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## Gender-Based Violence among Women and Girls with Disabilities in Sub-Saharan African Countries: A Scoping Review of the Literature

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Health and Rehabilitation Sciences

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## **Abstract**

Despite numerous studies about gender-based violence (GBV) in Sub-Saharan Africa (SSA), little attention has been paid to violence against women and girls with disabilities. Thus, this scoping review provides an overview of the empirical literature on GBV and disability within the SSA context. Selected literature included various aspects of GBV epidemiology, prevention and response, and interventions. Other aims were to identify the gaps in the current knowledge base and to contribute to an evidence-informed framework for the development of relevant and holistic programs and policies. A key finding is that efforts to seek help are often hampered by barriers, stigmatization, and denial of human rights. Educational opportunities are limited or inaccessible. Health promotion programs are often perceived as non-disability-specific or non-inclusive. Women and girls with disabilities have few options when seeking to leave abusive relationships, a problem that is compounded by the fact that their abusers are frequently their caregivers.

**Keywords:** Gender-based violence, Sub-Saharan African countries, women and girls with disabilities, health promotion.

## Summary for Lay Audience

Women and girls living with disabilities are at high risk for experiencing gender-based violence (GBV) in Sub-Saharan African (SSA) countries. However, individuals and organizations that work with this population lack an understanding of the issue or knowledge about the relationship between disability and GBV. Stigma and discrimination, often linked to social-cultural stereotypes, compound the challenges. There is a need to provide training, knowledge, and skills to help women and girls overcome gendered and disability-related barriers that limit access to equal and equitable human rights services. The purpose of this scoping review of the literature is to provide an understanding of gender-based violence among women and girls with disabilities in Sub-Saharan African countries. A key learning from this study is that there are few existing programs designed specifically to prevent and respond to GBV against women and girls with disabilities, and little recognition of the problem. As a result, there is limited knowledge about how to best assist women and girls with varying types of disabilities. It is recommended that practices, strategies, and policies be informed by a trauma- and violence-informed approach that takes into account histories of trauma and violence at the micro and macro levels.

### **Co-Authorship**

Aimee Josephine Utuza conducted the scoping review for her masters' thesis under the supervision of Dr. Helene Berman, Dr. C. Nadine Wathen, and Dr. Arlene MacDougall, who will be co-authors on presentations and publication of the manuscripts resulting from this thesis.

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## **Chapter One**

This chapter discusses general background information about gender-based violence (GBV) among women and girls with disabilities, emphasizing Sub-Saharan African (SSA) countries. The rationale for this geographic focus will be addressed; the significance and purpose of the study will be presented, along with theoretical underpinnings and the research questions. The chapter will conclude with an overview of the thesis organization.

### **Introduction and Background**

Globally, GBV is the most common form of violence experienced by women and girls. The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." (UN, 1993, P.2). Approximately one out of three women worldwide report having experienced physical or sexual violence during their lifetime (Devries et al., 2013; Dunkle et al., 2020). GBV encompasses various acts of violence, including rape, sexual assault, trafficking, forced marriage, and child prostitution. Other forms of violence including intimate partner violence, and harmful traditional practices such as female genital mutilation and honor killing may be characterized as GBV (Dunkle et al., 2020; Garcia-Moreno et al., 2015).

Worryingly, there is an elevated prevalence of GBV in developing countries, including those in SSA countries. Existing studies suggest that 11.6% to 75.6% of women and girls have experienced one form of violence or another in SSA (Gust et al., 2017). Less is known about the level of GBV against women and girls with disability in general, and in SSA countries in particular. Nevertheless, South Africa has one of the highest rates of GBV. It is possible for

women and girls with disabilities to experience other forms of violence in addition to GBV (Van der Heijden et al., 2020). Intimate partner violence (IPV), which is a serious public health and human rights violation impacting one in three women worldwide, is one of the GBV forms. The fact that women with disabilities experience increased rates of IPV correlates with the significant rate of GBV in this area. However, this population faces added burdens and heightened vulnerability as a result of the intersections among gender, socioeconomic class, and stigma (Dunkle et al., 2020). Many SSA countries have a shared history that increases individual or mass gender-based violence, including colonialism and war. Deeply entrenched socio-cultural and gendered roles often serve to further disadvantage and disempower women, making it even more difficult for those with disabilities to become self-sufficient. European countries, such as Germany, Belgium, Italy, United Kingdom, France, Portugal, and Spain, colonized many Sub-Saharan African countries to obtain natural resources and wealth from the region. This process of colonization affects human rights, adding to environmental degradation, an erosion of political and social cohesion and stability, and an increase in GBV. The net result is heightened risk and loss of protections to vulnerable groups such as women and girls with disabilities.

Women and girls with disabilities who live in developing countries are among those most vulnerable to GBV. Evidence shows that about 80% of these women and girls live in extreme poverty, lack education, and are more socially disadvantaged than men with disabilities or women and girls without disabilities (World Health Organization & World Bank, 2011). Although women living with disabilities are at greater risk of violence in a broader range of settings than are those without disabilities (Vazquez et al., 2019), the current efforts to end violence against girls and women with disabilities appear to have been undermined by inadequate evidence and under-recognition, globally. Women and girls living with a disability

often face gender and power inequality, lack of respect for their reproductive health and rights, and socio-cultural norms that discriminate against them (Vazquez et al., 2019). Additionally, essential interventions focusing on the connections between gender, violence, and disabilities in the SSA region are scarce. A lack of data and appropriate information related to the interconnection of gender, violence, and disability and comprehensive programs, policies, and strategies aimed at eradicating gender-based violence, especially among women and girls with disabilities, may worsen the problem of GBV in the African context. This notion is supported in research by Adams et al. (2018) who noted that the risk of gendered violence is higher when paired with disability. Furthermore, several studies from the Global North and growing evidence from the Global South indicate that women and girls with either physical or cognitive disabilities are at a greater danger of IPV than women without disabilities, including risk for the more significant duration and severity of IPV (Chirwa et al., 2020; Dunkle et al., 2020; Hahn et al., 2014; Garcia-Moreno et al., 2015; Scherer, 2016).

Violence against women and girls harms their physical and mental wellbeing, and those with disabilities are at increased risk of experiencing GBV. Although the knowledge base is somewhat limited, there is a small body of literature that suggests that women and girls with disabilities are at more significant risk of experiencing all forms of violence than both women without disabilities and men with disabilities; IPV is the most common form of violence they experience (Ballan et al., 2015; Krnjacki et al., 2015; Scherer, Snyder & Fisher, 2016; Walter-Brice et al., 2012). People with disabilities are often marginalized from society by disability-related stigma for representing differences that are socially devalued (Campbell & Deacon, 2006). Women and girls with and without disabilities face marginalization. However, those with disabilities often experience multifaceted forms of social exclusion due to the intersecting and

compounding effects of stigmatization and discrimination. The United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) states that girls and women with disabilities are frequently in greater danger, both inside and outside the home, of abuse, violence, or injury (United Nations, 2006). The detrimental impacts of IPV on both physical and mental health have been well-documented and include pain, depression, post-traumatic stress disorder, increased substance abuse, adverse sexual and reproductive health outcomes, injuries, and death (Ellsberg et al., 2008; Thomas, 2006; World Health Organization & World Bank, 2011). GBV is now generally understood to be a significant violation of human rights and a problem with considerable social and economic costs to individuals, communities, and nations.

More specifically, it is estimated that GBV cost the world economy more than USD \$8 trillion per year: USD \$5.8 billion in 2003 in the United States (Centers for Disease Control and Prevention, 2003); GBP \$22.9 billion in 2004 in England and Wales (Walby, 2004), and R \$28.4 billion in South Africa (Bonomi et al., 2009). As an estimate, violence against women costs Australia a total of AU\$21.7 billion per year: \$3.4 billion costs to the economy, \$7.8 billion costs to the taxpayer, and \$10.4 billion costs of pain, suffering, and premature mortality (Price Waterhouse Coopers Australia (PwC), Our Watch & VicHealth 2015). More broadly, the economic costs of intimate partner violence against Canadian women are valued at \$4.8 billion annually. The economic costs of sexual assault/other sexual offences against Canadian women are estimated to be \$3.6 billion annually (Zhang, et al., 2012). Finally, in Rwanda, “the results showed that GBV makes up a small percentage of GDP in Rwanda at 0.003%. Victim costs were measured at \$10,355,812.97, whilst government costs were found to be \$13,082,542.07 and civil society costs incurred amounted to \$4,684,428.00” (Spence, 2020, p.1).

The scientific research on the association between disability and IPV comes predominantly from the Global North and consistently shows that women with disabilities are the population most vulnerable to IPV compared to any other group (Basile et al., 2016; Hahn et al., 2014; Hughes et al., 2012; Scherer et al., 2016; Smith, 2008). Even if men and boys with disabilities sometimes face gender-based violence, most victims are women and girls.

### **Purpose of the Study**

The purpose of this scoping review of the literature is to provide an understanding of gender-based violence among women and girls with disabilities in Sub-Saharan African countries. It evaluates the strengths of the scientific evidence on GBV, identifies gaps and central issues in the current research, and considers the need for future research on the prominence of GBV as seen in women and girls with disabilities. This scoping literature review also offers implications for practice, policy, and education related to gender-based violence against women and girls with disabilities.

### **Theoretical Frameworks**

Two theoretical perspectives have helped to inform the current review, Feminist Disability Theory and Trauma- and Violence-Informed Care. The former, Feminist Disability Theory, incorporates the concept of intersectionality and utilizes the Social Model of Disability. The Social Model of Disability views the community as an entity with impairments and disabilities in a world where disability is considered a socially constructed phenomenon (Barnes et al., 2010). Feminist Disability Theory is relevant for this investigation as it situates gender inequalities among women and girls with disabilities as the root cause of the GBV they experience. The second framework, "Trauma- and Violence-Informed Care" (TVIC) may be viewed as complementary to Feminist Disability Theory, because both acknowledge the effects

and impacts of social inequities experienced by people (Browne et al., 2015). Within the context of SSA countries, gender inequalities affect women and girls in multiple ways, as evidenced by the statistics on violence, disability, poverty, unemployment, lack of education, morbidity and mortality.

### **Feminist Disability Theory**

Mays (2006) used Feminist Disability Theory to write about the intersections among disability and gender. As understood within this framework, "disability is socially constructed from biological reality" (Goodley et al., 2018, p.201). Understanding disability from this perspective requires that we consider how we think about "human diversity, the materiality of the body, multiculturalism and the social transformations that interpret bodily differences" (Garland-Thomson, 2002, p.3). The study of GBV within the social and historical contexts of SSA countries requires that we consider not only gender and disability, but violence as well. In order to develop holistic supports that will promote the health and human rights of women and girls with disabilities, the specificity of disability categories needs to be examined, along with barriers encountered. As well, attention must be directed to barriers such as access to services, lack of education, unemployment, lack of health-related information especially concerning sexual and reproductive health.

Several scholars whose works are included in this literature review discussed barriers and challenges related to disability and gender experienced by women and girls in SSA countries, including social structural, political, and economic factors. The intersection of these factors creates numerous instabilities, including homelessness, internal and external immigration during conflicts, genocide, political strife, and wars. Living amid ongoing violence and trauma leads to multiple adverse health outcomes, including lack of opportunity to develop, poverty, social

inequities, and stigmatization (Banks et al., 2017; Marshall et al., 2018; Stern et al., 2020; Van der Heijden et al., 2020). Feminist Disability Theory responds to social stigma by attending to the relationship between women and girls with disabilities and disability-specific socially experienced stigma or stereotypes. Recognizing the intersection among these, Feminist Disability theorists maintain that gender, disability, and violence should be studied together, as intersecting concepts that interact to shape the lives of women and girls with disabilities.

### **Trauma- and Violence-Informed Care**

Trauma- and Violence-Informed Care (TVIC) is an approach that recognizes the relationships among trauma, violence, negative behaviors, and adverse health outcomes. TVIC is theorized as an institutional change procedure focused on values to heal and decrease the risk of re-traumatization for vulnerable persons (Wathen et al., 2021). TVIC principles promote a strengths-based approach to recognizing and enhancing individual and group resilience and coping mechanisms, creating safety, and authentic choice, through understanding of violence and trauma and their effects on people's lives (Browne et al., 2015; Ponic et al., 2016; Wathen et al., 2019). TVIC involves both structural and clinical applications that acknowledge the complex effects that trauma, interpersonal and structural violence have on clients and healthcare providers (Wilson *et al.*, 2013). Trauma-informed approaches provide an understanding of the long-term consequences of trauma and violence on people's lives, taking into consideration past and current trauma, and may be useful as a means to prevent further harm (Ponic et al., 2016).

TVIC has the potential to enhance practice, education, policies, and strategies in SSA countries to reduce harm and re-traumatization among women and girls with disabilities and their caregivers. For example, TVIC education sessions with health and social service providers have been shown to improve understanding and individual practices, as well as identifying

organizational and/or system-level changes required to improve care experiences (Wathen et al., 2021b). Through TVIC education of providers, organizational commitment to TVIC, and specific program supports based on TVIC principles, women and girls with disabilities may offer ways to challenge and overcome the socio-cultural stigma, discrimination, and dehumanization.

Four main principles of TVIC (Appendix A), including the reinforcement of people's strengths, focus on trust and safety, enhancing understanding and awareness, and providing genuine choices by true collaboration and connection, would help women and girls to receive safe, respectful, and friendly trauma and violence informed services (Wathen et al., 2019). Together, both of these theoretical perspectives have relevance to the current project and turn our attention toward the larger 'macro' issues that shape how violence is experienced by women and girls with disabilities at the individual or 'micro' level. While none of the articles included in the current scoping review of the literature used these theories, I believe there is merit in considering the body of literature in light of these perspectives.

### **Significance of the Study**

Substantial evidence suggests that gender-based violence against women and girls with disabilities is a significant public health issue, with important physical and mental health implications. Despite this assertion, the issue has been largely overlooked, especially in Sub-Saharan Africa. This scoping review of the literature represents one effort to critically examine what is known in this area, and what we need to know in order to provide meaningful and holistic care to this population. More specifically, the findings will be crucial in establishing or revising appropriate strategies aimed at the prevention of gender-based violence and the promotion of health among women and girls with disabilities. The findings from this study may

serve as a foundation for further studies exploring the strategies that could enable health professionals in Sub-Saharan Africa and elsewhere.

### **Research Questions**

The following research questions guided our study:

- a) What is known about GBV against women and girls with disabilities in Sub-Saharan African Countries?
- b) What are the gaps and challenges addressing gender-based violence among women and girls with disabilities in Sub-Saharan African Countries?
- c) Based on the findings of the above questions, what kind of evidence-informed research, policies, practices, and education are required to best support women and girls experiencing GBV in Sub-Saharan African Countries?

### **Self-Declaration, Reflexivity and Personal Relevance of the Study**

In this section, I share a short autobiographical note that reflects why I have chosen to focus my research on "Gender-based Violence against Women and Girls with Disabilities in Sub-Saharan African Countries." I am a Rwandan mother of five children, completing a Master's Degree in Health Promotion within the Health and Rehabilitation Sciences program at Western University, Canada. I have a Master's degree with a background in clinical psychology, mental health, and general nursing and have worked for more than 15 years in the Rwandan health sector. When I was 18 years old, I experienced and survived the atrocities of the 1994 Genocide against the Tutsi People in Rwanda. During that time, I took on the role of surrogate mother to other younger Genocide survivors, caring for my cousin and younger sister, who also survived. I

had no idea if or when I would become an 'ordinary teenager' again, without adult responsibilities.

The personal motivation for choosing my research topic is that my biggest fear growing up was never being able to experience what family harmony is. I witnessed IPV during childhood and adolescence and I grew up with a constant fear that would not stop. This fear continued even while I was enjoying success in my studies at boarding school. That feeling of being unsafe made me constantly doubt that I would ever live in a peaceful and protecting family in a safe environment. I questioned what a safe environment would be like for me, whether at home, at school, in the community, in my country, or somewhere else in the world. In my mind, I rationalized my feelings and thoughts, thinking that those questions were challenging because I was just an innocent and immature girl.

Unfortunately, that was not the case. During the Genocide, as a young girl, I witnessed and experienced the violence and rape that was used against Tutsi women and girls as weapons of war. I was very fortunate to survive without getting pregnant or contracting Human Immunodeficiency Virus (HIV). Witnessing IPV in childhood, experiencing GBV during and after the Genocide, and feeling disempowered as an orphan girl resulted in stress and trauma, and remained imprinted throughout my life. I took this issue very seriously, and I am very aware that my sociocultural identity, including gender, disability and the context in which I lived, shape the way I view this work. I view GBV as a worldwide dilemma which is overlooked in research, especially in relation to people with disabilities. I want to contribute to the prevention of all forms of GBV against women and girls, especially those with disabilities, for two reasons: I didn't want to grow up with constant feelings of fear, uncertainty, shame, and disempowerment. I also wanted to avoid the horrific things that continue to happen to other women and girls in the

world, especially those with disabilities, or others living in insecure places such as refugee camps. Those women and girls tend to experience more GBV.

### **Organization of Thesis**

Three chapters constitute this thesis. Chapter One presents an introduction to the topic and background, the purpose of the review, theoretical underpinnings, significance of this work, research questions and the thesis organization. Chapter Two will provide a complete description of the research conducted, and will include methodology, study results, and discussion. Chapter Three concludes with a presentation of the study's implications and recommendations for research, practice, education, and policy as they relate to gender-based violence as it is experienced by women and girls with disabilities. Chapter Three also describes the study's limitations and provides the general conclusions of this thesis.

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## Chapter Two

### Background and Significance

The prevalence of gender-based violence (GBV) among women and girls with disabilities in Sub-Saharan Africa (SSA) countries is very high, with evidence showing that 11.6% to 75.6% of these women and girls had experienced GBV (Gust, et al., 2017). This may be due to the interplay of social, gendered, and economic processes associated with stigma towards and discrimination against people with either cognitive or physical disabilities. Collectively, these factors exacerbate their vulnerabilities and limit their options for self-protection (Chirwa et al., 2020; Dunkle et al., 2020). This scoping review of the literature focuses on Sub-Saharan Africa countries where there is a shortage of data and appropriate information related to the intersections among gender, violence, and disability. The relative lack of comprehensive programs, policies, and strategies aimed at preventing gender-based violence experienced by women and girls with disabilities further highlights the need for research in this area. It may be anticipated that the problem will only become worse if it continues to be overlooked from a research, policy, and programmatic perspective.

The fact that women and girls with disabilities experience increased rates of intimate partner violence (IPV) corresponds with the significant rate of GBV in Sub-Saharan Africa. Adams and colleagues (2018) have found that the risk of gendered violence is higher when paired with disability in the African context. The transaction of social, gender and financial cycles related to stigma and discrimination against individuals with disabilities increases vulnerability and interferes with women's sense of safety in this area (Dunkle, et al., 2020). Sub-Saharan African countries share many historical events and contexts that increase individual or societal gender-based violence. Included among these are Colonialism, war, and cultural norms

that may inadvertently or explicitly contribute to violence. The authors further stated that about 80% of these women and girls in SSA countries live in extreme poverty, lack formal education, and are more socially disadvantaged than men with disabilities or women and girls without disabilities (WHO & World Bank, 2011). They may have an additional burden for accessing healthcare and adaptive device expenses, further exacerbating poverty (Dunkle et al., 2020; Mitra et al., 2013). Bearing in mind that women and girls with disabilities frequently depend on their intimate partner or others for care, they have fewer options for exiting a violent relationship; some experience violence from their caregivers (Iudici et al., 2019; Scolese et al., 2020). Women and girls with disabilities also experience added stigma, and/or IPV, when they cannot fulfill normative gendered roles assigned to women in a given context (Hunt et al., 2018). Given the additional risk factors and unique challenges experienced by women with disabilities, they may have different IPV prevention and intervention needs than those that are effective for women and girls without disabilities (Iudici et al., 2019).

### **Prevalence of Violence and its Association with Disability among Women and Girls**

In their comparative study evaluating the impact of an intervention in Rwanda and South Africa, Dunkle and colleagues (2020) revealed that at the baseline, physical IPV was 31.6% and 40.5%, respectively in the control and experimental group, sexual IPV was 35.8% and 41.4% respectively, and physical and sexual IPV was reported as 38.2 and 46% in Rwanda. In South Africa, physical IPV was reported at 59.9% vs. 56.6%, sexual IPV was 28.7% vs. 26.6%, and physical and sexual IPV was 55.5% vs. 50.6% respectively in the control and experimental group of women with disabilities. Considerably higher estimates were provided by Chirwa et al. (2020) who reported that the prevalence of women with disabilities who have experienced physical, sexual, emotional, or economic IPV was 80.7% in Rwanda, 87.1% in South Africa, and 54.3% in

Ghana. Based on their research in Uganda, Valentine et al. (2019) found that approximately 2/3 (64%) of Ugandan women with disabilities reported having ever experienced physical, sexual, or mental IPV, compared to slightly more than half (55%) of women with no disabilities.

Furthermore, there is an elevated prevalence of women with disabilities who experienced physical violence (49% versus 39%), sexual violence (35% versus 22%), and emotional violence (51% versus 39%) during their lifetime, when compared to their peers without disabilities.

Collectively, these numbers lend support to the assumption that women and girls with disabilities experience a higher prevalence of IPV than do women and girls without disabilities.

Based on degree of disability, there is some evidence that women with severe disabilities experience a higher incidence of IPV than their peers with mild disabilities. Consistent with this idea, Scolese et al. (2020) included in their research women living with severe disabilities. This group was characterized as those with total dependence on others for care due to the inability to carry out everyday activities. Their findings revealed higher physical and/or sexual IPV (85.0 versus 76.5), physical IPV (67.5% versus 47.1%), and sexual IPV (77.5 versus 70.6%) among those with severe disability as compared to those without severe disability.

Several other researchers have examined the issue with respect to particular conditions. Arulogun et al. (2012) found that 87.4% of girls with deafness had experienced at least one form of violence, including mental/psychological (32.4%); bullying (24.7%), physical (22.6%) and sexual (18.5%). Stigma and discrimination were particular challenges faced by this group, with 32.4% being ridiculed because of deaf status and 13% reporting exclusion from activities. The occurrence of any type of violence was very high among respondents who were older (91.7%), out-of-school (88.9%), and those not working for pay (100.0%). According to the authors, out-of-school participants were 1.2 times more likely to be exposed to any type of violence as

compared with those who were in school, and those aged above 16 years were more likely to experience any type of violence than those younger than 16 years (Arulogun et al., 2012).

Overall, these statistics provide clear evidence that gender-based violence in Sub-Saharan African countries is substantially higher for women and girls with disabilities than the global prevalence of approximately 33% for those without disabilities. Having any type of disability brings distinct challenges which increase the vulnerability and likelihood of experiencing GBV for women and girls with disabilities especially in Sub-Saharan Africa countries.

### **Research Questions**

The following research questions guided this study:

- a) What is known about GBV against women and girls with disabilities in SSA?
- b) What are gaps and challenges in addressing gender-based violence among women and girls with disabilities in SSA??
- c) Based on the findings to the above questions, what kind of evidence-informed research, policies, practices and education are required to best support women and girls experiencing GBV in SSA??

### **Methodology**

#### **Study Design and Setting**

A scoping review was conducted to identify the empirical, peer-reviewed literature about gender-based violence (GBV) among women and girls with disabilities in Sub-Saharan Africa (SSA). This geographic region is the portion of Africa that lies south of the Sahara and is comprised of all African countries except Algeria, Mauritania, West Sahara, Libya, Morocco, and Tunisia. The SSA countries were chosen as an appropriate region for inclusion in this thesis because they share some similarities regarding their perceptions of health issues and the

utilization of the health services (Deaton et al., 2015). As well the problem of GBV is commonly and widely experienced within these countries. The scoping review was selected as the most suitable method for this review as it calls the synthesis of evidence from a body of knowledge that is heterogeneous in methods or disciplines (Tricco et al., 2018). The framework for the current scoping review will be conducted in congruence with the guidelines suggested by Arksey and O'Malley (2005), Levac et al. (2010), and Peters et al. (2015). The five stages of this scoping review involve: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting of the data; and (5) collating, summarizing, and reporting the results. Title and abstract screening commenced in March 2021, and data charting was completed in June 2021.

### **Stage 1: Identifying the Research Question**

Research questions on gender-based violence against women and girls with a disability are relevant to health promotion as GBV affects public health and human rights with short and long-lasting psychosocial and health impacts. Health promotion covers a wide range of social and environmental interventions designed to benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health. Scholars have highlighted that most violence prevention programs for empowering women and girls in low- and middle-income countries (LMIC) consist of a series of educational workshops, social communication, and community mobilization regardless of disabilities (Ellsberg et al., 2015). Studying the intersections among gender, violence, and disability draws attention to an aspect of health that has received little scholarly attention, particularly among health researchers. The research questions posed here will yield important insights that may contribute to the development of health promotion programs and policies for women and girls with disabilities.

The questions in this scoping review include:

- a) What is known about GBV against women and girls with disabilities in Sub-Saharan African Countries?
- b) What are gaps and challenges in addressing gender-based violence among women and girls with disabilities in Sub-Saharan African Countries?
- c) What kinds of evidence-informed research, policies, practices, and education are required to best support women and girls experiencing GBV in Sub-Saharan African Countries?

## **Stage 2: Identifying Relevant Studies**

A librarian from Western University was consulted for guidance on the search strategy and resources to search. PsycInfo, Medline, Embase, Scopus, and Cumulated Index to Nursing and Allied Health Literature (CINAHL) were searched. The search considered the peer-reviewed journal articles containing empirical research on gender-based violence focusing on women and girls with disabilities from Sub-Saharan African countries. A combination of database-specific keywords and search terms with a connection to disability was used (e.g. "physical\*", "intellectual\*", "learning", "disability\*", "disable\*", "handicap\*"), violence (e.g. "Spouse Abuse", "Domestic Violence", "Gender-Based Violence", "Battered Women", "Intimate Partner Violence") and Africa (e.g. "Africa\*", "developing countries.mp") within the above-mentioned databases. In order to provide a current and comprehensive overview of gender-based violence among women and girls with disabilities found in Sub-Saharan African countries (inclusion criteria), no date limits were applied to the searches. This decision also was supported by the fact that this body of literature is quite sparse. The search resulted in publications dating from 1997 until 2021.

### **Stage 3: Study Selection**

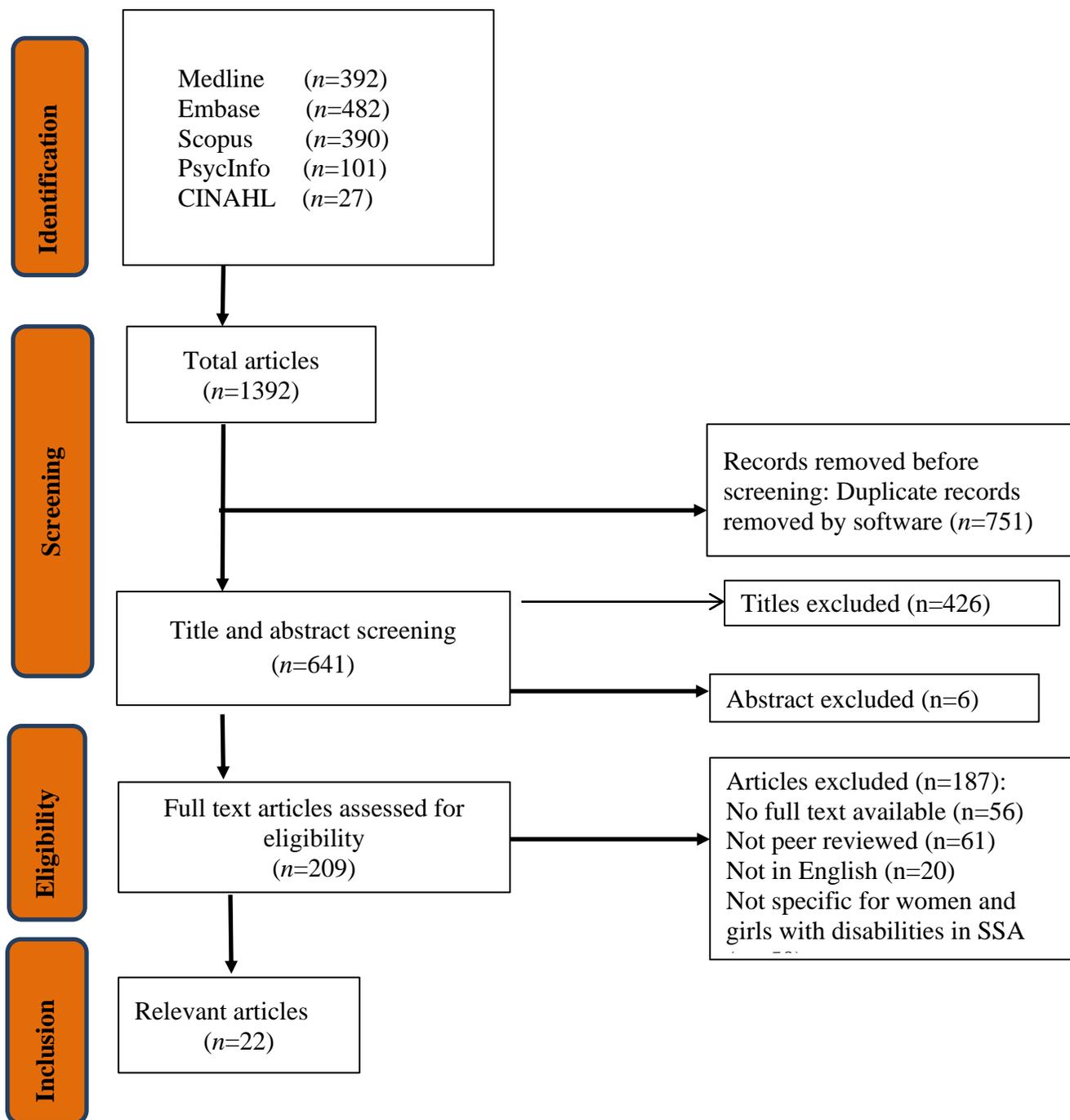
This review includes peer-reviewed empirical research. Exclusion criteria were any literature which did not explicitly address GBV among women and girls with disabilities in SSA countries or any other review or opinion publication. Grey literature, including theses, books, news articles, blogs, were also excluded. Figure 1 presents the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) diagram for the inclusion of studies in the final data set. The search of PsycInfo initially produced 101 articles published between 1997–2021; this number was reduced to 2 after applying the inclusion criteria. The search of Medline produced 392 papers published in 1982–2021, falling to 5 after consideration of the inclusion criteria. A search of Embase produced 482 papers published between 1970-2021, falling to 7 after excluding those that did not meet our inclusion criteria. The search of Scopus generated 390 citations published in 1982–2021, which fell to 5 when using database options to exclude non-peer-reviewed or non-English-language cases. Lastly, the search of CINAHL generated 27 articles published in 2004–2021, which fell to 3 when using database options to exclude non-peer-reviewed or non-English-language cases.

### **Stage 4: Charting of the Data**

This search resulted in 22 articles deemed appropriate for inclusion in this scoping review. Details are shown in the PRISMA flow chart, Figure

**Figure 1**

*PRISMA Flow chart of scoping review, (based on framework by Arksey and O' Malley, (2005))*



As presented in Figure 1, after the inclusion criteria were applied, 22 studies were retained. These are summarized in Table 1. During the title and abstract screening, the endnote

X8 was removed 751/1392 due to duplications. Afterward, the title and abstract of the remaining 641 articles were screened: 426 articles with titles, and six articles with abstracts, not related to women and girls with disabilities were excluded. Subsequently, 209 full-text articles were assessed for eligibility; 187 articles were excluded due to lack of full text ( $n=56$ ), not peer-reviewed ( $n=61$ ), not in English ( $n=20$ ), or not specific for women and girls with disabilities in SSA ( $n=50$ ).

### Stage 5: Collating, Reporting and Summarizing the Data

The processes of collating and reporting resulted in the retention of fourteen qualitative studies, five quantitative studies, two with mixed methods, and one systematic review which included grey literature. Study information was gathered around four named categories: a) studies indicating GBV epidemiology (presenting GBV distribution, incidence, effects, and factors); b) studies on GBV prevention and response (e.g., sensitization and advocacy to reduce GBV and disability-related stigma, access to some services); and c) studies focused on intervention measures (e.g., education and income-generating activities for women and girls with disabilities). Details regarding selected study characteristics are provided in Table 1.

**Table 1**

#### *Study Characteristics*

Article ID	Lead author, (year), Searched Database and Study location	Sample	Objective	Study Design, Methods and Measurement	Key findings	Observation
<b>GBV epidemiology (Types and prevalence, distribution, factors, effects)</b>						
1	Chirwa et al. (2020) SCOPUS Rwanda, South Africa, Ghana	Total n =4157 Rwanda-couples (n=1600) South Africa (n=680) Ghana (n=1877)	To demonstrate if the association between disability and risk of IPV increases with the severity of	Pooled analysis of baseline data from 4157 adult women participating in 3 IPV prevention studies IPV measure: WHO Violence	Any IPV prevalence on women without vs. with disability: Rwanda-Couples (73.7%, 80.7%), South Africa (80.5%, 87.1%), and Ghana (29.8%, 54.3%). The results indicated that	To explore how the association between disability and IPV may be mediated or moderated by education,

			disability increase.	Against Women Instrument	women with disabilities were more likely to experience past 12-month physical IPV (OR=1.79), sexual IPV (OR=1.98), emotional IPV (OR=1.84), and economic IPV (OR=1.66), with an overall association between disability and past 12-month physical/sexual IPV of OR=1.93, Compared to women without a disability. Overall, both women with moderate disability (OR=1.86) and women with severe disability (OR=2.63) were significantly more likely to experience any form of IPV when compared with women without a disability.	poverty, and employment.
2	Scolese et al. (2020) CINAHL DRC	Quantitative sample (98 women) Qualitative sample (57men and 59women)	To investigate how women's disability status may influence violence against women within conflict settings	A mixed methods analysis	Quantitative findings "Women who reported mild disability reported higher experiences of past-month physical and/or sexual IPV (85.0%) compared to those who reported severe or no disability (76.5% vs. 70.8%, respectively). Older women with mild disability were more likely to report physical IPV compared to their younger counterparts as well (OR = 1.23)" Qualitative findings: Dependence, familial obligation, and unfulfilled expectations were thought to contribute to offense towards women with disabilities.	-The sample size was small. Therefore, the outcomes were self-reported, and therefore, may be subject to social desirability bias that may lead to under or over-reporting.
3	Valentine et al. (2019) EMBASE Uganda	N= 8592 women, including 299 participants	To document the pervasive and consequences of IPV exposure among Ugandan	Multistage cluster sample survey design. IPV screening: Conflict Tactics Scale	<b>IPV experiences:</b> -physical, sexual, or emotional IPV (64%); Physical IPV (49%); sexual IPV (35%); emotional IPV (51%).	-The Uganda Demographic and Health Surveys does not provide

		with disability	women with disabilities.		-Compared to women without disability, women with a disability had 1.4 times, 1.7 times, 1.4 times odds of experiencing physical, sexual, and emotional IPV, respectively. <b>Effect of IPV</b> -women with disabilities with exposure to IPV had nearly twice the chances (OR = 1.95) of losing a child under five years of age.	information about the severity, duration, onset, and cause of disability.
4	van der Heijden et al. (2019a) CINHAL South Africa	N=30 women have a physical disability.	To explore how gender and disability intersect in women's experiences of violence during their lifetime.	Cross-sectional study An interview	Violence experienced. Neglect and deprivation: Women experienced multiple layers of neglect and deprivation. For instance, a teacher at a special needs school refused to change a participant's diaper. <b>Emotional and psychological abuse:</b> It mostly took the form of verbal abuse or name-calling, leaving women feeling belittled, humiliated, or worthless. <b>Financial abuse:</b> Many women had limited education and skills to be fully employed, and most were reliant on the disability grant that places them at risk of financial abuse. <b>Physical abuse:</b> women reported receiving beatings by teachers, parents, or caregivers because they were "too slow" or had wet themselves <b>sexual abuse:</b> unwanted sexual behavior that occurred during their lifetime, including fondling,	population-based evidence is needed to quantify the prevalence and the types of violence women with disabilities experience. Population-based surveys need to use different scales to pick up disability-related violence such as extorting welfare grants, neglect, isolation and deprivation, and the disability stigma they specifically experience.

					forced oral and anal sex, and non-consensual sexual intercourse,	
5	Njelesani et al. (2018) Guinea, Niger, Sierra Leone, and Togo	N= 419 children	To explore violence Experienced by children with disabilities.	Cross-sectional design An interview	<p><b>From the day they are born:</b> The study noted that violence begins when children with disabilities were born (they explain that a child with a disability was a demon or punishment from God).</p> <p><b>All too common:</b> The children with disabilities reported experiencing violence from parents, teachers, peers, or community members.</p> <p><b>Differences in impairment and participation:</b> Participants spoke that violent experiences vary according to the type of impairment and the child's participation in their community.</p>	-Separating violent experiences among girls and boys. -Unequal gender representation among participants.
6	Olatosi et al. (2018) Nigeria	179 participants (dentists attending postgraduate update course)	This study aimed to determine the experience and knowledge of CAN among a group of Nigerian dental residents.	Cross-sectional study design Ad hoc questionnaire with four sections.	<p>Most respondents (85.5%) reported that children with physical/mental disabilities were at risk of being abused and neglected.</p> <p>“The respondents demonstrated good knowledge of the forms of child abuse, with an average score of 95.2%. (85.5%) respondents correctly identified the risk factors for CAN as children with physical/mental disabilities (84.4%) as products of unwanted pregnancies (71.5%) as children from polygamous families and (68.2%) as children from low socioeconomic families. Physical, sexual, and</p>	-There is no prevalence of child abuse and neglect among girls and boys separately. - Lack of participation of either women or girls with disability.

					emotional mistreatment and neglect were majorly identified as bruises behind the ears (90.5%), oral warts (63.7%), poor self-esteem (88.3%), and untreated rampant caries (76.5%), respectively. Forty-six (46.5%) of the respondents did not evaluate children for CAN, and only (14.1%) of those who observed suspected cases of CAN were reported to the social service. Lack of knowledge of referral procedures and concerns about confidentiality were the major barriers to reporting cases of CAN.”	
7	Winters et al. (2017) EMBASE East Africa	41 studies	Mapping the existing evidence-base to document the coverage, patterns, and gaps in existing research on the mistreatment of children with disabilities in East Africa.	Systematic mapping	Challenges in designing effective programs against children abuse and the suggestion to consider child abuse among political priorities as it is a global health concern	Limited ability for the study to provide a synthesis of effects of systematic abuse of children
8	Hendricks et al. (2014) MEDLINE Cameroon, Central Republic, Ghana, Sierra Leone, Representative and Djibouti & countries from other continents.	representative samples of 45,964 two-to nine-year-old children and their primary caregivers in 17 developing countries.	To understand relations between cognitive, language, sensory and motor disabilities, and Child Rearing discipline and violence.	Cross-sectional study The 11 items in the Child Discipline module	Primary caregivers reported on their children’s disabilities and whether they or anyone in their household had used nonviolent discipline, psychological hostility, and physical violence toward the target child and believed that utilizing corporal punishment is necessary. Logistic regression analyses upheld the hypothesis that children with disabilities are treated more harshly than	The authors failed to distinguish between girls and boys with disabilities

					children without disabilities.	
9	Arulogun et al. (2012) EMBASE Nigeria	N= 167	To assess the types and prevalence of violence experienced by deaf girls in the Ibadan metropolis.	Cross-sectional study Structured questionnaire	<p><b>Violence:</b> -mental/psychological (32.4%) - bullying (24.7%) - Physical (22.6%) - Sexual (18.5%)</p> <p><b>Physical abuse perpetrators:</b> Teachers (45.1%), fathers (28.6%), and neighbors (12.1%).</p> <p><b>Sexual violence perpetrator:</b> neighbors (50.0%), teachers (37.5%), fathers (7.5%) and step-fathers (5.0%). Respondents who are out-of-school are more likely to suffer any type of violence than those in-school (OR= 1.2), and those older than 16 years are more likely to experience any type of violence than those younger than 16 years (OR=1.4).</p>	The study requested effective interventions regarding specific disabilities.
10	Kvam et al. (2008) MEDLINE Malawi	N= 23	To disclose and describe the nature of possible sexual assault against women and girls with disabilities.	Cross-sectional An interview	<p><b>Childhood Sexual Abuse:</b> All interviewees noted that they did not experience sexual abuse in their childhood.</p> <p><b>Sexual Abuse and Sexual Relations in Adult Life:</b> Few participants had heard such stories, but they had no personal information.</p> <p><b>What Can Be Done?</b> -They wanted to have laws that made the fathers economically responsible for their biological children regardless of where they lived. -They must get better access to their special education needs. In general, the respondents did not note a sexual abuse</p>	

					experience. However, they regarded sexual abuse as the shared experience of men who offered them marriage and leave once they got pregnant.	
<b>GBV Prevention and Response</b>						
11	Njelesani (2019) Guinea, Niger, Sierra Leone, and Togo.	N= 419 (157 women/ girls)	Explores responses to aggression against children with disabilities, including preventative courses of action and treatment of victims in the West African countries.	Cross-sectional An interview	Critical communal responses were identified across the four countries and three key themes were highlighted, one at the level of the macrosystem (Policies and laws aren't always part of the solution) and two at the mesosystem and exosystem level (Communities leading from the bottom and sent away for safety). Although these three themes highlight similarities across each country, overall responses to violence did not appear to be primarily influenced by the type or severity of violence or where it occurred (i.e., school, home) but varied depending on its socio-political context.	The number of girls was small compared to males, and the sample was recruited from a few West African countries.
12	Van der Heijden et al. (2019c) PSYCINFO South Africa	N= 30	To explore how disability stigma intersects with womanhood to characterize intimate partnerships in South Africa.	Qualitative case study	Findings suggest that disability stigma may hamper the attainment of normative womanhood and intimate relationships for women with disabilities in South Africa. Limited opportunities to meet potential lovers, hegemonic gender expectations, and local sexual and physical contact shape their intimate partnerships. However, women with disabilities also challenge ableist constructs of normalcy	-Women with Disabilities were recruited from a range of protective workshops and residential rehabilitation facilities only. -Lack of participants with cognitive and severe communicati

					and discredit negative images of disabled womanhood.	on impairment. -
13	Peta (2017) SCOPUS Zimbabwe	N= 16	To explore how various social life attributes like disability, culture, and gender intersect to frame the experiences of GBV and sexuality among women with disabilities in Zimbabwe.	Qualitative narrative approach	<p>Violence:</p> <ul style="list-style-type: none"> <li>-Sexual coercion and rape: The sub-theme of the prevalence of sexual coercion and rape within families and communities came up in one way or the other in most of the interviews.</li> <li>-Physical abuse: physical abuse that emerged in this study arises from deaf participants and those who marry later on in their lives. The findings also reveal that women with disabilities who marry later on in their lives may experience physical abuse perpetrated by their intimate partners.</li> <li>-Risk of acquiring HIV: There is evidence that almost all the participants are at a high risk of contracting HIV due to the repeated breakdown of their intimate partner relationships and GBV.</li> </ul>	
14	Bayat (2015) MEDLINE West Africa (Ivory coast)	N=89 (professionals working in the disability and health fields, teachers, and parents of children with disability).	Follow-up of investigation to understand the phenomenon of snake children further.	Longitudinal study An interview	<p><b>The origins of the snake child phenomenon:</b></p> <p>The researcher noted that having a developmental or intellectual disability (inability to move and hold head straight) is associated as being a snake child in childhood and one of three outcomes may arise: being killed, being left to die, or being allowed to live in the community as the 'other' non-human. Possible mistreatment of the children with</p>	The children with disabilities were not asked to explore the abuse or violence they face.

					disabilities in Cote d'Ivoire: In the survey part of this study, about 93% of all professional participants (teachers and social workers) admitted that they used some kind of corporal or emotional punishment, such as 'beating,' 'shouting,' as a way of teaching and disciplining children with disabilities with whom they worked.	
15	Banks et al. (2017) EMBASE Uganda and Malawi	43 children (20 girls [ten girls in each country])	To provide a better comprehension of the context of violence endured by children with disabilities and if and how they get child protection mechanisms in Uganda and Malawi.	Cross-sectional, An interview	-Experiences of violence: The children with disabilities in both the Malawi and Uganda samples reported undergoing some form of aggression (Malawi n = 20/22; Uganda, n = 13/21). Children interviewed reported enduring physical and emotional abuse (e.g. bullying, abusive name-calling) and stigma and isolation. <b>Barriers</b> - Some of the main factors impeding access to child protection for children with disabilities included: lack of local government disability-inclusive planning and budgeting; centralization of limited disability and social protection services; financial obstacles to seeking and receiving care; and stigma the negative attitudes toward disabilities.	Participants came from rural areas; therefore, generalization of results was limited.
<b>GBV Interventions</b>						
16	Dunkle et al. (2020) SCOPUS Rwanda, South Africa and Afghanistan	-Rwanda: n=28 clusters  -South Africa: n=34 clusters	To express the extent to which effective IPV prevention programs for general populations	-Rwanda: A two-arm Cluster-randomized control trial. -South Africa: A cluster randomized controlled trial.	Rwanda: Physical and sexual IPV >1 type or occurrence 46.0%, 31.6% at baseline and Endline prevalence, respectively.	Inability to look at differential impact by type(s) of disability, such as

			of women are accessible to, and accessed by, women with disabilities	-Sexual IPV: WHO's Domestic Violence and Health Scale. - physical IPV: WHO Domestic Violence and Health Scale.	South Africa: Physical and/or sexual IPV >1 type or occurrence 50.4%, 44.2% at baseline, and Endline prevalence, respectively. [we considered intervention arm] Results showed that at baseline, between 17.7% and 26.2% of women reported being disabled. For IPV avoidance, in seven out of eight tests across three courses, women with and with no disabilities had similar outcomes. For economic, health, and substance use results, there was more variation, with women with disabilities reporting both better and worse outcomes than women with no disabilities; however, there was no clear pattern in these differential results.	mobility, visual or hearing impairments
17	Stern et al. (2020) SCOPUS Ghana, Rwanda, South Africa	N=25 (Rwanda: 4 women and three men, Ghana: 6 women and five men, South Africa: 7 men).	The aim was to learn from women and men with disabilities what is required to develop more disability-appropriate and accessible programs to prevent and respond to IPV.	Population-based observational study In-depth interview	Participants described enduring disability-related stigma, discrimination, exclusion, and for women, increased vulnerability to IPV. Obstacles to full participation in programs included limited accessibility and lack of disability-specific tools, recruitment, or outreach. Enablers of inclusion included recruitment and monitoring methods aimed at people with disabilities, collaborating with a local disabled people's organization, training workers in disability	-Limited by not assessing programs that had specific disability-related programming - Lack of girls (children) with disability

					inclusion, and raising awareness of disability rights”.	
18	Van der Heijden et al. (2020) CINAHL South Africa	N= 30	To show the inclusivity and accessibility of GBV services for women with a range of disabilities. (exclusion of barriers)	Cross-sectional interview study In-depth interview	Thematic analysis revealed that women with disabilities experience unique disability-related barriers to GBV care and support. Disability-related stigma, accessibility barriers, inadequate training, limited resources, and lack of funding contributed to inadequate GBV service provision for women with disabilities. While awareness and training, accessible information, reasonable accommodations, increased funding, and disability relevant referrals need to be integrated into existing GBV services to ensure sustainable and accessible pathways to inclusive violence prevention, support, and responses in the country”.	-limitation to the study’s representativeness (exclusion of women with severe cognitive impairment). - Participant selection was made through DPOs only (ignoring women who were isolated and more vulnerable).
19	van der Heijden et al. (2019b) South Africa	N= 30	To stimulate debate around the inclusion of reasonable accommodation, accessibility, and equal participation in planning Moreover, conducting ethical and disability-inclusive GBV research.	Qualitative case study In-depth interview	Ethics regarding research inclusion of women with disability: Defining disability and inclusive recruitment, Reasonable accommodation, and accessibility of consent and referrals, Confidentiality and intermediaries, Additional researcher training and skills, Benefits and compensation, Emancipatory research for positive social change, Research for who? Accessibility of knowledge and research uptake	-Women with disabilities were recruited from a range of protective workshops and residential rehabilitation facilities only. -Lack of participants with cognitive and severe communication impairment.

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20	Devries et al. (2018) EMBASE Uganda	42 primary schools, students aged from 11 to 14 years old selected from P 5,6 and 7	To test if the Good School Toolkit reduces physical aggression from peers and school staff towards pupils with and without disabilities in Ugandan primary schools.	Cross-sectional study Violence screening tool: International Society for the Prevention of Child Abuse and Neglect Screening Tool—Child Institutional (ICAST-CI).	53% of control group pupils with no functional hardships reported violence from classmates or school staff, versus 84% of students with disabilities at the end line.	The study did not show violence prevalence among girls with disability.
21	Marshall et al. (2018) MEDLINE Rwanda	N= 54 papers 54 people	The project's main objective was to document current knowledge about the intersectionality between SGBV, communication disability, and refugees.	Cross-sectional study -Systematic review  -An interview	-15 publications consistently documented the increased risk for refugees with disabilities to Sexual Gender-Based Violence (SGBV) compared to people without disabilities. <b>-The main subjects included:</b> 1. Disclosure of SGBV to community authorities or service providers (people with communication disabilities not being acknowledged or believed due to stigma and the inherent dangers associated with “proxy reporting”). 2. Accessing support, including medical, legal, psychosocial support, and protection (challenge of reporting a sexual GBV affects the way victims access the help). 3. Sexual and reproductive health education (the study showed that people with communication disabilities would also be less likely to access sexual and reproductive health education and SGBV prevention services).	The study did not explore ideas from people with communication disabilities themselves.

22	Meer et al. (2017) PSYCINFO South Africa	N=58 service providers	To describe familial relationships for women with intellectual disabilities in South Africa who experience gender-based violence.	Cross-sectional study. An interview	Social context: poverty, patriarchy, and exposure to violence: lack of supportive structures and services, ostracization, familial neglect, and inability to access extended family and community networks due to stigma associated with intellectual disabilities. <b>Families are significant in aiding resilience and protection for women:</b> Families play an essential role in ensuring safety and limiting or preventing exploitation and violence. <b>Families' responses to GBV:</b> Families are vital for the daily living and well-being of women with intellectual disabilities. Respondents underlined that where cognitive or speech impediments exist, caregivers often negotiate daily interactions, including in seeking disability and GBV services.	The study did not consult the disabled women.
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## Results

Throughout the mapping process of reviewed literature regarding this research topic, key themes were identified after analyzing the content of twenty-two selected articles and the synthesis of evidence. Inclusion and exclusion criteria and the defined research questions helped identify the article's relevance and the key themes from the literature content.

Based on the research questions that guided this scoping review, seven thematic areas emerged: 1) Prevalence of violence and its association with disability; 2) Types and perpetrators

of violence against women and girls with disabilities; 3) Effects of gender-based violence towards women and girls with disability; 4) Barriers to accessing the helping services for women and girls with disability; 5) Contributing factors of GBV, 6) Responses to the violence targeting women and girls with disability and 7) GBV prevention programs with some identified examples. The prevalence was examined earlier, in the background section of this chapter. The remaining themes will be discussed in the following text.

### **Types and Perpetrators of Violence Against Women and Girls with Disabilities**

One study in this review explored the types of gender-based violence encountered by women and girls with a disability. The study conducted in South Africa among women with a physical disability showed six categories of violence directed toward women and girls with disabilities including emotional and psychological abuse, sexual abuse, physical abuse, financial abuse, and neglect and deprivation (van der Heijden et al., 2019a). The same study indicated that it is also possible for these women to experience other forms of violence including abuse related to socio-cultural myths. Rape is also a significant problem targeting women with disabilities in South Africa. Their lives are commonly characterized by fear, shame, and stigmatization, which hinder the women's ability to report the violence they experience. Women who are able to report often face disbelieving or skeptical attitudes, or services that are perceived as 'unfriendly'. Where services are available, resources were described as largely insufficient (van der Heijden et al., 2019a).

Three studies included in this review focused on the perpetrators of violence against girls with a disability. Arulogun et al. (2018) found that teachers, fathers and neighbours were the main perpetrators of physical abuse while the perpetrators of sexual violence were neighbours, teachers and stepfathers among deaf girls in Ibadan Metropolis, Nigeria. Devries et al., (2018)

found that gender-based violence experienced by primary students in Uganda tended to be perpetrated by students, peers, and school staff (Devries et al., 2018). Njelesani et al. (2018) stated that children with disabilities reported experiencing violence from parents, teachers, peers, or community members. In addition, Hendricks et al. (2014) reported that most primary caregivers of children with disabilities used a range of disciplinary methods, some non-violent, others explicitly violent. Those in the latter group justified the use of violence, stating their belief that corporal punishment is necessary to help children obey rules and learn to behave ‘properly’ at home or in class. Moreover, one study done by Bayat (2015), conducted in the Ivory Coast, noted that a child with a developmental or intellectual disability was often referred to as a “snake child”, a derogatory phrase that essentially means ‘non-human’. As Bayat observed, one of three outcomes may arise: being killed, being left to die, or being allowed to live in the community as the ‘other’. It is clear from this body of research that children experience many acts of maltreatment, often from people who are known to them.

### **The effects of Gender-Based Violence Towards Women and Girls with a Disability**

Gender-based violence has detrimental effects on the lives of women and girls with disabilities and may worsen their disability status. Three studies specifically addressed the effects of gender-based violence on women with disabilities (Peta, 2017; Valentine, et al., 2019; van der Heijden et al., 2019a). Women who have been exposed to IPV had nearly twice the odds (OR = 1.95) of having a child die before the age of five in Uganda (Valentine et al., 2019). According to Peta (2017), almost all participants in a study conducted in Zimbabwe were at high risk of contracting HIV due to the repeated breakdown of their intimate partner relationships and GBV. Other researchers have reported that women with disabilities who had been exposed to GBV were 1.3 times more likely to face pregnancy loss or termination and 1.2 times more likely

to face delivery at a health facility as compared to women without disabilities and with no exposure to GBV (Valentine et al., 2019; van der Heijden et al., 2019b).

### **Barriers to Accessing the Helping Services for Women and Girls with Disability**

Four studies found that women and girls with disabilities who experienced gender-based violence face unique barriers to accessing helping services, such as lack of transportation facilities, low literacy, and inaccessible equipment (Banks et al., 2017; Marshall et al., 2018; Stern et al., 2020; Van der Heijden et al., 2020). The study carried out in South Africa shows that disability-related stigma, accessibility barriers, inadequate training, limited resources, and lack of funding contributed to poor GBV service provision for women with disabilities, thereby reducing the likelihood of receiving help (Van der Heijden et al. (2020). Women with disabilities from Rwanda, Ghana, and South Africa faced similar barriers that inhibited full participation in programs including limited accessibility, and lack of disability-specific materials, recruitment, or outreach (Stern et al., 2020). The inability to disclose sexual violence to community leaders or service providers due to a communication-related disability, challenges of reporting sexual GBV, and fewer opportunities for sexual and reproductive health education heightened the vulnerability among women with disabilities in Rwanda (Marshall et al., 2018). In Uganda and Malawi, Banks and colleagues (2017) reported that some of the key factors blocking access to child protection for children with disabilities included: lack of local government disability-inclusive planning and budgeting; centralization of limited disability and social protection services; financial barriers to seeking and receiving care; and stigma and negative attitudes toward disabilities.

Most barriers elaborated upon in this review reflected on disability-related factors, inadequate information, and awareness, lack of training, limited resources, limited funding, the

lack of knowledge in referral procedures, concerns about confidentiality, and fear of the consequences to the child (Olatosi et al., 2018; Van der Heijden et al., 2020). In addition, geographic accessibility was noted, as most programs were urban-based, and financial vulnerability were described as further obstacles for women and girls with disabilities (Banks et al., 2017).

### **Contributing Factors of GBV among Women and Girls with Disability in Sub-Saharan Africa**

As presented in Table 1, five studies out of the 22 articles included in this review have pointed to various contributing factors of gender-based violence among women and girls with a disability (Marshall et al., 2018; Meer et al., 2017; Olatosi et al., 2018; Scolese et al., 2020; Stern et al., 2020; van der Heijden et al., 2019a). Scolese et al. (2020) found that dependence, familial obligation, and unfulfilled expectations on the part of women or girls with disabilities contributed significantly to offences towards this population. The association of poverty, patriarchy, lack of supportive structures and services, ostracism, familial neglect and inability to access extended family and stigma related to intellectual disability all combine to exacerbate victimization of women with disabilities (Meer et al., 2017). It was revealed that many of the women and girls described experiencing disability-related stigma, discrimination, exclusion; many were at increased risk of IPV (Stern et al., 2020). Findings from this study suggest that disability-related stigma may hamper attainment of normative womanhood and sexual relationships for women with disabilities in South Africa (van der Heijden et al., 2019c). In Rwanda, few opportunities for sexual and reproductive health education contributes to gender-based violence (Marshall et al., 2018). Although the research related to children with disabilities and GBV is limited, Olatosi et al. (2018) revealed that children with physical or mental

disabilities were at increased risk of being abused and neglected, followed by children who were products of unwanted pregnancies (84.4%), children from polygamous families (71.5%), and children from low socioeconomic families (68.2%).

### **Responses to the Violence Targeting Women and Girls with Disability**

Responses to the violence targeting women and girls with disabilities were highlighted by three studies included in this review; one at the level of the macrosystem and two at the mesosystem and exosystem level (Njelesani, 2019). A study conducted in Malawi (Kvam et al., 2008) highlighted the need for women with a disability to receive improved access for their special education needs. These researchers advocated for laws that made their husbands economically responsible for their biological children. Among their recommendations is a call for improved GBV prevention programs that explicitly address the risk of intimate partner violence faced by women and girls with disabilities. Enhanced outreach activities for disability-oriented services, and greater attention to the need for accessibility were emphasized (Chirwa, 2020). Several researchers also drew attention to the need to support children with disabilities. Societal factors such as cultural stereotypes and religious beliefs that stigmatize children with disabilities affect their social integration, resulting in their isolation. These factors are not only a burden for children; they are also a burden for their family members including their mothers, contributing to anxiety and stress within the family (Njelesani, 2019).

### **GBV Prevention Programs**

There remains limited evidence as to whether IPV prevention interventions developed for an able-bodied population can benefit women and girls with disabilities. Two existing interventions for GBV prevention are Stepping Stones and Creating Futures Intervention (South Africa) and Indashyikirwa (Agents for Change) Rwanda Intervention. No disability-specific

program elements were identified. Overall, as to be expected, women with disabilities in all three courses reported considerably higher rates of IPV than did the able-bodied participants at both baseline and at follow-up (Dunkle et al., 2020). Although not developed explicitly for women with disabilities, an evaluation of these programs showed similar results for those with and without disabilities (Dunkle et al., 2020).

### **Stepping Stones and Creating Futures (SS-CF) Intervention**

SS-CF can be described as a participatory, facilitator-led intervention comprised of 21 sessions, each approximately three hours in duration. Stepping Stones focuses on gender, relationships, violence, communication, and sexual health (Stern et al., 2020). Creating Futures focuses on livelihood strategies, financial management, and getting and keeping jobs. The sessions encourage dialogue and reflection regarding people's situations. About 20 women are in each grouping, and there are parallel groupings for men.

Evaluation of this program in South Africa revealed an inferring of differential benefits for women with disabilities in terms of depressive symptoms with a significant decrease that was not mirrored among women without disabilities; however, the interaction term showed only limited evidence of a difference between the groupings ( $p=0.12$ ), indicating that there was no difference in efficacy of the intervention between the women with disabilities and those without disabilities in terms of depression symptoms. Women with disabilities reported a borderline prevalent increase in overall alcohol intake ( $\beta=3.42$ ,  $p=0.06$ ), contrasting to a non-significant decrease among women with no disabilities ( $\beta=-1.14$ ,  $p=0.10$ ), indicating that disability status increases the risks of taking alcohol.

### **Indashyikirwa Rwanda *Intervention***

Another program, Indashyikirwa (meaning ‘agents for change’ in Kinyarwanda), was implemented from August 2014 to August 2018 in seven districts in the Eastern, Northern, and Western provinces of Rwanda in predominantly rural communities (Stern et al., 2020). This program was put into action by CARE Rwanda, Rwanda Women’s Network (RWN), and the Rwanda Men’s Resource Centre (RWAMREC). The program aimed to reduce IPV, improve survivors’ well-being, and shift attitudes, behaviors, and norms that uphold IPV among couples and communities. Indashyikirwa was composed of four interrelated components: (1) a 21-session couples curriculum to build healthy, equitable relationships with male-female couples where at least one person was a participant of a village savings and loan association (VSLA); (2) activist training and society activism; (3) training and engagement of local opinion authorities; and (4) community education, outreach, and support for victims offered through women’s safe spaces (Dunkle et al., 2020). Women with and without disabilities have shown significant improvement in health outcomes in follow-up evaluation in Rwanda. There were more significant benefits to women with disabilities in reducing depressive symptoms.

In summary, the themes presented here collectively address all of the research questions. Five themes address the first question which asks what is known about GBV against women and girls with disabilities in Sub-Saharan African countries. To some extent, these themes also address the second research question which seeks to understand the gaps and challenges of addressing GBV among this population. These ideas are elaborated upon here.

Prevalence of violence and its association with disability. Defining and contextualizing GBV and disability, as they are experienced by women and girls with disabilities and establishing the prevalence of violence faced by this group, serves to raise awareness regarding

the extent and experience of the problem and how to recognize it. Knowing the extent of GBV across SSA countries facilitates the development of meaningful and relevant policies, strategies, and programs, and provides direction for the planning, implementation, and evaluation of interventions to respond accordingly.

Types and perpetrators of violence. GBV is grounded in power inequality relations. Women and girls with disabilities experience various types of GBV throughout their lifecycle. Understanding what types of GBV occur, who are the perpetrators and who are on the receiving end of violence enhances the possibility of overcoming gendered and disability-related discrimination and stigmatization. Moreover, this knowledge can be used to foster the integration of GBV positive behaviour change in SSA and consideration of a trauma- and violence-informed approach within this context.

Effects of gender-based violence. GBV effects negatively influence women and girls' lives and hinder their safety.

Barriers to accessing the helping services. GBV persists in SSA. It's crucial to avail pre and post GBV exposure services, including information, counselling, referral, and other services such as social and legal justice to women and girls with disabilities.

Contributing factors of GBV. Different factors such as harmful sociocultural norms including gender and disability related stereotypes encourage abuse culture and force women and girls with disabilities to remain in vulnerable conditions of poverty, social disintegration, and unemployment.

The two last themes, namely Responses to the violence targeting women and girls with disabilities and GBV prevention programs with some identified examples, addressed the third research question. This question asks what kind of evidence-informed research, policies,

practices, and education are required to best support women and girls experiencing GBV in Sub-Saharan African countries. It is anticipated that health and social service professionals and policymakers would commit to improving health care friendly services and reducing gender inequalities to respond to GBV issue. Efforts to prevent and respond to GBV are a positive investment in women empowerment to reduce GBV cost and its long-term consequences on women and girls' economic development.

GBV among women and girls with disabilities knowledge gaps and their experienced challenges reported in each article were noted and summarized in the last column of table 1 and under the limitation section of this research. That helps respond to the second question regarding gaps and challenges in addressing gender-based violence among women and girls with disabilities in Sub-Saharan African countries.

### **Strengths and Limitations to the Current Literature**

The reviewed literature yields important beginning knowledge regarding the relationship between GBV and disability. Collectively, the studies included in this review focus on the problem as it is experienced across the lifespan, from early childhood to the senior years. While this is an important strength of the reviewed research, it is noted that few of the studies looked at gender-specific impacts and were largely gender-neutral.

There is some evidence of region-specific concerns. For example, Winters and colleagues in 2017 reported the systematic abuse of children with disabilities in East Africa. To what extent, or how, this finding could be extended to other countries in the region is not known and reflects an important gap in the current body of knowledge. A small number of studies revealed particular challenges faced by women and girls with disabilities experiences, but this is clearly an area that is ripe for further investigation. Through the current scoping review, it may be

possible to glean promising approaches for the prevention of GBV, along with appropriate response and intervention strategies.

While this body of literature offers important insights, there are several noteworthy limitations inherent in the body of research included in this review. More specifically, these include: the failure to look at differential impacts by type(s) of disability, such as mobility, visual or hearing impairments; lack of attention to the association between disability and GBV and how this may be mediated or moderated by education, poverty and employment; limitations to the study's representativeness, and importantly, the exclusion of women with severe cognitive impairment; the limited evaluation of existing programs that had specific disability-related content; and the lack of inclusion of girls, or children more broadly, with disability. Furthermore, many of the outcomes were self-reported, and therefore, may be subject to social desirability bias that may lead to under- or over-reporting. Finally, some studies conducted with children provided little information about gender or age, making comparisons difficult to ascertain (Hendricks et al, 2014; Njelesani et al,2018).

### **Discussion**

This scoping review of the literature aimed to provide a comprehensive review of the available literature on GBV and disability within the Sub-Saharan Africa (SSA) context. A total of 22 articles were reviewed. Several studies about gender-based violence were identified, however very little scholarly attention has been paid to this phenomenon as it pertains to people with disabilities, and especially women and girls with disabilities. This gap is, in itself, noteworthy, and in conjunction with the presented findings, has important implications for researchers, policymakers, educators, and health and social service professionals working with this population.

The discussion presented here is organized according to the aims of our study and the research questions posed. With respect to what is known about GBV against women and girls with disabilities, it is clear that further research is needed. Based on the relatively small number of studies conducted in this area, a consistent finding is that gender-based violence experienced by women and girls with disabilities occurs at disturbingly high rates within Sub-Saharan African countries. These numbers exceed the statistics on the global prevalence of GBV, a fact that should cause concern among practitioners, and that has implications for policymakers. The current knowledge base is further limited by the absence of voices of women and girls with disabilities. Although several studies included interviews, these were typically conducted with caregivers or others who could speak about and for those with disabilities, rather than speaking with those most directly impacted, the women and girls themselves (Hendricks et al., 2012; Scolese et al., 2020, Valentine et al., 2019). This failure to include women and girls, either as study participants or in the development and implementation of the research, ensures that their perspectives will be heard in only limited ways. Moreover, without the inclusion of people who would benefit from the research findings, in this case women and girls with disabilities, it's virtually impossible to expect that their voices would be heard by decision-makers developing the specific anti-GBV related policies and strategies.

In addition, it would be relevant for researchers to extend the study of GBV among women and girls with disabilities to a greater number of Sub-Saharan African countries, and more globally. The reviewed studies represented a small portion of the 48 SSA countries. While there may be similar patterns, trends, and prevalence, how and to what degree the current findings extend to the other SSA countries cannot be stated with any certainty. As specified in some of the reviewed articles, investigators focused on different types of violence against women

and girls with disabilities. There is a considerable number of studies about children, including girls, and perpetrators of GBV actions were named. Unfortunately, little was said about the importance of the early childhood education and the role of both parents. Furthermore, less is discussed about the GBV victims' sexual and reproductive health, legal and social protection implementation laws to enhance women and girls with disabilities' human rights. There is evidence that girls were at risk for being sexually abused, and or married against their will at premature age (Olatosi et al, 2018). In both of these scenarios, the risks are elevated for sexual reproductive health complications and adverse maternal newborn and child health outcomes including prematurity and malnutrition, leading causes of death among children under five years of age in Africa.

The family-oriented approach is missing in the reviewed literature for a comprehensive understanding of how to support women and girls with disabilities to live life to their maximal potential and become socially integrated. Gender-based violence is not an isolated health or social problem. Rather, it has causes and consequences that are widespread, including mental health challenges for mothers and their newborn or children, while also impacting families, communities, and societies. Similarly, the impacts extend beyond physical and mental health. The financial costs of GBV have been shown to be significant, affecting also a country's economy. The prevention of GBV against people with disabilities, especially women and girls of different ages groups who are most vulnerable persons to experience violence in SSA, needs to be considered among priority programs in the region. Women in reproductive years over the age of 16 are likely to be at greater risk for IPV vulnerability (Arulogun et al, 2012). Women and girls especially those with severe disability present higher physical and sexual violence at different ages (Scolese et al, 2020). In addition, high rates of any type of violence were observed

among deaf girls, with high prevalence for those unemployed (100%), older (91.7%), and out-of-school (88.9%). Women and girls lack sex education in SSA. Kvam and colleagues (2018) reported that youth, including girls, receive misinformation or are not educated about disability and sexuality. They are dependent on third persons, such as parents or care providers, for sex education (Berman & Harris, 1999).

Knowledge about GBV, its causes and effects, and barriers for women and girls with disabilities accessing services were addressed in several of the reviewed studies. The evidence, however limited, has the power to raise awareness for community members to be trauma- and violence-informed. This review revealed a number of barriers and distinct challenges faced by women and girls with disabilities. Paramount among these is their dependence on support from their caregivers, who in some cases become their abusers. This fact raises concerns about how to create favorable and violence-free environments, in which they can be safe, gain a sense of being equal, and enjoy the human rights they deserve without stigmatization or discrimination. While the literature reviewed here did not identify strategies to achieve these aims, we consider potential promising practices in Chapter 3.

Efforts to end gender-based violence against women and girls with disabilities need to consider the intersection of disability, gender, violence, trauma, and other health outcomes. It is imperative that we take into account the causal roots of GBV and its particular manifestations in the context of disability. Such efforts include attention to cultural stereotypes, systemic inequities, and gender. The examination of the intersection among these will foster the development of comprehensive and ethically sound GBV policies, strategies and programs. This review demonstrated that women and girls with disabilities have specific needs for their development and empowerment. Particularly important are the needs for accessible disability-

specific materials, specific education, and jobs. The ability to receive care in a manner that ensures confidentiality, that allows women and girls to make informed decisions about their care without coercion despite their relative lack of power is critical.

Efforts to end GBV against women and girls vary across SSA countries, and there is limited literature to guide those who work with this population, particularly among women and girls with disabilities. With strong leadership, it may be possible that the protocols, tools, and guidelines can be borrowed from the global north and be contextualized considering cultural positive values and language sensitivity to prevent GBV for equitable integration of women and girls with disabilities in the SSA communities. Nevertheless, there is still a long journey to harmonize, implement, and evaluate effectively anti-GBV plans, legal frameworks, and other supporting systemic programs for women and girls with disabilities in SSA countries. The GBV question remain open and pertinent for future researchers to nourish existing policies and strategies and holistically support women and girls with disabilities

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## **Chapter Three**

### **Study Implications**

The purpose of this study was to gain a comprehensive understanding of gender-based violence experienced by women and girls with disabilities in Sub-Saharan African countries. The findings from this scoping review of the literature have the potential to increase public awareness of GBV among this population, and to foster preventative, responsive anti-GBV oriented policies, strategies and programs in this region, and perhaps, beyond. The current study findings offer insights into the prevalence of GBV, risk factors associated with GBV, types, and perpetrators of GBV, and barriers to accessing helping services among women and girls with disabilities in Sub-Saharan African Countries. Furthermore, the findings can be used to provide guidance for health professionals working with women and girls with disabilities and may encourage critical reflection of their knowledge and practice. Understanding the nature of the violence to which women and girls with disabilities are exposed is an essential step toward the development of practical and inclusive GBV prevention and support services. The results of this thesis have important implications for health and social service professionals from a range of disciplines who encounter the problem of GBV at different levels of service delivery. It is hoped that the findings will also contribute to a holistic provision of programs and services strengthening education, practice, research, and policy to promote health of women and girls with disabilities. These ideas will be elaborated upon throughout this chapter. We include here ideas and recommendations that have been gleaned from the articles reviewed in Chapter 2, as well as from papers and reports found in the 'grey literature'. Although many of these have not been subjected to peer review, and were thus not included in Chapter 2, we believe they offer

insights and suggestions that potentially have a great deal of relevance. Importantly, a number of these have described initiatives that were conducted in SSA countries.

### **Implications for Health Promotion and Education**

Limited knowledge currently exists regarding gender-based violence experienced by women and girls with disabilities. This gap highlights the need for further study, particularly within the field of health promotion. The first International Conference on Health Promotion, meeting in Ottawa in 1986, defined health promotion as the following: “Health promotion is the process of enabling people to increase control over, and to improve, their health”. During this conference, basic health conditions and assets were identified, including “peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity” (Public Health Agency of Canada, 2017, p.1). Consistent with this definition and prerequisites for health, the literature reviewed for this thesis has demonstrated that the health status of women and girls with disabilities in Sub-Saharan African countries, is severely affected by GBV. This finding may serve as a motivational call for health promotion and education-oriented actions.

The lack of studies on GBV and disability and their long-term effects on women and girls’ lives in sub-Saharan Africa presents an ongoing concern (Chirwa et al., 2020; Van der Heijden et al., 2019). Van der Heijden and colleagues highlighted the scarcity of research evidence on violence against women with disabilities in South Africa. Chirwa and colleagues noted that even in the Global North, where most of the research on IPV has been conducted, researchers continue to encounter the challenges, including inconsistent measurement tools. The varied ways that investigators measure both disability and IPV hinders the ability to make comparisons over time and place.

The findings from this scoping literature review also revealed a lack of education among women and girls with disabilities which hinders opportunities for them to learn about GBV and the ways in which it intersects with disability. In their research in Rwanda, Marshall and colleagues (2018) discussed the importance of sexual and reproductive health (SRH) education for women and girls with disabilities who still have difficulties accessing education and prevention measures related to SRH. According to the African Union Commission (2006), SRH consists of the rights for all people, regardless of age, gender, and other characteristics, to make choices regarding their sexuality and reproduction. These rights are often denied to women and adolescent girls who experience GBV and many face unplanned pregnancies. The prevalence of adolescent pregnancy in Sub-Saharan African countries is 19.3% higher than the overall prevalence in Africa of 18.8% (Kassa, 2018). The inaccessibility of contraceptive services, the unfavorable attitudes of communities towards adolescent contraceptive use, poor knowledge of SRH issues, and widespread sexual violence are some reasons for the high rate of adolescent pregnancy in Africa. All of these factors are compounded for women and girls with disabilities.

According to Langham (2015), adolescents are sexually active and curious about sexual activities because these years are a time when sexual maturity begins. Intense sexual activity can lead to adolescent pregnancy which, in turn, may result in poverty, street children, and orphans, and a heightened occurrence of sexual abuse or rape (Langham, 2015). While violence against women and girls can have direct and immediate health consequences, it also increases their risk of future maternal newborn and child health problems including poor mental health, STIs, HIV/AIDS infections, depression, and repeated unwanted pregnancies (WHO, 2013). The likelihood of adverse health outcomes is intensified when women and girls live with a disability and are dependent on others for their most basic and intimate everyday care needs. There is

evidence that some care providers are the perpetrators of gender-based violence (Arulogun, 2012).

Pregnant girls, especially those living with disabilities in SSA, commonly face stigma, social isolation, and abuse, all of which may impede their ability to seek and obtain antenatal health care. In general, there has been little recognition of stigma as a factor that compromises health and fosters social inequalities (Battle, 2013). However, there is some evidence that social stigmatization leads to negative consequences such as depression, social isolation, low self-esteem, poor school performance, and mental health-related troubles, including trauma. Collectively, these outcomes make the task of parenting particularly difficult. Thus, pregnant adolescents, and especially those with disabilities, need careful attention, non-judgmental, and welcoming health services and education during their pregnancy and after delivery (Yadufashije *et al.*, 2017).

Health professionals and educators also need to address the need for knowledge translation. GBV sensitization messages must be clear, and it is critically important that these messages are accompanied by teaching and training materials that are accessible and specific for use with women and girls with disabilities (SASA, 2019). As Scolese (2020) reported, based on research in the Democratic Republic of Congo, women with mild disabilities are more likely to experience IPV and depend on their caregivers, causing more family obligations. All women and girls with different disabilities have the right to be educated without discrimination, stigmatization, or exclusion from existing programs. In their research in Rwanda, Ghana, and South Africa, Stern and colleagues (2020) considered what types of anti-violence programs are most appropriate and accessible for those with disabilities. These researchers cited the need to raise awareness of the rights of people with disabilities. They specifically called for programs

that are available, accessible, and inclusive, taking into account specific forms of disability; working in partnership with local organizations of people with disabilities; and making training tools and other educational materials friendly for people with disabilities.

In order for the teaching and education processes to promote the health of women and girls with disabilities, there is a need for this group to be engaged, for their voices to be heard as an integral part of the process. There is a widespread tendency for programs to be developed without input from those directly impacted. In order to enhance the likelihood that programs and policies will be meaningful and relevant for women and girls with disabilities, efforts should be made to include them 'at the table'. Disability rights activists have long advocated for 'nothing about us without us', an idea that resonates with this population.

Several important intervention programs in SSA countries were identified in the studies included in this scoping review of the literature. The evidence shows that when programs are comprehensive and inclusive, they can be effective in reducing the impacts of GBV on women and girls with disabilities. "Stepping Stones and Creating Futures" (SS-CF) is a program that was implemented in South Africa and the "Indashyikirwa" program was carried out in Rwanda (Dunkle et al., 2020; Stern et al., 2020). Participants observed positive changes in stigmatization, decreased vulnerability to IPV, gender-related awareness, and elevated self-esteem, among other benefits of programs. Although these programs were not specifically designed for people with disabilities, they showed benefits for this group. In particular, they afforded people with disabilities, especially women, an opportunity to meet in safe places, discuss their daily lives, and share concerns such as alcohol abuse and experiences of discrimination. Many of the participants, especially women with disabilities, were able to discuss possible solutions to their daily problems and seek solutions together. One of these solutions was to create a small project

generating income as a way to increase self-esteem and independence. The program also helped to reduce social isolation.

Other scholars (Arulogun et al, 2012; Hendricks et al, 2014; Njelesani, 2019; Olatosi et al,2018) highlighted the importance of addressing the roots cause of GBV, and the relevance of considering the contributing factors and effects of GBV on women and girls with disability. Education for the promotion of health directed toward women and girls with disabilities is critical and can't be achieved without the active involvement of multidisciplinary anti-GBV teams. By educating women and girls with disabilities and their support networks, including peers, family members, caregivers, and teachers, the expectation is that key stakeholders in SSA countries, including local organizations working with people with disabilities, family members, teachers, health care providers, researchers, policymakers, and programs implementers, would be sensitive to the GBV problem, and consequences in the context in which they live and work.

### **Implications for Practice**

Based on our study findings, GBV prevention and response programs in the Global South must become more skillful in direct outreach to, and inclusion of, women and girls with disabilities. Health promotion practitioners are expected to care for women and girls with disabilities who are at risk for, or have experienced, gender-based violence. This care must include knowledge about personal safety, human rights and existing legal protections against any form of violence and social injustice, available comprehensive services and referral systems, and access to legal support. The programs need funding to work effectively, increasing the social and economic independence for women and girls with disabilities, enhancing their self-sufficiency and providing support that allows them to leave abusive homes if they choose to do so, and provide for their needs. It is essential for prevention and response programs to raise gender and

disability- related awareness and provide knowledge capacity to reduce the occurrence of violence. Opportunities are needed for women and girls with disabilities to create and join peer support groups to help them in various community-based rehabilitation activities. These may include income-generating training and mentorship initiatives, establishing small businesses, and other activities to enhance their social wellbeing (Dunkle et al., 2020; Njelesani, 2019; Stern et al., 2020).

Women and girls' decision-making for their sexual rights remains a challenging aspect of life. Some disclosed having little or no say in safe-sex practices. It is difficult for them to stand up for themselves due to fear of being abandoned by their abusers, who are sometimes also their caregivers. Women and girls with disabilities have more trouble knowing how to avoid these situations since they are often excluded from sex and reproductive health education programs. There is a lack of information about existing referral systems. The little available information about safe sex is generally not available in more inclusive ways, such as braille or large print.

Marshall and colleagues discussed the lack of reporting of GBV from women and girls with disabilities for different reasons, including the fear of losing support from their guardians or the concern about facing family and social stigma attached to the violence and disability. Thus, it is crucial to elicit feedback from the women and girls with disabilities and continuously interacting with the participants and service delivery institutions. In addition, programs must ensure that communication channels, venues, program materials, and activities are developed with maximum accessibility in mind (Marshall et al, 2018).

Women and girls often find themselves in an unequal power dynamic where their guardian or parent is the perpetrator of the experienced GBV. This disturbing fact makes it harder for survivors to leave the abusive environment as they depend on them to survive.

Further, the difficulties in leaving are compounded by delays in services provided to these women, obstacles in the justice system, and failure to administer help to these women and girls living with disabilities. As the current review of the literature has revealed, there remains little recognition of the risks for GBV faced by women and girls with disabilities. Together, these factors combine to leave the vast number of women and girls with disabilities trapped in abusive relationships in their homes (UNFPA, 2019).

The statistics presented here demonstrate that women and girls with disabilities are an ‘easy target’ and suffer the consequences of GBV, mainly IPV, more than those without disabilities. For that reason, interventions and practices should focus on creative approaches to prevent GBV, both at work and at home. Trauma and Violence-Informed Care (TVIC) is a framework that has a great deal of relevance for this population, directing attention to the social and historical conditions that give rise to individual and structural violence. Key principles of this strengths-based approach are awareness and understanding; safety and trust; authentic choices through connection and collaboration; and emphasis on strengths and resilience (Ponic et al., 2016; Wathen et al., 2021). Health and social service professionals must understand the nature of the violence to which women with disabilities are exposed, including its social and historical underpinnings. This knowledge can form the basis for the development of effective prevention and support services. Critical components of such initiatives include content about the physical, social and psycho-emotional impacts of GBV, including particular risks and vulnerabilities for women with disabilities. As literature reviewed here shows, the perpetrators are often known to women and girls. Therefore, any program should include strategies that women and girls can use to prevent, respond to, resist, and overcome GBV. However, this

responsibility does not rely entirely with the women and girls and must be taken up by society more broadly.

Women and girls with disabilities have the right to live in a peaceful and safe environment. Those working in post-conflict settings or in refugee camps need to explicitly recognize gender-based violence and ensure GBV and disability-specific inclusive response measures in peace-building and conflict resolution activities. Without careful attention and the development of appropriate indicators, there is a real risk that this matter will not be adequately monitored or documented in Sub-Saharan African countries, and especially in rural settings where the geographic accessibility of services is virtually non-existent. There is a heightened need for training of stakeholders working with women and girls with disabilities. Training village volunteers, police officers and local organizations and council members in support of survivors, disability rights, basic counseling and how to make referrals, training self-help groups on domestic violence, rape, and the risk of sex trafficking are important steps. Awareness about the existing legal protections and social justice frameworks, international and national disability and anti-GBV existing laws, policies and strategies for dissemination would be crucial for the protection of women and girls.

Partnerships among stakeholders such as UN agencies, governments, local non-government organizations, might be strengthened from the central to the community levels to consider the priorities and integration of anti-GBV practice. Partners have the mandate to define the precise role of each of them and identify proper coordination of activities to avoid duplication while implementing programs. The distribution of available supports in various settings of targeted women and girls with disabilities is necessary. The collaboration with the

organizations that work with women and girls with disabilities will be essential to ensure skilled and inclusive programmatic responses to IPV among women and girls with disabilities.

There is a need for practitioners to learn from the GBV reporting system, and interventions to upgrade anti-GBV best lessons implementation in many SSA countries in community settings. More attention to this area is warranted to further develop guidelines for disability-inclusive development, implementation, and evaluation of IPV prevention and response efforts. The United Nations Sexual and Reproductive Health Agency (UNFPA) developed a guideline document addressing young people and women with disabilities, sexual and reproductive health and rights, and GBV (UNFPA, 2019). The guidelines (Appendix E) include practical information to consider and enhance social justice, rights and restore the dignity of women and girls with disabilities. Given the current statistics regarding GBV, it can be assumed that many health professionals have, themselves, experienced at least some form of GBV. Thus, in SSA Countries where there is also a limited number of specialized anti-GBV services providers, it is necessary for them to attend to their own health in general, and especially their mental health, so that they can provide meaningful care to women and girls with disabilities, integrating the principles of Trauma and Violence Informed Care.

Trauma and Violence-Informed Care (TVIC) is a framework that helps individuals and organizations provide safe and inclusive health-related services. TVIC reduces service barriers and promotes organizational strategies and changes to result in more loving, compassionate, person-centered, and non-judgmental care" (Raja et al., 2020). TVIC enhances the capacity of providers and organizations to offer services to clients suffering from trauma without centering the attention on their story details, disclosing, or focusing on handling trauma signs and symptoms (Browne, 2016). Instead, TVIC promotes clients' safe conditions and spaces to

prevent harm and re-traumatization. TVIC acknowledges the effects of trauma on the client who experienced GBV, such as physical, emotional, and sexual abuse and structural inequities and systemic violence on clients' health, services demand and use, and their well-being (Browne, 2015). Integrating elements of TVIC in GBV prevention programs, health promotion, education, and especially in sexual and reproductive health and rights for women and girls with disabilities in SSA, is critical in order to reduce the impacts of various maternal newborn and child health adverse outcomes.

### **Implications for Research**

Statistics indicate that, globally, over 1 billion persons live with disabilities (CRPD, 2006). The articles reviewed here reflect the reality that women and girls with disabilities are a largely overlooked and understudied population. This statement is particularly true with respect to the phenomenon of GBV. Moreover, certain groups, such as women and girls with severe cognitive impairment, were virtually absent from the literature (Van der Heijden et al., 2020). The same pattern is evident in relation to the scarcity of studies on migration populations, and the absence of studies focused on refugee women and girls with disabilities (Marshall et al., 2018; Scolese et al., 2020). Women and girls experience high rates of GBV and related atrocities, especially rape and sexual torture, during wars and conflicts. During the 1994 Genocide against the Tutsi People in Rwanda, women and girls experienced extreme violence, including emotional animosity abuse, whereby perpetrators forced women and girls to witness the torture or killing of loved ones. These actions created deeply painful memories in the minds of a significant number of women and girls who survived. There is an observed phenomenon of seeing more violence against women and girls in post-colonial conflict settings such as Democratic Republic of Congo (Scolese et al., 2020). Thus, researchers are required to be supportive of, and sensitive to,

women's rights and socio-cultural, language and historically sensitive, to avoid any harm during the research process involving women and girls with disabilities in post conflict and refugee camp settings.

The inclusion of women and girls with disabilities poses a number of ethical challenges to researchers. The net result is that this group has been excluded from research, creating a knowledge gap that effectively limits our ability to fully understand their needs for prevention and intervention (van der Heijden et al, 2019). Thus, future research is clearly needed with this population. Several of the reviewed articles were based on studies conducted in South Africa. In order to gain a more comprehensive understanding of the issue, research in other SSA countries is needed. A further limitation lies in the currently available data collection techniques. Many of these are simply not feasible or appropriate for use with women and girls with disabilities. Moreover, there is a critical need for the establishment of appropriate guidelines on safety and ethics for researchers and program planners (Chirwa et al., 2020).

For the research-based evidence to be useful, it is important in the context of SSA countries to develop and support partnerships among the institutions at national and international levels, and across universities and teaching hospitals, and to foster multidisciplinary collaborations among health professionals, practitioners, policymakers, and educators. Such collaborations will facilitate and strengthen research efforts and the development of GBV-related curriculum, tools, and other research-oriented requirements to work with women and girls with disabilities, with careful attention to their rights and needs for confidentiality in research. The literature reviewed here addressed the exclusion of women and girls with disabilities in research, and in the dissemination of research findings. Strategies to enhance women and girls' involvement and engagement in GBV and disability-related research reflects an important future

direction. Research that examines the association between disability and GBV, how this relationship may be mediated or moderated by education, poverty, and employment among women and girls with disabilities has been identified as a key research direction (Chirwa et al., 2020). A lack of studies assessing programs with specific disability-related programming, and a lack of girls with disabilities in almost all studies with a disability, was identified (Stern et al. 2020). Therefore, future research is needed to address these literature gaps.

Further studies are also recommended to use a non-self-reported measure of GBV, which minimizes social desirability bias that may lead to under or over-reporting (Scolese et al., 2020). Furthermore, there is a general lack of studies on the prevalence of child abuse and neglect among girls and boys separately, which should be addressed in future studies (Olatosi et al., 2018). Moreover, it was noted that 12/22 (45.4%) studies scored low on measures undertaken (Banks et al., 2017; Devries et al., 2018; Marshall et al., 2018; Meer et al., 2017; Njelesani, 2019; Olatosi et al., 2018; Peta, 2017; Scolese et al., 2020; Stern et al., 2020; Van der Heijden et al., 2019a; Van der Heijden, et al., 2019b; Van der Heijden et al., 2020). Studies with a vigorous measure of GBV or constructing a measure of GBV among women and girls with disabilities in Sub-Saharan African countries are crucial.

### **Implication for Policymakers**

The results of this scoping review suggested that women with disabilities who were able to participate in GBV interventions could generally benefit and also contribute to the awareness by sharing their experience and working on their protection (Chirwa et al., 2020; Dunkle et al., 2020;). This assertion has positive implications for the development of GBV prevention and intervention policies to support the health promotion of women and girls with disabilities. The United Nations Convention on the Rights of Persons with Disabilities has established that

women and girls with disabilities are at increased risk of experiencing violence and abuse. This problem has increased even more due to the quarantine and lockdown measures enforced globally to stop the spread of COVID-19. Many women and girls were forced to live with their abusers due to the Covid-19 situation and faced even more harmful behaviors due to the quarantine/stay home requirements. The lockdown has also made it hard for these women to receive the proper care and services they need, with significant difficulties leaving home to access health facilities. The Covid-19 pandemic also negatively impacted the justice system functioning with the delays in court judgments of GBV perpetrators. The rights to justice for women and girls with disabilities are continuously denied or offended. Their case-related shreds of evidence or proof, especially those from abused women and girls with cognitive impairment, do not receive serious consideration by lawyers and judges who often doubt their capacities and ability. That limitation in supporting the legal system reinforces harmful stereotypes and affects the health status and future hope for women and girls with disabilities (Suarez, 2020). The overall message is that women and girls with disabilities should never be denied their fundamental human rights, regardless of a pandemic.

The findings highlighted the importance of effective leadership in ensuring that the program design, GBV services delivery and interventions support victims and family members (Meer, 2017). Women's leadership is necessary to support women's agencies that can raise the voices of vulnerable women and girls, especially those with disabilities. This statement is borne out by the experience in Rwanda where a significant number of women hold leadership positions. In 2003, the Rwandan constitution set a quota of 30% women representation for all decision-making bodies (GMO, 2015). In addition, Women, Peace, and Security resolutions to prevent SGBV, encourage significant participation of women in peace and security processes,

and protect women's rights in conflict and post-conflict situations (McLeod & O'Reilly's (2019). Besides the political willingness and adopted resolution, women and girls with disabilities remain voiceless, experiencing abuse in most SSA countries' communities. Policies and strategies need to develop new orientation solutions to resolve countries' disintegration caused by civil wars, external interferences, and long-lasting conflict. Continuing reflection on the connection between women's participation in the peacebuilding process and effective conflict transformants is crucial for the sustainable peace and development of women and girls with disabilities.

Individuals implementing and evaluating GBV prevention programs should strive to make their programs accessible to women and girls with a wide range of disabilities. There is a necessity to articulate strategies for the inclusion of participants with disabilities, increase the outreach and monitor/evaluate whether programs are equally effective for participants with disabilities, and to explore whether changes in women's experience of disability over time are linked to changes in exposure to IPV (Chirwa et al., 2020; Dunkle et al., 2020;). Achievement of these goals requires GBV funding policies, strategies, and a long-term plan to address GBV and to support women and girls with disabilities.

The results of this scoping review of the literature suggest that including women and men with disabilities in programs targeting the general population may mitigate their risks for violence and promote economic empowerment and well-being while challenging disability-related stigma and discrimination. Efforts aimed at the empowerment of women and girls, reduction of gender-related inequalities, and consideration of their social justice, sexual and reproductive health have the potential to significantly impact maternal newborn and child health outcomes. Strategies to ensure that people with the most severe disabilities, especially women

and girls with disabilities are supported and cared for can be effectively developed, and reached by IPV prevention programs (Stern et al., 2020). Gender-based violence is a violation of public health and human rights. The findings from this review of the literature imply the need for policies that integrate GBV prevention services in various sectors to overcome its effects on women and girls with disabilities, including sexual and reproductive health effects such as HIV/AIDS.

These findings lend support to the need for decentralized health promotion policies supporting women and girls with disabilities, especially policies which help communities and institutions to be informed about gender and disability and the associations with trauma and violence. Policies for early childhood education are welcomed through this review to work in support of child protection from GBV, physical punishment, psychological violence, negligence, deprivation, intolerance actions, and influence positive parenting mechanisms.

### **Limitations**

The main limitations for this scoping literature review are related to the fact that little is known about GBV among women and girls with disabilities in several sub-Saharan African Countries. The reviewed studies were conducted in just a few countries out of a total of 48 countries of SSA. This review did not explore GBV as experienced by women and girls with severe cognitive impairment and did not learn from evaluating programs that had specific disability-related components as the information on those aspects were missing in reviewed articles. The almost complete absence of girls with disabilities as participants in the research is another notable limitation of this review. Furthermore, this review did not identify information exploring differential impacts by type(s) of disability, such as mobility, visual or hearing impairments on GBV, and mediation or moderation of education, poverty, and employment

between the association of disability and GBV among women and girls with disabilities. As shown in Table 3, it was hard to capture from the reviewed literature the age difference of targeted study participants. In addition, it was difficult to clarify what constitutes “a girl” because the term, “children”, was often used to represent boys and girls without distinction of gender or age. The fact that only English Language literature were included would be considered as an additional limitation. Future research is needed to address these literature limitations.

### **Conclusion**

In this scoping review presents the literature from 22 selected studies that focused on GBV against women and girls with disabilities in Sub-Saharan African Countries. In general, there is a lack of research on GBV among women and girls in sub-Saharan Africa. This dearth of knowledge is especially concerning in light of the high prevalence of GBV among women and girls in the reviewed study’s findings. These findings provide knowledge about GBV among women and girls with disabilities including the types of GBV, the importance of IPV, and its impacts on the health and psycho- social status of women and girls with disabilities.

Experiences of gender-based violence negatively impact the lives of women and girls with disabilities, limiting their physical, emotional, sexual, and economic development from an early age. These effects often persist throughout their lives and are particularly difficult to manage in SSA countries where resources, including health and social service professionals, are scarce. The literature reviewed indicated that women and girls with disabilities experience various socio-cultural and contextual barriers such as discrimination, toxic masculinity in the African context, stigma, poverty, and lack of education. These barriers present an opportunity for the development of trauma- and violence-informed policies and strategies aimed at the prevention and treatment of gender-based violence. Innovative programs that can to reduce the

burden of poor health and associated stigmatization are needed (Bayat, 2015; Van der Heijden et al., 2019).

Stigmatization affects the mental health, including stress, trauma, and depression, of women and girls with disabilities. There is a need to foster the implementation of TVIC programs in the SSA context to reduce harm and ensure the physical and cultural safety of women and girls who suffer from violence and trauma. Marginalization or isolation of groups of people or individuals and the removal of their civil rights such as fair housing options, access to land, education, full participation in civic life in society, and employment opportunities may result from discrimination (Green et al., 2005). Health and social service professions would coordinate their interventions and distribute them in an equitable, equal, and inclusive manner moving beyond the stereotypes of stigmatization to apprehend and support women and girls with disabilities in a more responsive trauma and violence-informed care approach. It is crucial to review and update existing laws and programs, to boost the social justice, community rehabilitation, and equal protection of women and girls with disabilities in SSA communities. Family members have a significant role to play. Early childhood education would be integral to the rehabilitation programs of children suffering from abuse, including neglect, deprivation, killing, and abandonment at school, in institutions, and families.

Sustainable peacebuilding and security maintenance require a systematic examination. The participation of women and girls with disabilities in representation and leadership roles will help to raise their voices. Their core activities and success are in different domains such as education, governance, security, justice, unity and reconciliation, health, human rights, socioeconomic and environment. Civil Society Organizations (CSOs) and local organizations (NGOs) should apply substantial advocacy operations to ensure that the Government and the

International Community provide the necessary sustenance and training for women and girls with disabilities at grass-roots levels. Multilateral and bilateral donors and international organizations should provide technical assistance to improve women and girls' capabilities and provide a reliable mechanism to ensure the sustainability of their interventions. The country has to work on roots causes of conflicts, allow the resilience process, recognize the existence of complaints, and hear and deal with them appropriately (Zraly & Nyirazinyoye, 2010). Future research is needed to assess GBV and disability among women and disabilities, with attention to specific disabilities and including women with severe impairments. These efforts are vital for the full participation of women and girls with disabilities in all facets of everyday life.

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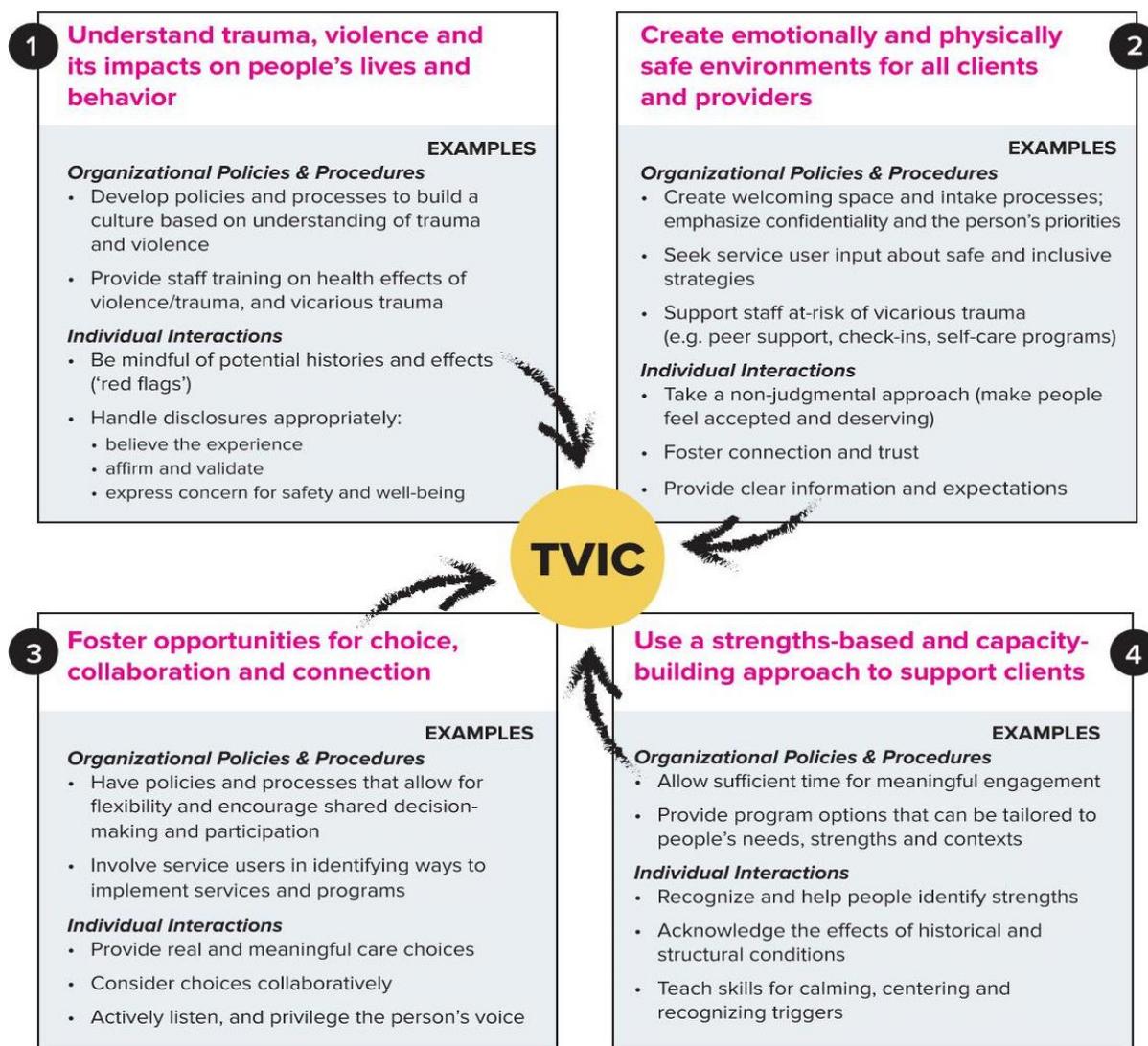
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## Appendix A: Trauma and Violence Informed Care Principles



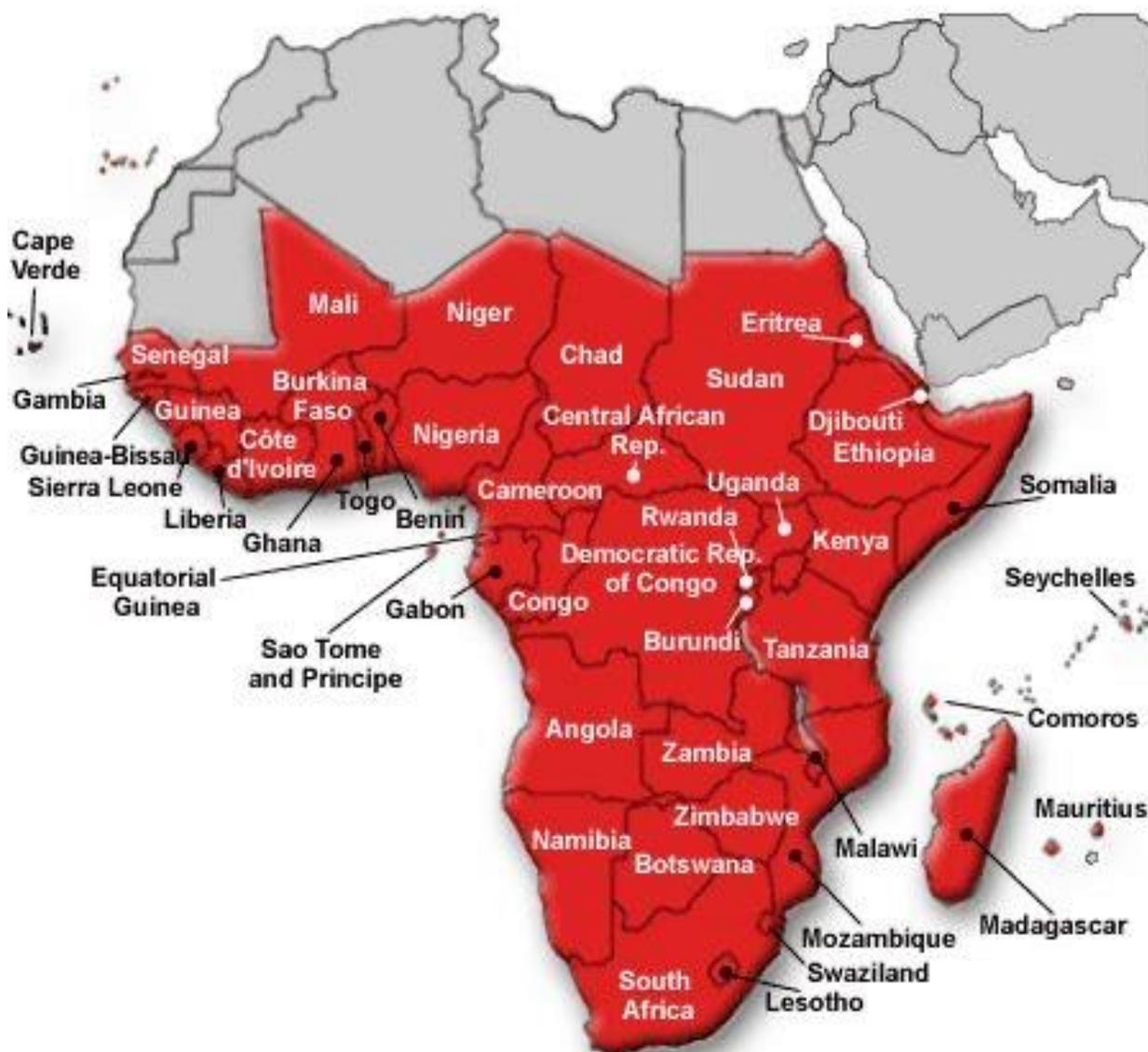
# Principles of Trauma- and Violence-Informed Care (TVIC)

There are four, inter-related principles of Trauma- and Violence-Informed Care:



EQUIP Health Care & the Health Equity Toolkit were originally funded by CIHR. To learn more about EQUIP Health Care, please visit [www.equiphealthcare.ca](http://www.equiphealthcare.ca)

## Appendix B: Map of Sub-Saharan African Countries



### **Appendix C: List of Abbreviations**

CAN: Child Abuse and Neglect

CDPC: Centers for Disease Control and Prevention

CRPD: Convention on the Rights of Persons with Disabilities

CSOs: Civil Society Organizations

GBV: Gender Based Violence

GDP: Gross Domestic Product

HIV: Human Immuno-deficiency Virus

ICAST-CI: International Society for the Prevention of Child Abuse and Neglect Screening Tool—Child Institutional

IPV: Intimate Partner Violence

NGOs: Non-Governmental Organizations

OR: Operation Research

SGBV: Sexual Gender Based Violence

SRH: sexual and reproductive health

SSA: Sub Saharan African

SS-CF: Stepping Stones and Creating Futures

STIs: Sexually Transmitted Infections

TVIC: Trauma and Violence Informed care

VSLA: Village Savings and Loan Association

**Appendix D: Search Strategy (March-April 2021)**

- 1 exp Domestic Violence/ or exp Battered Females/ or exp Intimate Partner Violence/ or exp Sexual Abuse/ or gender based violence.mp.
- 2 domestic violence.mp.
- 3 battered female\*.mp.
- 4 intimate partner violence.mp.
- 5 sexual\* abuse\*.mp.
- 6 trauma\*.mp. or exp Trauma/
- 7 1 or 2 or 3 or 4 or 5 or 6
- 8 disabilities.mp. or exp Disabilities/
- 9 disability.mp.
- 10 8 or 9
- 11 exp Developing Countries/ or Africa\*.mp.
- 12 7 and 10 and 11

## Appendix E: UNFPA Guidelines to address GBV and SRHR

The following chart provides a summary of *Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*.

FOUNDATIONAL GUIDELINES FOR ACTION	
<p><b>1. Creating an enabling legislative and policy environment.</b></p> <ul style="list-style-type: none"> <li>a. <i>Legal Environment Assessment and Monitoring</i></li> <li>b. <i>Legislative Advocacy and Lobbying</i></li> <li>c. <i>National Policies and Plans</i></li> </ul>	<p><b>2. Programme development, implementation, and monitoring.</b></p> <ul style="list-style-type: none"> <li>a. <i>Engagement of Women and Young Persons with Disabilities</i></li> <li>b. <i>Capacity Building</i></li> <li>c. <i>Programme Delivery</i></li> <li>d. <i>Available Services</i></li> <li>e. <i>Effective Identification of Needs and Referrals</i></li> <li>f. <i>Accessible Services/ Accommodations</i></li> <li>g. <i>Acceptable Services</i></li> <li>h. <i>Quality Services</i></li> <li>i. <i>Rights Based Services</i></li> <li>j. <i>Data Collection and Monitoring</i></li> </ul>
	<p><b>3. Accessible facilities.</b></p> <ul style="list-style-type: none"> <li>a. <i>Identifying Barriers</i></li> <li>b. <i>Physical Accessibility</i></li> <li>c. <i>Sensory Accessibility</i></li> <li>d. <i>Information and Communication Accessibility</i></li> <li>e. <i>Economic Accessibility</i></li> </ul>
GBV Services	SRHR Services
<ul style="list-style-type: none"> <li>1. GBV prevention</li> <li>2. Health services for GBV victims/survivors</li> <li>3. Justice and policing services</li> <li>4. Social Services—protection services</li> <li>5. Social Services—rehabilitation services</li> <li>6. GBV services for women and young persons with disabilities in institutional settings</li> <li>7. Adolescent- and youth-friendly GBV services</li> </ul>	<ul style="list-style-type: none"> <li>1. Contraceptive information, goods, and services</li> <li>2. Maternal and newborn health services</li> <li>3. Comprehensive sexuality education and information</li> <li>4. Information, testing, and treatment services for sexually transmitted infections, including HIV</li> <li>5. Access to other women's health information and services</li> <li>6. Adolescent- and youth-friendly health information and services.</li> </ul>

## Curriculum Vitae

Aimée Joséphine UTUZA

Health Promotion & Public Health Specialist  
Clinical psychology & mental health professional  
General Nursing

London/Ontario

### Education:

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Graduate Studies in Health and Rehabilitation Sciences/Health Promotion Stream **2019 - Now**  
Western University, London, Ontario, Canada  
Thesis topic: “Gender Based Violence against Women and Girls with Disabilities in Sub-Saharan Africa”: A Scoping Review of the Literature.

Supervisor: Dr. Helene Berman/Canada

Master’s in Public Health/Health Service Management Stream **2014**  
Mount Kenya University (MKU), Rwanda Branch  
Dissertation Title: “Assessing Domestic Violence and Resilience Status among Women Experiencing Domestic Violence”

Supervisor: Dr Jean Damascene IYAMUREMYE

Post graduate in counselling **2011**  
University of Rwanda (Former Kigali Health Institute), KHI  
Instructor: Bonaventure Tuyisenge

Bachelor’s degree in clinical psychology **2011**  
Institute of Agriculture, Technology and Education of Kibungo (INATEK), Rwanda  
Dissertation Title: “Analyse des Atrocités Psychosociales liées à la Violence base sur le Genre”

Supervisor: Dr. Eugene RUTEMBESA

Diploma of « Perfectionnement en santé mentale » **2006**  
Institut des Affaires Publiques (IAP), Brussels, Belgium

Diploma in mental health nursing **2000**  
University of Rwanda (Former Kigali Health Institute), KHI, Rwanda  
Dissertation: “Analyse de la Qualité de Soins de Santé Mentale à l’Hôpital Neuro-Psychiatrique CARAES-NDERA”

Supervisor: Frère HATEGEKIMANA Celestin

Pre-national university language studies (English) **1997**

University of Rwanda (Former National University of Rwanda), NUR

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### **Work experience**

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Feb 2016 – Dec 2018

#### **TSAM-MNCH Senior Project Manager**

Training Support Access Model in Maternal Newborn and Child Health Project in Rwanda and Burundi, a 4 -year international development project with funding provided to the University of Western Ontario (Western) by Global Affairs Canada (GAC). Working closely with the Ministry of Health, Ministry of Education, Medical and nursing and midwives councils, professional associations, and health facilities in Northern and southern provinces of Rwanda. Director: Prof. David Floyd Cechetto in Canada and Dr. Desire Ndushabandi in Rwanda

#### **MNCH Project Manager**

Maternal Newborn Child Health (MNCH) Project in Rwanda, a partnership project between the University of Western Ontario (UWO), London, Ontario, CANADA and the University of Rwanda. Director: Prof. David Floyd Cechetto in Canada

#### **MCCH Project Manager (Consultant)**

Africa Health New Horizons/Arizona University working with International Medical Corps on a project to provide support in the improvement of Maternal Community Child Health in Rwanda. Director: Dr. Linda Voyles and Dr. Modeste Kigabo

Jan 2012 – Aug 2012

#### **Founder and Director of operations at local, and international NGOs**

Living with Happiness-Icyemezo local non-government organization created with the purpose to contribute on the development of the Rwandan society in consideration of the peaceful coexistence and moral values of Rwandans.

#### **National Program Officer / Health**

Swiss Cooperation bilateral program working with the Government of Rwanda, to strengthen health system in Rutsiro and Karongi districts of western province. Maya Schaub

### **Research Interests Domain**

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Health promotion, Community based initiatives, Youth psychosocial and development initiatives, vulnerable groups support, Family harmony, Equality, Diversity and Inclusion.

### **Experience in Canada (December 2018-Now)**

#### **Academic Experience:**

Courses and Seminars: 6 courses and 1 common seminar (completed)

1 course of philosophical foundation of qualitative methodology and 1 health promotion seminar (completed)

Regular work as teaching assistant and research assistant to some instructors in the Health and Rehabilitation Sciences program at Western University

Active in public seminars and other forum organized at Western. Accepted abstracts, research project proposals and other works presented at Western.

Awards received from Africa Institute in 2019

Active participation in learning and teaching organised sessions

Member of advisory committee of Africa Institute  
 Health Interdisciplinary Development Initiative (HEIDI) group member, to discuss important aspect of partnership for global health and Equity.  
 Liaison person to the education committee looking at the development and writing of case studies for teaching in Rwanda and in Canada settings  
 Member of Trauma and Violence Incubator group, participating to the discussion of the relevance of Trauma and Violence Informed Care  
 Partner to the Western Heads East to supervise intern students working on the “Fiti yoghurt project”  
 Community based initiatives: Annual Fundraisings in Canada from from 2018-2021, Zirikana campaign 2020 initiative to raise fund to support families in Rwanda during the Covid-19

### **Presentations during international forum**

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Presentation about Rwandan culture and youth role in “Euros 2000”. Belgium 2000  
 Presentation done on “HIV/AIDS and palliative care” at Entebbe. Uganda 2004  
 Presentation done on “HIV AIDS Mainstreaming at workplace. Tanzania 2012  
 Présentation on “Etre-Mères, parlons-en”. Experience from Rwanda. Belgium 2013  
 Presentation on “Assessing domestic violence and resilience status among women experiencing domestic violence” in nursing network on violence against women international conference at, Niagara/Canada 2018  
 Other presentations done at Western university various conferences from 2018-2021. Canada

### **Publications**

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What do we mean by critical and ethical global engagement? Questions form a research partnership between universities in Canada and Rwanda. 2021

Authors: Canas E., Gough R., Smith MJ., Monette EM., McHugh DD., Le Ber MJ., Benjamin-Thomas TE., Kasine Y., Utuza EJ., Nouvet E.

Developing and implementing a novel mentorship model (4+ 1) for maternal, newborn and child health in Rwanda. 2020.

Authors: Ngabonzima, A., Kenyon, C., Hategeka, C., Utuza, A. J., Banguti, P. R., Luginaah, I., & Cechetto, D. F.

Treating traumatic memories in Rwanda with the rewind technique: Two-week follow-up after a single group session. 2012

Authors: Utuza, A. J., Joseph, S., & Muss, D.

Enhancing the Diversity in the Academic World. A Practical Mission or Just a Dream? 2020

Authors: Utuza, A. J.

Assessing domestic violence and resilience status among women living in Rusororo sector in gasabo district. 2014

Authors: Utuza, A. J.

### **Languages qualification/skills**

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#### *Languages*

<b>Item</b>	<b>Speak</b>	<b>Read</b>	<b>Write</b>
English	Good	Good	Good
French	Excellent	Excellent	Excellent
Kinyarwanda	Mother's tongue	Excellent	Excellent

### **Involvement with Associations/Company**

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#### **In May 2011**

Creation of Non-governmental organization “Living with Happiness-Icyemezo” LWHI, in Rwanda” which intervene for:

- Community based mental health promotion
- Contribute to the activities against any forms of violence
- Youth inspiration against poverty for sustainable development
- Research action

Living with happiness-Icyemezo is now organization member of “Make mother matter International”

#### **In November 2011**

Creation of a company “Power of Vision” which operates in various domains for income generation:

- Other human health activities
- Other amusement and recreation activities
- Support services to forestry
- Non-specialized household goods
- Other transportation support activities
- Restaurant and mobile food services activities
- Management consultancy activities

Power of vision is operational in Rwanda and contribute occasionally to the activities of both organizations: Living with happiness-Icyemezo and Rwandan Mothers-TEAM.

#### **In February 2014**

Creation of Non-governmental organization “Rwandan Mothers-TEAM” RMT, in Rwanda” which intervene for contributing to:

- Empower Mothers actions at home, at work and into the community

- Enhance Mothers exchange and education
  - Build Mothers relationship with their children
  - Promote Mothers and children's interventions for sustainable development
- Rwandan Mothers-TEAM is a partner to the "American Mothers International"

### **Grant received**

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A 6-month project Grant of 20,000 Euros given to "Living with happiness-Icyemezo" by French Embassy in Rwanda to promote community based mental health through training and psychosocial support.  
June to December 2013

### **Personal Interests/Hobbies**

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Organization of socio cultural and promotional events. Example "Kids Talent show", "Etre meres, parlons-en"

Traveling for professional exchanges, studies

Internet browsing / writing stories / Research Action

Swimming, watch movies

Strive for dignity and humanity and hate ignorance and arrogance

Group networking of divorced and separated women in Rwanda, motivating each other for self definition, self esteem, and self valuation to live happy and positively

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