when talking about gender-related disability issue and GBV. She spoke Krio, the local language that the participants are fluent in to facilitate fully informed consent and dialogue. All male key informant interviews were conducted by the male researchers. These interviews were mostly conducted in English, the professional language in Sierra Leone. All interviews were recorded and transcribed with interviews in Krio being translated into English. Transcripts from the interviews were coded under broad initial categories using Nvivo by the IfD researchers, with themes being developed from the data with the additional input of researchers from Leonard Cheshire.

Ethics approval was obtained from the Sierra Leone Ethics Scientific Review Committee and the MSI Reproductive Choices Ethics Review Committee (ERC) prior to the study commencement. All participants received an information sheet that provided detailed information about the study (e.g., its purpose, what would happen during the research process) and informed consent was gathered from all participants. The research process was adapted so as to be accessible to different participant groups. For example, information sheets and consent forms were read verbatim to participants with visual impairments and a sign language interpreter was provided to participants with hearing impairments to assist them with communication with the research team.

Findings

Policy analysis

The policies identified and rated through this research are shown in Table 2, along with the summary category assigned to the Policy from the scoring.

Table 2. Policies reviewed and scoring summary.

No	Policy	Year	Score				Level of inclusion
			Conceptualisation	Accessibility and inclusion of services	Participation and Coordination	Resources mobilisation	
1	Domestic Violence Act (DVA) 2007	2007	0	0	0	0	Invisible
2	Mental Health Policy	2010-2015	2.5	1	0	0.5	Awareness
3	The Persons with Disabilities Act 2011	2011	0	1.5	0	0	Invisible
4	Sexual Offences Act (SOA) 2012	2012	1.5	0.5	0	0	Invisible
5	The National Action Plan on Gender Based Violence (NAP-GBV)	2012-2016	0	0	0	0	Invisible
6	Gender Equality and Women's Empowerment Policy (GEWE)	2018	5	0	0	0	Intentional Inclusion
7	Medium Term National Development Plan (2018-2023)	2019-2023	0	0	0	0	Invisible
8	The Sierra Leone National Action Plan II (SiLNAP II)	2019-2023	0	0	0	0.5	Invisible
9	Gender Empowerment Bill/Act	2021	0	0	0	0	Invisible

Overview of disability

The constitution of Sierra Leone 1991 does not specifically define disability but protects people with disabilities' rights through article no. 8 which guarantees that the care and welfare of the aged, young and disabled shall be actively promoted and safeguarded (Government of Sierra Leone, 1991).

To specifically address high rates of violence and abuse against children and women, the Government of Sierra Leone has signed international and regional treaties which includes the 1989 Convention on the Rights of Child (CRC) and 1988 Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and its optional protocol.

The Persons with Disabilities Act 2011 defines, "persons with disabilities as those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full effective participation in society on an equal basis with others. The Act provisions for the right to free education, protection from discrimination in educational institutions and employment (Government of Sierra Leone, 2011), as well as free medical services, a barrier free environment; access to public transport & premises, and recreation and voting rights.

Analysis of gender-based violence and disability

Overall, gender-based violence toward women with disabilities is weakly addressed in the policy context of Sierra Leone, as well as being entirely absent from most non-gender focused policies. For example, violence is not covered as an issue in the Persons with Disabilities Act 2011, while the Domestic Violence Act 2007 does not address the needs of people with disabilities. The Sexual Offences Act (SOA) 2012 strengthens the capacity of Sierra Leone to investigate and prosecute violence against women in creation of Family Support Units (FSU) based within the police. Disability is mentioned in the Act but only in context of physical and mental disability comprising aggravating factors in sexual offences that justify more punitive sentencing and not (for example) providing support mechanisms so that women with disabilities are better able to report and seek care after experiencing violence.

Perhaps the biggest missed opportunity to join up support for victims and survivors of gender-based violence to the disability context has been in the development of the National Action Plan on Gender Based Violence 2012-2016 (NAP-GBV). The Plan provides an overarching framework to prevent, respond and prosecute the acts of GBV and guides service providers, governments and civil society to coordinate and implement effectively and provide sustainable protection and services to victims and survivors of GBV. The NAP-GBV is a comprehensive plan to address GBV and considers various acts and policies addressing gender issues but does not at all attempt to address the needs of people with disabilities. More recent policies such as the Medium-Term National Development Plan (MTNDP) 2019-2023 do not address violence in the disability context; The Sierra Leone National Action Plan II (SiLNAP II) 2019-2023 recognises gender-based violence as disproportionally impacting women 'and other vulnerable groups' but does not elaborate who these are.

However, there is progress in the form of the Gender Equality and Women's Empowerment Policy (GEWE). Its key objective is to mainstream gender into not only all national, sectoral and local policies but also in plans, budgets and programmes to achieve gender equality and women's empowerment and a specific pillar of the policy aims to do this in context of gender-based violence. This policy again does not consider gender-based violence in the context of disability, but it does recognise women with disabilities as a distinct group that are disproportionally affected by gender and disability-related barriers. The policy aims to review existing policy and legislation so that it is responsive to the needs of women with disabilities, ensure public buildings are accessible and monitor medical services policies for people with disabilities. These are all actions that could support women in seeking care for GBV if extended to the right areas and services.

Looking at other sectors, the Mental Health Policy (2010-2015) has been drafted by the Ministry of Health and Sanitation with a vision to 'make mental health services available and make it available, affordable, accessible and sustainable to all people in Sierra Leone'. It recognises violence as a cause of poor mental health and provisions for all training of general and specialised healthcare worker to cover violence and abuse in the context of women's health. The policy also aims to form partnerships with stakeholders to ensure people with a mental health disability receive effective psychological and social support. The existence of this policy implies Sierra Leone could have national training approaches for healthcare workers that focus on addressing violence in the context of mental health disability, which could inform broader disability-inclusive training efforts.

Taken together, the findings show that gender-based violence is not yet considered as an area of special concern for women with disabilities at the policy level. It is beyond the scope of the research to assess degree of implementation of these policies, but it is encouraging that recent policies (Gender Equality and Women's Empowerment Policy (GEWE)) recognise women with disabilities as a group experiencing specific barriers, and there may be entry points to supporting women with disabilities who are victims of GBV through some of the actions proposed by this policy. Additionally, violence and abuse are recognised in Sierra Leone as an issue disproportionally impacting those with mental health disability (especially women). These individuals are supposed to have access to psychosocial support and healthcare workers in Sierra Leone are supposed to be trained in supporting victims of violence at a national level.

Literature Review

The literature review highlighted a general paucity of evidence on gender-based violence and women with disabilities in Sierra Leone. This is linked also to a broader absence of disaggregated statistical data on disability and violence in the African region. Cases of gender-based violence are also expected to be under-reported through the region, including among women with disabilities, due to factors like low trust in the authorities or cultural perceptions that instances of violence must be dealt with within the family or the community.

A key source identified by the review was a 2021 non-peer-reviewed literature review, which identified 22 peer-reviewed research articles focused on gender-based violence and women and girls with disabilities in Africa (Utuza, 2021. Of these, fourteen were qualitative studies, five were quantitative, two were mixed methods, and one was a systematic review. Utuza identified several key themes from this corpus of literature, including prevalence of GBV and its forms, its causes and consequences and GBV response & prevention. Of interest to the present study, Utuza (2021) identified four studies which looked at barriers to accessing support services for women and girls with disabilities conducted across Malawi, Rwanda, South Africa and Uganda (Banks et al., 2017; Marshall et al., 2018; Stern et al., 2020; Van der Heijden et al., 2020). A lack of disability-specific support materials and targeted disability outreach (Stern et al., 2020), inaccessible transportation (Banks et al., 2017) and disability-related stigma & inadequate provider training (Van der Heijden et al., 2020) were all highlighted as barriers in this research. In Rwanda, the inability to disclose sexual violence to community leaders was also highlighted as a challenge, especially among women with communication disabilities (Marshall et al., 2018).

No studies were identified by the Utuza (2021) review or the present review that specifically investigate gender-based violence and women with disabilities in the context of accessing support. Utuza identified only three peer-reviewed studies including a focus on GBV and disability in Sierra Leone. These were studies that looked at violence toward children with disabilities specifically. Findings from these studies indicate that violence is an issue throughout the lives of people with disabilities in Sierra Leone, with Njelesani et al., (2018) emphasising that it occurs “from the day they are born” due to harmful myths about disability stigma (e.g., that children with disabilities are cursed). Njelesani (2019) explored community (e.g., parents of children with disabilities) and key stakeholder (e.g., teachers) perceptions about how violence toward children with disabilities can be addressed in Sierra Leone. Respondents frequently did not see laws and policies to address violence as helpful, noting that they were impacted by mismanagement. One participant noted that the Family Support Unit (see p. x) had not effectively dealt with a report of violence toward a disabled child. Levels of knowledge about organisations that could provide support to children with disabilities experiencing violence were also poor. Instead, participants emphasised the importance of leadership within local communities. Violence against children with disabilities was primarily dealt with by parents and supportive staff in schools (Njelesani, 2019).

Qualitative Research

Prevalence of gender-based violence

Women with disabilities (WwD) and other key informants perceived gender-based violence as prevalent in Sierra Leone especially among women with disabilities. Intimate partners (e.g., husbands, boyfriends) were often the perpetrators of this violence. In particular, women with disabilities regularly experience relationships with non-disabled men who only want to use them for sex, colloquially known as 'night husbands', because the men do not like to be seen with women with disabilities during the day:

> **"My husband used to flog me until he leaves my face with wounds."**
> Woman with a disability (Outreach site)[3]
>
> **"Issues of gender base violence are happening a lot in Sierra Leone. We have men whose aim is to have sex with you and leave you"**
> Woman with a disability (Outreach site)
>
> **"It is very widespread. It happens every day. In our community we receive such complaints every day."**
> Community Leader[4]

Types of violence mentioned by respondents as prevalent among women with disabilities were physical violence, psychological violence (e.g., name-calling) and sexual violence/assault. In addition to the many harrowing consequences violence has for women with disabilities, respondents also mentioned abandonment when pregnant and lack of support as a common form of psychological or emotional violence they encounter:

> **"[Psychological and emotional violence] means that men take advantage of women. For example, I am living with this man for eight years. After this struggle, if he decides to abandon me [this is psychological and emotional violence]."**
> Woman with a disability (Non-outreach site)
>
> **"So, if you come around her and have sexual intercourse with her and later dump her with pregnancy that is also gender-based violence."**
> Key informant, Sierra Leone Union of Polio Persons

Respondents highlighted that in their perception GBV happens regularly to all women in Sierra Leone, but that women with disability experience higher rates and encounter factors that increase their vulnerability.

> **"Gender-based violence against girls and women such as domestic violence at home and harassment at workplaces is happening everywhere irrespective of age and location".**
> Key informant, Ministry of Social Welfare
>
> **"If you are a woman, it is very likely for you to be faced with violence and if you are a woman with a disability that has double your chances and puts you in a more vulnerable position."**
> Key informant, National Commission for Persons with Disability

While all respondents interviewed for this study were aware of what constituted gender-based violence, they noted that some women who experience GBV may not recognise what is happening to them for cultural reasons:

> **"Some women just believe that GBV is a cultural and social norm and that their husbands have the right to punish them and their children"**
> Key informant, Ministry of Social Welfare
>
> **"GBV is very common though not all of us are conscious of that."**
> Woman with a disability (Non-outreach site)

Additionally, while all respondents acknowledged high rates of GBV overall in Sierra Leone, some respondents perceived that GBV cases had been decreasing due to strong new policies and penalties (see p. 4):

> **"The legal status has contributed a lot to this because people are now afraid that if they beat up any woman the law will hold them accountable."**
> Key informant, Epilepsy Association

Causes of GBV and the increased vulnerability of women with disabilities

Respondents highlighted key causes of the high rate of GBV toward women in general in Sierra Leone. In particular, patriarchal attitudes embedded in Sierra Leonean society were seen as a key cause:

> **"GBV/SRGBV normally happens because of the power dynamics between men and women and because of the society, where men feel like they have all the privileges over women, and they can walk all over them."**
> Key informant, Purposeful

Similarly, high rates of poverty and its associated consequences (e.g., poor access to services) were highlighted as a cause of GBV:

> **"One key driver for gender base violence is poverty, ignorance and poor or weak or no access to basic social services."**
> Key informant, Sierra Leone Association of the Blind

Respondents also highlighted several interrelated causes of GBV toward women with disabilities specifically, such as a lack of support structures, increased risk of abandonment, discrimination poverty and dependence on relationships with men, particularly night husbands and push boys (see below). Underpinning these myriad of causes is a pervasive cultural stigma toward disability:

> **"Our parents don't accept us as PWDs. They abandon us because of our disability. Because of this lack of support, many PWDs are out on the street begging. Our elders let us down."**
> Community Leader
>
> **"[People with disabilities] that are fortunate to complete schooling find it very difficult to get employed due to discrimination and their physical appearance."**
> Key informant, Sierra Leone Union of Polio Persons
>
> **"The disabled are vulnerable they are not taken as important people as I told you before disability is a curse and so whoever is using violence is trying to break the curse."**
> Key informant, Epilepsy Association

As can be seen from these examples, disability stigma and discrimination cause women with disabilities to be excluded by their families and from education and employment. This increases their risk of poverty. Myths about disability (e.g., that it is a curse) may also precipitate violence directly, and also are a factor as to why many non-disabled men act as night-husbands then abandon women with disabilities (see also Carew et al., in prep):

> **"Women with disabilities are worse off because when abled-bodied men fall in love with us, their friends mock them and that will make them abandon us in many cases after getting us pregnant."**
> Woman with a disability (Non-outreach site)

This research also highlighted "push boys" as common perpetrators of gender-based violence toward women with disabilities. Women with disabilities, particularly childless women, are dependent on men ("push boys") to push their wheelchairs around, so that they can eke out a living and survive through begging. However, these men demand sex in return for their service:

> **"Guys who push these women around to ask for alms demand sex from women with disabilities in return for helping to push them around. In many cases, they get these women pregnant and don't take care of, or support them. These women are left with no choice. If they resist, these guys will stop pushing them around, and making a living becomes difficult."**
> Woman with a disability (Non-outreach site)

Barriers to obtaining support for gender-based violence

Respondents identified a general reticence in victims of GBV to "speak up" and report it:

> **"Some people just resort to compromise [with perpetrators] because they fear that the system will not work for them due to their financial and cultural background."**
> Key informant, Purposeful
>
> **"Women across the country are fear to come out and report some of the violence they face with their partners. This because no action is taken against such things."**
> Key informant, United Muslim Brothers and Sisters

One respondent highlighted that such cultural barriers may interact with disability stigma to prevent women with disabilities particularly from deciding to report/seek support from GBV:

> **"Some women are not speaking up, and some believe challenging a partner on GBV will lead them to lose that relationship. Women with disability suffer a lot, and because of our disability, we suffer a lot to keep hold of our partners"**
> Woman with a disability (Non-outreach site)

Often, cases of gender-based violence that are reported are not done so directly by the GBV victim or survivor to the police but are first taken to informal community structures that decide which cases warrant attention and reporting tothe police:

> **"The chairman, and chairlady who will sit to discuss the issue. If they can't find a solution, the case is sent to the police."**
> Woman with a disability (Non-outreach site)"
>
> **In many cases, the chief resolves issues without involving the police."**
> Woman with a disability (Non-outreach site)

However, while women with disabilities who participated in the study had low awareness of specific laws and policies around GBV in Sierra Leone, all were aware that GBV could be reported to the police directly in principle. However, even with this awareness, most cited barriers to successfully reporting to the police that were directly related to, or exacerbated by, disability. Stigma and discrimination from police staff, inaccessible environments and high costs (e.g., for transportation) were all cited as reasons why women with disabilities do not or are unable to report gender-based violence to the police:

> **"If we report our issue at the police station and if we intended to show our rights, the police themselves will say we are too difficult to deal with. So sometimes that will discourage us next time to take our issues to the police station."**
> Woman with a disability (Non-outreach site)
>
> **"Major barriers women with disabilities may face [to accessing healthcare] are distance, lack of funds to cover the cost of drugs and transportation to and from the facilities."**
> Key Informant, Forum for African Women Educationalists (FAWE)
>
> **"Any service now requires you to pay money to the police. If you don't pay, the police don't take your case seriously."**
> Community Leader
>
> **"[Government] nurses are blaming women with disability for getting pregnant [saying] 'my dear you are in this condition [and] you are still getting pregnant'"**
> Key informant, Polio Challenge Association

Negative experiences of police and health services were not uniform however and there appeared to be pockets of good practice:

> **"Most of the police officers are kind to us and they take our reports seriously even though it is not always the case, and they sometimes become furious when we withdraw cases from the police station to settle them at home."**
> Woman with a disability (Non-outreach site)
>
> **"I know of the police doctor who examines victims of GBV, and that examination is used as evidence. She attends to women for free. I don't know if she has moved to another location, but she was very accessible where her office was located"**
> Woman with a disability (Non-outreach site)

There was also recognition among some participants that some women with disabilities face more barriers to successfully seeking support for GBV than others, particularly those with hearing or communication disabilities:

> **"So how can somebody with a speech disability come with, if their caregiver is the rapist, how can they come with their rapist to come to report sexual violence? If the rapist is the one that is supposed to translate what they're saying."**
> Key informant, Rainbo Initiative

Pathways for women with disabilities to access support or care

Overall, women with disabilities also had low awareness of routes beyond the police to seek support for GBV, such as the services of NGOs like MSSL. None of the women with disabilities interviewed for the study either at outreach or non-outreach sites were aware that MSSL offer services for victims and survivors of gender-based violence (e.g., counselling) beyond normal healthcare.[5]

> **"I do not know about any other support provided by MSSL apart from family planning services provided for women with disability."**
>
> **"I know of Marie Stopes, but I am not aware that they provide support to GBV survivors."**
>
> Woman with a disability (Non-outreach site)

Nonetheless, when informed of support that MSSL offer, such as counselling and an anonymous GBV reporting line, women with disabilities viewed these services as valuable and recommended greater awareness-raising of them.

> **"The counselling services that [MSSL] are providing, it is very good for us, because not everyone one can be trusted with every single matter relating to family problems."**
>
> Woman with a disability (Outreach site)
>
> **"We need the toll-free line to be shared with other homes so that [women with disabilities] can reach out to them when we face GBV challenges."**
>
> Woman with a disability (Outreach site)

At the same time, one of the reasons while MSSL's general outreach service was perceived as so valuable was because many healthcare facilities in Sierra Leone are not accessible. Thus, among some respondents, there was concern about their ability to access services like counselling that may need to take place away from the community:

> **"Most MSSL facilities do not have ramps, and if they want us to use their facilities ramps should be built in all their centers."**
>
> Woman with a disability (Outreach site)

Both women with disabilities and the other stakeholders interviewed for this research saw value in advocacy and awareness raising in regards to GBV and women's' rights, specifically targeted to women with disabilities as well as sensitisation of men in the community:

> **"We want engagement with our husbands so that they will treat us with respect"**
>
> Woman with a disability (Non-outreach site)
>
> **"[GBV] can only be reduced when us as women with disability know our rights, we will be able to report and follow up on actions. Most women don't know their rights. We need sensitization for women on their rights. We need these rights more for women with disabilities because of challenges from families or other people."**
>
> Woman with a disability (Non-outreach site)

As one participant noted, there are different ways this advocacy could be operationalised. For example, it may be effective for MSSL to target sensitisation to intermediaries:

> **"Organisations should engage the chairman and tell him to mobilize community members to conduct community sensitization about these issues."**
> Woman with a disability (Non-outreach site)

Participants also suggested actions for other entities like government or the police to take (e.g., better data on GBV or enforcement of GBV policies and penalties). For healthcare organisations specifically, participants suggested ways in which they could collaborate with other stakeholders to improve GBV support for women with disabilities. For instance, in disability-sensitive healthcare provision, any opportunities to build the capacity of government in this respect would make a valuable in-road in addressing GBV toward women with disabilities:

> **"Healthcare organizations need to train government staff to recognize that women with disabilities have distinct and different needs, and these trained staff should work to respond to these needs."**
> Key informant, Rainbo Initiative

Many GBV survivors who require care from MSSL will require counselling (or other support services) from staff either directly trained in sign language interpretation or that arranges are made for an interpreter to be present. These women also require sigh language interpretation to report GBV cases to the police. MSSL may be a useful source of practical support in this respect (e.g., by arranging for a sign-language interpreter to accompany a woman).

> **"Sign language interpreters should be employed in hospitals and police stations to enable us to access these facilities."**
> Woman with a disability (Non-outreach site)
>
> **"When some of our colleagues especially those with speech impairments went to make a report to the police, the police lack the training to understand or process such reports."**
> Key informant, One Family People Organisation

Finally, healthcare organisations like MSSL represent a valuable source of information for women with disabilities to learn about external pockets of good practice that may help them seek support or otherwise be safe from GBV. For example, this research has identified that men who push women with disabilities' wheelchairs during the day often perpetrate GBV toward them at night. Where assistive products like wheelchairs are available to people with disabilities in Sierra Leone (Ossul-Vermehren, Carew, & Walker, 2022) they are often ill-fitting or in need of repair. Having access to better assistive technology would help women with disabilities to be more independent and mobile and may help reduce reliance on push boys. However, some women may not know where to get suitable quality products and may be unaware of new government or NGO-led initiatives to provide access to assistive technology. Healthcare staff can play a valuable role in informing women with disabilities of opportunities and initiatives like these.

Recommendations

This research has highlighted that although the policy environment of Sierra Leone is being strengthened in regards to gender-based violence, people and women with disabilities are not currently recognised within Sierra Leone's policies as a group that requires special protection. At the same time, the current evidence base around women with disabilities and gender-based violence in Sierra Leone and sub-Saharan Africa more generally is sparse.

Thus, the qualitative work conducted with women with disabilities and other key informants can provide particularly valuable insight in supporting disability-inclusive practice in GBV-survivor facing services. Providers should use the information contained in this research to better understand the causes and sources of GBV that women with disabilities face and adapt their practice accordingly. For example, women with disabilities may experience GBV at night from men who (unlike other women) they depend on to physically move around and keep safe during the day ("push boys"). GBV support practitioners like counsellors must adapt their practice to recognise and support women with disabilities' experience of GBV because of unique causes like this. For example, it may be useful for healthcare organisations to strengthen institutional knowledge about government assistive technology provision schemes or other, free or low-cost (e.g., NGOs) assistive technology services, which may ultimately be able to support some women at risk of GBV from push boys to move around independently. Targeted recommendations from this research for healthcare organisations providing GBV support services in Sierra Leone are:

i) Women with disabilities would benefit from advocacy and awareness raising about their rights in relation to GBV. Healthcare organisations should consider developing disability-inclusive community awareness events on GBV or adapt existing programmes so they are disability-inclusive. This entails both that women with disabilities can access GBV programme content that is targeted to all women in the community and that programme content is expanded to include issues that specifically impact women with disabilities. Community-level awareness programmes may also be effective at raising awareness among women with disabilities of GBV support services that healthcare organisations offer.

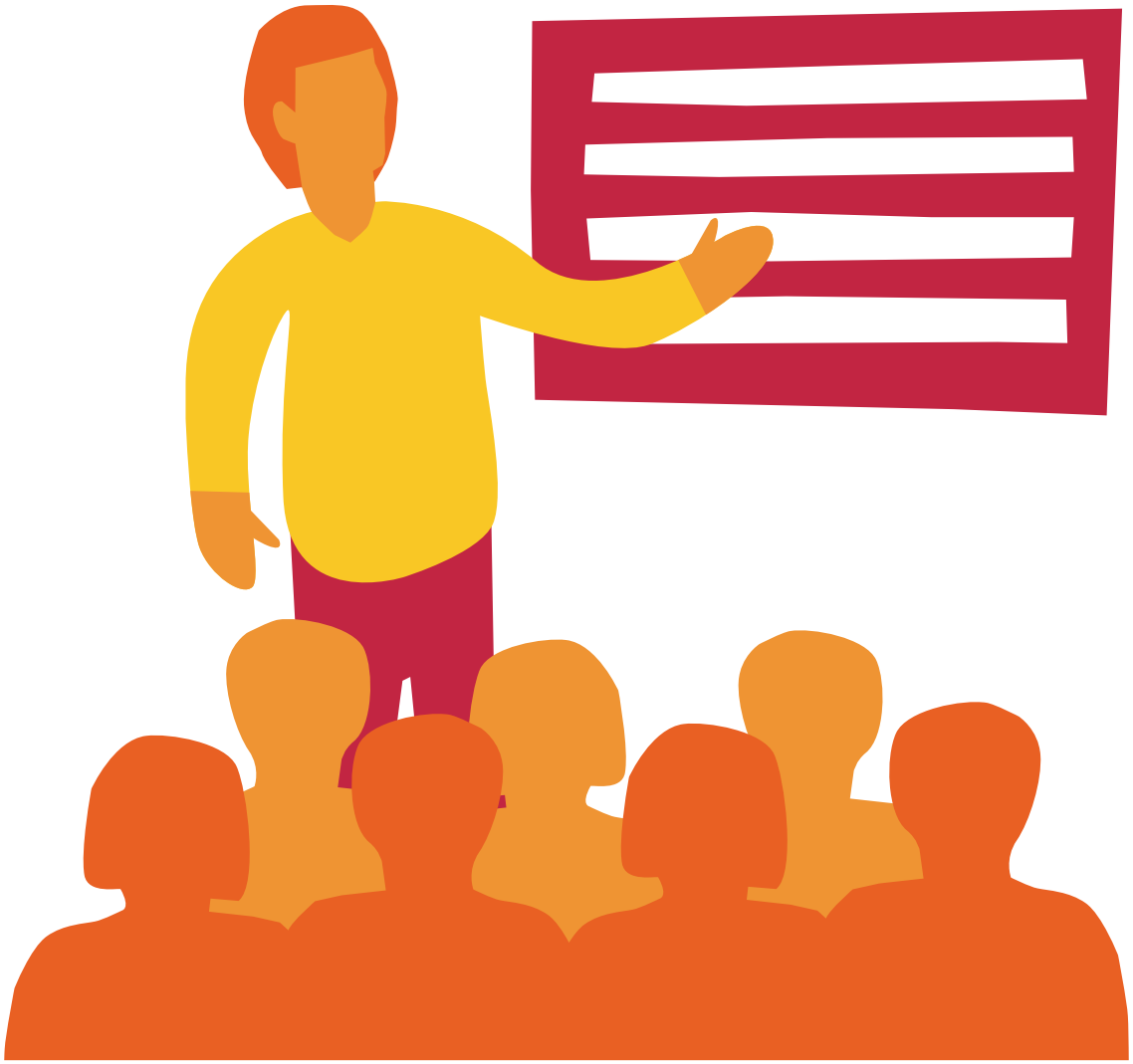
ii) Extension of community-level GBV sensitisation interventions to men in the community would also be valuable. An alternative/additional approach is to target sensitisation and awareness-raising to community leaders for onwards dissemination. This latter approach may be useful in circumstances where cost is a constraint.

iii) Healthcare organisations should engage in broader advocacy and awareness raising about disability and gender-based violence targeted to health policymakers as this has the potential to help address the disability gap in Sierra Leone's GBV policies, as well as shift pervasive stigma about disability that exists within Sierra Leone.

iv) GBV support services like counselling must be fully accessible. Specifically, they must take place in an accessible area (including at an external venue if the community is not a safe space for the user) and sign language interpretation must be provided. Where these arrangements are already in place, women must be made aware of them.

v) Disability-inclusive GBV support can be scaffolded through multi-stakeholder collaboration between healthcare organisations and other stakeholders (e.g., government, disability NGOs). Partnerships that may support women with disabilities to seek care for GBV include:

- Training government staff and healthcare workers on disability-inclusive practice.
- Working with disability NGOs and Organisations of Persons with Disabilities to help women with communication disabilities find an independent, low-cost sign-language interpreter, to assist with any onwards reporting of GBV (e.g., to the police) that they may choose to do.
- Liaising and working with assistive technology providers who may be able to support provision of free or discounted products to women with disabilities.



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Appendix

Policy scoring matrix and scoring criteria

No	Category	Questions
1	**Conceptualisation:** Questions seek to analyse if policy refers to women with disabilities, acknowledges their vulnerability to GBV and prioritise their needs. Whether the policy is able to ensure that women with disabilities have access to basic needs in all services on an equal basis with other women, while addressing their specific needs	■ Does the document mention women with disabilities? (yes/some/no) ■ Does the document identify women with disabilities as a marginalised/ most discriminated group? (yes/some/no) ■ Does the document state the specific needs of women with disabilities? ■ Does the document recognize the compounding inequities resulting from discrimination on grounds of gender, disability, ethnicity, LGBTQI+, socio-economic status? ■ Does the document promote the recognition of the diversity within women with disabilities? ■ Does the document establish the casual link between GBV and a physical impairment/serious psychological trauma? ■ Does the document include any strategies on prevention and elimination of gender-based violence against women and girls with disabilities? ■ Does the document prohibit the use of forced sterilization, forced abortion and forced contraception on women with disabilities? ■ Does the document encourage investigation, prosecution and punishment of perpetrators of GBV against women with disabilities?

No	Category	Questions
3	**Accessibility and inclusion of services:** Questions seek to analyse whether the policy includes the concept of accessibility to all users and make specific provisions for vulnerable groups including women with disabilities. The policy should provide instructions on the provision of accessible services and information. It should also ensure that service providers are trained on working with women with disabilities who are victims/survivors of GBV	■ Does the document ensure that all GBV response programs, complaint mechanisms and services for survivors are fully accessible? ■ Does the document ensure that information about GBV laws and policies and GBV prevention and response is provided in a variety of accessible formats? ■ Does the document ensure all phases of accessing justice for survivors of GBV are accessible (physically accessible, police stations and courts, available sign language interpretations) ■ Does the document ensure training and supervision of service providers (shelter staff, social workers, medical personnel) about the rights and needs of women with disabilities and how to provide respectful care; and the training of police, judicial officials or other law enforcement personnel on responding to women with disabilities who are survivors of GBV?
4	**Participation and Coordination:** Questions seek to analyse whether to develop, enforce and monitor the policy provisions. The policy should ensure monitoring of accessible service provision	■ Does the document engage organisations of women with disabilities in the development of GBV programs and policies? ■ Does the document engage organisations of women with disabilities in the implementation and monitoring of GBV programs and policies?
5	**Resources mobilisation:** Questions seek to analyse if there is any focus on resource mobilization to prevent and respond to GBV against women with disabilities.	■ Does the document include separate budget line items for ensuring equal access to GBV prevention and response programming for women with disabilities ■ Does the document allocate resource for organisations of women with disabilities to participate in the development, implementation, and monitoring of GBV programs and policies? ■ Does the document allocate specific subsidies to women with disabilities who are survivors of GBV?

The scoring tool has 18 questions to measure the inclusion of women with disabilities. The score was built on the following

- Each “yes” gets 1 point
- Each “some” gets 0.5 point
- Each “no” gets 0 point
- If a question refers to a measure which was not conceived in the policy, the result is written as “Na” – non available, and the question is removed from the final calculation.

Scores are used to assign one of five levels of inclusion to the policy that measure the extent the policy is inclusive of women with disabilities:

i) **Invisible:** no or few mentions of women with disabilities

ii) **Awareness:** Mention of women with disabilities, discrimination is seen as important to address but no discussion of adequate resources nor specific practices towards them

iii) **Intentional Inclusion:** Women with disabilities are not only mentioned but targeted by specific practices

iv) **Strategic Inclusion:** Long term, strategic measures are taken to ensure women with disabilities needs are addressed and there are provisions for monitoring and accountability.

v) **Culture of inclusion:** Women’s multiple identities are considered and supported and systemic processes for maintaining inclusion are enforced.

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Table of participant demographics – Non-outreach sites

Participant number	Age	Type of disability	Marital status	Number of children	Number of people in their household
01	28	Multiple (Physical, Speech)	Cohabiting	4	6
02	31	Physical	Cohabiting	3	6
03	26	Multiple (Physical, Speech)	Cohabiting	4	12
04	45	Physical	Cohabiting	7	9
05	37	Physical	Married	3	6
06	48	Physical	Single	2	2
07	45	Visual	Widow	2	5
08	27	Visual	Single	3	5
09	30	Multiple (Physical, Speech)	Cohabiting	3	5
10	44	Visual	Widow	2	5
11	31	Physical	Cohabiting	3	5
12	40	Physical	Cohabiting	1	2
13	31	Multiple (Hearing, Speech)	Separated	2	3
14	35	Physical	Married	3	4
15	35	Physical	Cohabiting	5	5

Table of participant demographics – outreach sites

Participant number	Age	Type of disability	Marital status	Number of children	Number of people in their household
1	47	Physical	Cohabiting	4	4
2	31	Physical	Widow	4	7
3	34	Physical	Cohabiting	5	7
4	35	Physical	Single	1	2
5	41	Physical	Marriage	6	8
6	35	Physical	Single	0	3
7	37	Multiple (Physical, Visual)	Single	1	9
8	42	Physical	Marriage	5	6
9	27	Physical	Single	1	3
10	32	Physical	Cohabiting	5	7
11	37	Physical	Cohabiting	4	5

Endnotes

1. See: https://snradio.net/sierra-leones-president-julius-maada-bio-unveils-one-stop-centres-says-among-early-adopters-of-the-concept-in-africa/ & https://rainboinitiative.org/
2. Since the purpose of this scoring is to provide additional supplementary context regarding the general disability inclusiveness of the policies in addition to the main focus of the analysis on gender-based violence, this approach is not elaborated in detail.
3. Note that more targeted demographic information is not given throughout to preserve participant anonymity
4. Since in Sierra Leone many people with disabilities live together in the same community, this is a community leader of a community consisting mainly of people with disabilities
5. Although this points to a need to raise awareness of MSSL's GBV support among women with disabilities, the percentage observed in this research (100% are unaware) should not be extrapolated as a MEL finding due to the sampling approach

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