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## Abstract

This dissertation is a secondary analysis of a qualitative action research project looking at how staff in the healthcare and criminal justice sector in Kenya understand and respond to the sexual abuse of persons with disabilities (PWDs) and how changes to their practice could help to reduce rates of sexual abuse. A comprehensive literature review looks at research into sexual abuse of PWDs in Africa. 12 individual interviews with healthcare and criminal justice staff and 6 focus group discussions with PWDs and parents of PWDs are then analysed using a framework approach with discussion of findings focussed onto three key themes: negative traditional or cultural understandings of disability; negative treatment of PWDs in the community; and inadequate responses to the sexual abuse of PWDs. It is contended these three themes exist in a cycle with each issue perpetuating the next. Recommendations for interventions to break this cycle by both governmental and non-governmental actors are explored.

## Acknowledgements

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## Abbreviations and acronyms

- PWD: Person(s) with disability(ies)
- FGD: Focus group discussion
- UNCRPD: United Nations Convention on the Rights of Persons with Disabilities
- INGO : International Non-Governmental Organisation
- WHO: World Health Organisation

## Notes on language

It is noted that terminology when referring to disability is important and often contentious. There is no consensus on the 'correct' language in this area. This dissertation uses the term 'Person's with disabilities' (as opposed to Disabled People) throughout but accepts that this is not the preferred term in all cases.

When referring to sexual abuse the terms 'victim' and 'survivor' are both used in the literature. Although it is accepted that these terms have different connotations they are used synonymously throughout this dissertation.

## Introduction

About 15% of the world's population, over 1 billion people, have some form of disability (WHO, 2011). Evidence increasingly shows that persons with disabilities (PWDs), men women and children, are more likely to experience sexual abuse than their non-disabled peers (Groce, 2003). Research has shown that sexual abuse of PWDs happens across the world but anecdotal evidence and reports from some small studies have suggested rates of abuse are particularly high in African countries.

Kenya is one of the most quickly developing countries in East Africa with a population of around 44 million people. It is a country with huge amounts of diversity in terms of ethnicity, religion, culture and economic development. 80% of the population live in rural areas and 43% of people live below the poverty line (UNICEF, 2015). Kenya ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2008 which means that Kenya has a legal obligation to protect and promote the equal recognition of PWDs before the law, including freedom from exploitation, violence and abuse under Article 16 (UN, 2007). Despite this and national legislation which aims to provide further legal protection to PWDs high rates of violence have been reported within the country, with some estimates suggesting that as many as 15-20% of disabled children in Kenya have experienced severe forms of physical and sexual abuse (Stopler, 2007).

Advantage Africa, a UK based INGO working in East Africa through local partners, has received reports of sexual abuse of PWDs in Kenya in recent years. In the majority of cases victims of abuse do not receive effective medical or legal support following abuse, either because the abuse is not reported or due to poor handling of these reports. PWDs may be abused by family members or members of the wider community and if this is reported it is often dealt with 'within the community' through payments of compensation to the victim's family or similar methods of 'justice'. It is as a result of these reports made to Advantage Africa, and discussion with PWDs within East Africa which was the motivation for this research project. The action research project was in fact requested by the local disabled people's organisation (DPO) as a method for exploring the issue further with the aim of developing recommendations and future interventions to tackle this issue.

This dissertation aims to understand the cultural and institutional environment which is perpetuating the sexual abuse of PWDs within Kenya. With specific interest in why Kenya is failing to meet its legal obligations to protect PWDs and ensure justice is obtained following instances of abuse, it will focus on the role of the formal 'key responders' in the health care and criminal justice sector. These doctors, nurses, police and lawyers are the key professionals who are should deal with reports of sexual abuse of PWDs, to prevent future cases of abuse and to support the victims of abuse to achieve justice through the formal institutional routes. Low rates of conviction and high rates of continued violence suggests, however, that these professionals are not achieving these objectives.

This dissertation is a secondary data analysis project using a subset of a larger dataset (which included data from both Uganda and Kenya and included interviews with other community figures such as teachers, traditional healers and civil society groups) collected by

Advantage Africa, focussed particularly on interviews with these 'key responders'. The aim is to provide recommendations on how these professionals can increase rates of justice to survivors of abuse and decrease future incidents of abuse through answering the research question:

*“How do staff in the health care and criminal justice sector in Kenya understand and respond to the sexual abuse of disabled people and how could changes to their practice help to reduce rates of sexual abuse?”*

## Literature Review

### Methodology for the literature review

This literature review includes both published papers and grey literature. Key word searches were made in Scopus, Web of Science and Pub Med using search terms (disab\*) and (“sexual abuse” or rape or “sexual violence”) and (Africa). A total of 104 articles were identified. After removing duplicates 79 article abstracts were analysed for relevance, leaving 30 articles which were found to be relevant to the study. Three advocacy reports from the grey literature were added to these, bringing a total of 33 papers which were included for full analysis in this literature review.

Of the papers analysed 17/33 focus specifically on South Africa; 15/33 focus on intellectual disability; and 21/33 focus on ‘children’ or ‘learners’, although it should be noted that these categories may have a wider meaning than the Western understanding of childhood. In many African contexts a person is considered to be a ‘child’ until they are married, and in some contexts a woman is considered to be a child even after marriage. In addition due to difficulties in accessing education and the practice of missing years of school when fees are unavailable many school attendees in Africa are older than would be the case at the same stage in a Western educational environment. Finally in many contexts PWDs are infantilised and therefore labelled as children even after the age of 18.

This literature review is anchored within the broader disability discourse. Over the past 50 years concepts of disability and the rights PWDs have changed considerably. This dissertation is based from the perspective that disability is a human rights issue. Building on the ‘social model’ of disability (Shakespeare, 1994) which sees people as being disabled by their society rather than their bodies (as opposed to an impairment-focused ‘medical model’) this dissertation aims to understand how the society in which PWDs in Kenya live jeopardises their equal right to freedom from all forms of abuse and discrimination, and to make free choices concerning their relationships, as enshrined in the UNCRPD (UN, 2007, WHO, 2011).

### Incidence of sexual abuse of PWDs in Africa

The research project which informed this dissertation was initiated following reports from the disabled community of incidents of sexual violence. Such practitioner reports and anecdotal evidence suggest high rates of sexual violence towards PWDs in the African context. A significant deficiency throughout the literature, however, was present in terms of information on rates of sexual abuse of PWDs across Africa. No population level survey data is available. Several studies quoted statistics from international studies which suggest that PWDs experience higher levels of sexual abuse than non-disabled persons, but no large scale data is available from the African context (Hanass-Hancock, 2009b, Phasha and Nyokangi, 2012, Pillay, 2012, Shabalala and Jasson, 2011).

On the rare occasion figures are given on population level risk the sources of the information were difficult to trace. Hanass-Hancock, for example, quotes a Handicap International Study from 2007 in which “the results showed that 46% of disabled participants had experienced sexual violence”(2009b:37) . This study is not, however,

included in the references list of the paper and could not be found on the Handicap International Website, therefore the figure is difficult to verify. Similarly, the advocacy document 'Breaking the Silence: Violence against Children with Disabilities in Africa' from The African Child Policy Forum quotes an incidence of 70% violation of children in the developing world, referenced to Stöpler (2007). When looking closely at the referenced document, however, this figure can be attributed to a crime review relating to individuals with intellectual disabilities in the USA (Petersilia, 2001). These examples highlight the importance of accurate use of data, and the difficulties of working within a context where the required information simply has not been collected or analysed.

Due to this lack of data, several studies reported proxy measures or incidence within particular groups. South Africa, where several of the papers reviewed are focussed, has the highest rates of sexual violence of any country not at war and papers with a focus on South Africa regularly cited this high level of sexual violence in the general population as an indicator that similar or higher levels of violence should be assumed in PWDs (Dickman and Roux, 2005, Phasha and Nyokangi, 2012, Shabalala and Jasson, 2011).

This deficiency in information on incidence of sexual violence can be clearly linked to issues in the recognition, reporting and response to incidents of abuse towards PWDs. These issues are the key focus of much of the literature, as described below.

Negative views of disability: stigmas and 'traditional' practices

Throughout the literature there is a common focus on the way in which societies and individuals perceive PWDs and how these views perpetuate an environment in which sexual abuse takes place. Authors including Rohleder and Swartz (2009) point to the pervasiveness of negative representations of PWDs across all countries and periods of history, but many authors indicate that "this seems especially true in Africa" (ACPF, 2010:2). These negative stigmas are discussed broadly, in terms of their influence on the whole life of the PWD, and also with specific reference to encouraging or allowing for incidents of sexual abuse.

Broadly there are three categorisations of general negative views which arise from the literature: that disability is caused by curses or supernatural forces; that PWDs are sub-human or otherworldly; and that PWDs are a burden or of negative value in society. The view that impairments are caused by a curse, from a god, ancestors, or through witchcraft, is discussed throughout the literature with reference to similar views from across the continent. In Zulu culture Hanass-Hancock (2009b) describes how these views mean that the disability becomes a "personalized shame" with blame placed on either the PWD or their parents. In Uganda Stöpler describes the view that "when a family has a disabled child, it is widely believed that they have committed a crime against their forefathers", which creates such levels of shame as to cause parents to hide or disown their disabled child (2007:13). Similarly the view of PWDs as inhuman is discussed by Phasha (2014) with connection to beliefs in witchcraft and ancestral curses. She gives the example of a belief that intellectually disabled youth feel no pain, a view which her study finds echoed by both teachers and parents of these young people, who are described by a diviner as "just spirits moving everywhere" (2014:161). Even more pervasive throughout the literature is the view that PWDs are a burden on their family and community, incapable of providing any positive

contribution. PWDs are variously described as being viewed as 'unproductive burdens'; 'not valued as much as other children'; 'a social and economic burden'; and 'shunned as outcasts' (Handicap International, 2011, ACPF, 2010, Rusinga, 2012).

#### Views of disability that perpetuate sexual abuse

Other views of PWDs are implicated in the literature to directly increasing the risk of sexual abuse and decreasing the likelihood of such abuse being reported. Firstly the view that PWDs are unable or unwilling to report violence is described as creating a view that they are 'easy targets' for abusers. These views focus directly on the attributes of a person's impairment, their ability to scream; run away; identify abusers or understand the situation of abuse. The deaf, blind, physically impaired and intellectually disabled are variously identified throughout the literature as being viewed as 'easy targets' for abuse (Mall and Swartz, 2012a, Mall and Swartz, 2012b, Phasha, 2013, Rohleder, 2010).

Secondly the view that PWDs are sexually 'abnormal' is seen as a key factor in increasing the rates of sexual abuse of this group. These views are split into two distinct issues: firstly that PWDs are either asexual or conversely oversexed and secondly that they are unable to attract 'normal' sexual partners and that therefore sexual abuse can be viewed as 'doing them a favour'. This view is largely identified with persons with intellectual disabilities, but is also linked to epilepsy and physical disabilities and connected by various authors to an unwillingness to include PWDs in sexuality education or sexual health awareness programming (Phasha, 2009, Phasha and Myaka, 2014, Rohleder and Swartz, 2009, Rohleder, 2010). Phasha describes the view that PWDs are "not capable of establishing long-term relationships; and no one can propose love to them. Therefore, sexual intimacy with such a person, whether consensual or non-consensual, is an act of pity, especially if this is performed by a person who is a relative" (2014, 160). This view is echoed by several authors as being held both by perpetrators of violence but also by carers, including parents, who at times would encourage the abuse of the person within their care (Kvam and Braathen, 2008, Kassah et al., 2014, Hanass-Hancock, 2009b).

The third view expressed in the literature relating to ideas that promote incidents of sexual abuse is a link between disability and disease. Commonly linked to the myth of 'virgin cleansing' which purports that sleeping with a virgin can cure a person of HIV/AIDS this belief is intimately connected with the view of PWDs as sexually abnormal. Many authors quote Groce whose 2004 paper first discussed this issue in relation to PWDs but others also quoted similar views from their own interviews (Hanass-Hancock, 2009b, Kvam and Braathen, 2008, Rohleder, 2010). Also making a connection between disability and disease Phasha cites the view that "intellectual disability is caused by a lot of 'dirty' blood in the person" and that one way of curing this was thought to be through childbirth encouraging the sexual abuse and resulting pregnancy of intellectually disabled girls (2009:194). In a later paper by the same author a further encouragement for sexual abuse of PWDs was linked to the concept of empowered bodily fluids, although in this case the view was that the blood of an intellectually disabled person contained special powers which could be gained through the abuse of that person (Phasha and Myaka, 2014, 159).



## Structural 'causes' of abuse

Moving beyond the issues of cultural attitudes towards PWDs many papers looked at the structural issues which cause the environment in which PWDs in Africa live to perpetuate incidents of sexual abuse. These are closely linked with those stigmas and negative views described above. The first of these structural issues is the high rate of dependency upon others which is faced by PWDs in the African context. Linked to the view of PWDs as a burden this dependency is caused by a lack of available supportive care to allow PWDs to live independently. Many authors connected this dependency with a situation in which abuse is able to thrive due to the financial, physical and emotional control of the caregiver (Kheswa, 2014, Nyokangi and Phasha, 2015, Rohleder, 2010, Yousafzai et al., 2005). Dickman and Roux's (2005) finding that 89% of cases of sexual abuse were perpetrated by persons known to the survivor, and 23% by family members, mirrors the findings of several other authors. Cases of abuse within the household are often covered up by family members due to fear of losing the income from disability benefits (Phasha, 2009); jeopardising the income from the main breadwinner (Rohleder, 2010); or losing physical care provision by a carer if they are arrested (Yousafzai et al., 2005). The issue of dependency was also highlighted as a cause of high rates of sexual abuse within educational and institutional settings where educators and care staff have absolute power over the PWD (Phasha, 2013, Phasha, 2009, Rohleder and Swartz, 2009).

A second structural issue which is linked with the view that PWDs are sexually abnormal is the lack of sexuality education provided to PWDs. Firstly school attendance rates are considerably lower for disabled children in comparison with non-disabled children meaning that even where sexuality education is provided the disabled child is less likely to access this (Stopler, 2007). In the case where children do attend school and within the context of schools for intellectually disabled learners several studies pointed to a concern that providing sexuality education would "wake sleeping dogs" (Hanass-Hancock, 2009a) and encourage sexual behaviour, therefore the topic is avoided and ignored (Chirawu et al., 2014, Aderemi, 2013, Nyokangi and Phasha, 2015, Phasha, 2013). Outside of the formal education system PWDs were also found to be less likely to be involved in general population sexual health messages, for instance those relating to HIV, as these were either not thought to be relevant to this group or were not presented in a way that was accessible to them (Rohleder, 2010, ACPF, 2010). This lack of education has the impact that some PWDs were unable to understand when a situation of abuse occurred, or unable to articulate this in order to report the incident (Mall and Swartz, 2012b, Phasha, 2013, Rohleder, 2010). A lack of education on sexuality and sexual abuse was also highlighted by some as related to encouraging sexual abuse by PWDs due to lack of understanding of 'normal' sexual behaviour (Nyokangi and Phasha, 2015, Phasha and Nyokangi, 2012, Dickman and Roux, 2005).

The third structural issue which was repeatedly highlighted in the literature was the social isolation of PWDs and the impact this has on levels of vulnerability and susceptibility to manipulation by abusers. PWDs are often left at home alone while carers or family members attend work and school. A lack of social connections, linked with the views mentioned earlier which cause many PWDs to be shunned by their communities make them more

vulnerable to situations of sexual abuse. Studies reported that families often hide disabled children within the home due to the shame connected with bearing a disabled child, and that whilst secluded within the home the PWD becomes an easy victim of sexual, physical and emotional abuse by both family members and those able to enter from outside the home (Handicap International, 2011, Mall and Swartz, 2012b, Kvam and Braathen, 2008). This isolation also creates loneliness and desire for acceptance and affection which make PWDs less likely to resist sexual abuse (Hanass-Hancock, 2009b, Rohleder, 2010) or more vulnerable to manipulation to exchange sexual acts for money or small gifts (Aderemi, 2013, Stopler, 2007).

### Responses to sexual abuse of PWDs

So far I have focussed on the issues which lead to the abuse of PWDs in Africa, which if tackled would help to prevent abuse before it happens. Currently, however, high rates of sexual abuse continue and therefore it is important to look not only at prevention but also at how cases of abuse are dealt with when they do occur. This is central to this study and is a key theme throughout the literature.

A common feature throughout the literature is the issue of underreporting of sexual violence. Statistics are of course difficult to find when discussing how many cases of abuse have not been reported but examples were given by the African Child Policy Forum (2010) which found that only 51% of those who had been raped reported the incident and by Stöpler (2007) who reported that in general cases of sexual abuse in Kenya only 1 in 20 people reported cases of sexual assault. It is difficult to accurately understand these issues but key throughout the literature was a discussion of the causes of underreporting. First of all the survivor of abuse may not tell anybody what has happened, due to lack of understanding of the abuse as wrong or abnormal, dependency on the abuser or isolation from the community, as detailed above. Also identified, however are the barriers that occur for those who do report abuse to a family or community member. Firstly many 'traditional' authorities may decide to deal with the issue within the immediate family or community. Pasha (2009) described the practice of dealing with sexual abuse as a 'family matter' in South Africa through traditional cleansing rituals and the payment of a small fine, for instance a goat or cow, from the perpetrator's family to the disabled person or their family. Similar practices are described in the "Out of the Shadows" report which also notes that in some cases the perpetrator may be forced to marry the PWD in a further violation of their rights (Handicap International, 2011).

Even when the step is taken to report sexual abuse to the legally appropriate authorities, usually the police, the literature shows that several barriers exist to achieving a conviction. Several papers pointed to reports of sexual abuse of PWDs being ignored or dismissed when reported to the police or to other authorities such as teachers. The African Child Policy Forum (2010) found that 75% of boys and 52% of girls who reported rape felt that nothing had been done as a result while Nyokangi and Pasha (2015) described several instances of girls with intellectual disabilities who felt that their reports of sexual abuse made to teachers had been "ignored or covered up as if it had not happened". This lack of response contributes to underreporting and can perpetuate greater levels of abuse as it is felt that

such issues will not be dealt with even if they are reported (ACPF, 2010, Handicap International, 2011).

Even when abuse is reported, and those reports are investigated, several barriers still remain to achieving any form of punishment of the perpetrator or perceived justice for the victim. The primary issue identified throughout the literature for cases which do reach the stage of being brought to criminal courts is the lack of suitable adjustments made in the court process to meet the needs of the disabled person acting as a witness. In cases of intellectual disability in particular PWDs are assumed to be incompetent witnesses, often with little or no genuine assessment of their competency (Pillay, 2012, Dickman and Roux, 2005, Phasha, 2013, Hanass-Hancock, 2009b). Those with impairments affecting their communication can also be faced with barriers due to a lack of resources, such as sign language interpreters, to allow them to participate in the court process (Stopler, 2007).

It should be recognised, however, that there have been efforts made in some instances to improve the responses to sexual abuse of PWDs. One such example is given by Dickman and Roux (2005) of a psycho-legal service established in Cape Town, South Africa to aid persons with learning disabilities in sexual abuse cases, which has been successful in increasing the likelihood of prosecution. These initiatives are, however, few and far between and the number of cases which continue to fail to reach court or achieve a satisfying outcome for survivors of abuse show that much still needs to be done to improve the response to sexual abuse across the continent.

## Research questions

Following the review of the current literature as presented above this study aims to address the following research questions:

Key research question: How do staff in the health care and criminal justice sector in Kenya understand and respond to the sexual abuse of people with disabilities and how could changes to their practice help to reduce rates of sexual abuse?

Sub-questions:

1. What knowledge, attitudes, beliefs and practices do staff in the health care and criminal justice sector have of disability and PWDs in Kenya?
2. How do or might these views affect the way they deal with reported incidents of sexual abuse of PWDs?
3. What recommendations could be made to prevent sexual abuse of PWDs and to improve responses when such incidents do occur?

## Methodology

The data for this dissertation is part of an action research project conducted by Advantage Africa, a UK based INGO with projects in Uganda and Kenya. The sample analysed is a subset of a larger project which included similar data collection in Uganda and also data from other participants. Here the data set comprises transcripts from 12 semi-structured interviews and 6 focus group discussions (FGDs) which took place in two regions of Kenya. The interviews used for this dissertation were conducted with members of the healthcare workforce (7 interviews) and the criminal justice workforce (5 interviews), including police officers, nurses, doctors and lawyers. The participant range was informed by discussions at an initial workshop with local partners including PWDs, where it was decided to include a broad range of both junior and senior staff members. The data in the larger project included: focus group discussions with men with disabilities (2 FGDs); women with disabilities (2 FGDs); and parents of children with disabilities (2 FGDs). Each FGD had between 5 and 9 participants (total participant number: 43).

Data were collected by local staff who had been trained in basic qualitative research skills by an academic specialising in qualitative disability research. These researchers all had prior experience of working with PWDs who had experienced sexual abuse and were chosen for their relevant expertise and experience, but also for their intimate understanding of the local context, culture and languages. These researchers have also worked extensively with Advantage Africa staff in the past. The three researchers who collected the data analysed in this dissertation were:

- Male researcher 1: An experienced physiotherapist. Formally head of VSO's Children with Disabilities Empowerment programme in Kenya (2007- 2009). He has an MSc Community Disability Studies Institute of Child Health, University College London.
- Male researcher 2: Regional Mediator, Liliane Foundation. He has 30 years' experience in education and the community rehabilitation of persons with disabilities. He is a former Head teacher.
- Female researcher: Coordinator of the Kibwezi Disabled Persons' Organisation. She has extensive experience of managing community level disability support programmes. She also represents persons with disabilities at national advocacy / policy level. She is a woman with a disability.

The researchers used topic guides which were developed at a project initiation workshop with input from community representatives including PWDs and representatives of disabled people's organisations (DPOs). A process of brainstorming of possible questions and topics to be included in the interviews and focus groups was used and then draft topic guides were role-played within the workshop to check for length of the process, appropriate wording and translation into the local language. This also provided an opportunity for training of the data collectors in using the tools. Disabled people who were participating in the workshop played the roles of participants. These interviews and FGDs were conducted in the local language or English depending on the participant and were recorded and transcribed into English by the three local researchers. The topic guides are included in the appendices.

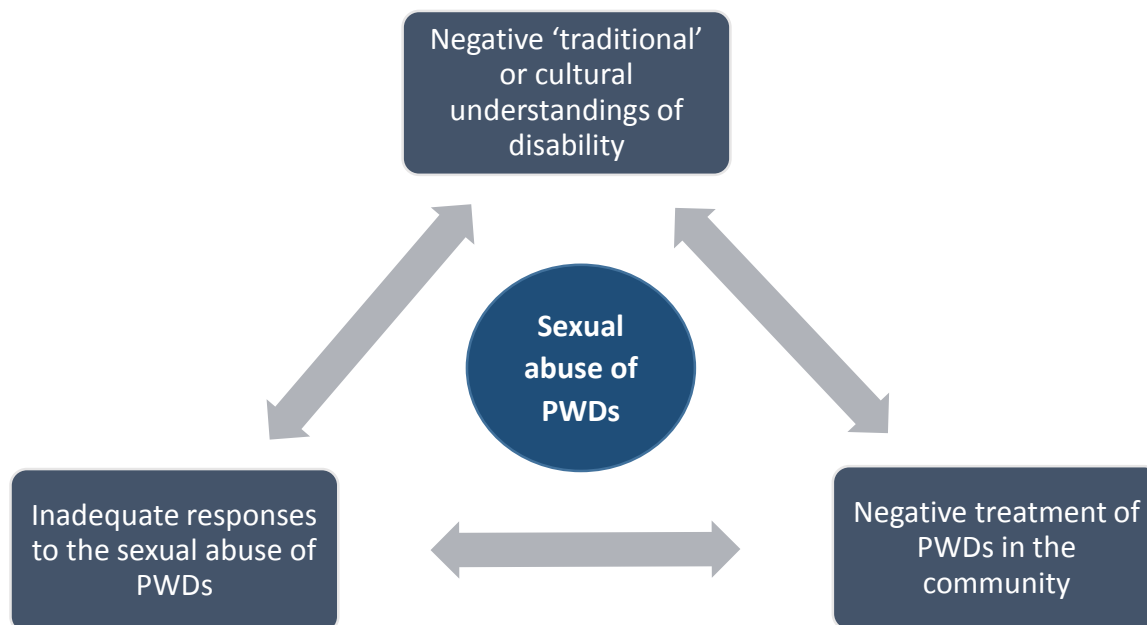
The data has been transferred in an anonymised format from Kenya to the UK and is held at the Advantage Africa offices. Electronic versions of the relevant transcripts were shared with the author of this paper. Permission to conduct the study was sought and gained from local authorities and ethical approval for the analysis of the data used in this dissertation was granted by the UCL Research Ethics Committee, Project ID: 6971/001.

Data was analysed using QSR NVivo 10. Analysis followed a thematic analysis methodology as described by Braun and Clarke (2006). I read through transcripts initially twice with initial memoing and note-taking of possible themes and codes. Each transcript was then coded using an inductive process with codes arising from the data. After all transcripts had gone through this initial coding process the list of 44 initial codes was analysed and restructured. A final coding framework was developed after which each transcript was re-read and coding adjusted accordingly. At the final stages data were printed out and manually analysed into three key themes in order to develop a conceptual visualisation before being written up into the analysis presented below.

## Results and Discussion

Introduction to the results and discussion

From the interviews with the healthcare and criminal justice staff, taken alongside the focus group discussion with PWDs and parents of children with disabilities (CWD) a number of interlinked themes emerged. These are represented by the conceptual model below.



Negative 'traditional' or cultural understandings of disability were highlighted which are both caused by and lead to negative treatment of PWDs, which in turn are caused by and lead to inadequate responses to the sexual abuse of PWDs by healthcare and criminal justice workers. All of these themes serve to allow for and increase the rate of sexual abuse of PWDs within Kenya. An examination of each of these themes is presented below along with recommendations on how interventions could be introduced at each of these levels in order to break the cycle which perpetuates these high levels of abuse.

Some of the nodes which were initially coded are not included in these key themes, particularly a number of societal issues which were seen as contributing to high levels of abuse such as drug and alcohol abuse; poverty; and the impact of seasonal working. It has not been possible to discuss all of these topics in detail in this dissertation and it should be noted that what is discussed below is a subset of a larger picture.

Key responders' knowledge, attitudes, beliefs and practices relating to disability and PWDs

Sub-question 1 asks "what knowledge, attitudes, beliefs and practices do staff in the healthcare and criminal justice sector have of disability and PWDs in Kenya?"

This section will unpick the understandings and beliefs which emerged in the data, and how these lead to differential treatment of PWDs.

Here there is a great deal of correlation with the findings of the literature review, particularly with respect to beliefs regarding the sexuality of PWDs. There are, however, also some signs of more progressive views from some interviewees which I will include in the final section of the discussion regarding future recommendations. As in the literature review I will look first at general views of disability and PWDs, and secondly at those particularly relating to sexuality and/or sexual abuse.

It should be noted that the structure of the questions posed to interviewees meant that it was not always easy to differentiate whether the views expressed were their own or those which they felt represented the views of the community. This is because it was felt that in order to elicit fuller responses and to reduce the impact of acquiescence bias questions were often phrased along the lines of “what is the attitude around here” leaving some ambiguity in the responses.

Disability as a curse

The view of disability as a curse or punishment due to transgression against forefathers was mentioned in the majority of the interviews and FGDs. Very often in the interviews a link was made between a belief that the parents of a disabled child had ‘sinned’ or angered the ancestors and that the birth of the disabled child is a punishment for this. This creates a double stigma towards both the disabled person and their family which in many cases results in the isolation or disownment of the child, very much a reflection of the similar views reported by Stöpler (2007) in Uganda. The sense of shame linked with this view was clearly articulated by one interviewee from the police who claimed that some parents chain or lock their disabled child up in the home. When asked to explain this behaviour he responded:

*“They are ashamed, they think they were bewitched and cursed, they think people will fear working with them to avoid their curse.”* (Senior Police, Male)

The issue of fear was echoed by one parent of a disabled child who claimed that:

*“...in our community disability is something people fear even more than HIV and AIDS. They believe it is a curse, somebody who is neglected from the family”*  
(Parent/CWD)

Another member of the police gave an indication of a move away from these ‘traditional’ views of disability, stating that

*“within our area in the African culture they see it as a curse yet in the modern world which we are living in right now is a problem to do with genetics/generic thing”*  
(Administration Police, Female)

Although this suggests a positive move away from blaming PWDs or their families for an impairment interviewees also emphasised a perceived need to ‘heal’ the disabled person, a representation of the ‘medical model’ of disability mentioned in the literature review and

something which in the case of many impairments is not possible. One healthcare worker explained that many families will invest time and money attempting to treat or cure the PWD but that:

*“...when they do not get better they get frustrated and give up on them”* (Clinical Officer, Male)

Comments like this show the need not only to challenge traditional concepts of disability as a curse or punishment but also to ensure that the social model of disability is promoted to ensure understanding of the role of the community in creating an environment where PWDs can be fully integrated into their community and accepted as citizens even with their impairments.

Disability as a burden

The second general view of disability and PWDs also reflects the findings of the literature review. This is the view that PWDs represent an unproductive burden or strain on the family or community. Again this view was represented across the interviews and FGDs with particular emphasis on the perceived inability of PWDs to contribute to their society due to the emphasis on physically demanding activities such as agricultural work or collecting water. One police worker clearly represented the impact that this view has on the position of the PWD within society by stating, when asked whether PWDs have the same rights as non-disabled person:

*“No, not at all, they are dependent and dependent people do not have equal rights in this community”* (Administration Police, Male)

These views were most strongly emphasised in the FGDs, where PWDs or their parents articulated frustration at being overlooked in access to education or work opportunities due to the belief that their impairments made them incapable of doing so. They expressed that disabled children are most often excluded from education in favour of non-disabled siblings and that few employment opportunities exist for those with disabilities.

One healthcare worker stated that there was a potential change in this form of discrimination linked to changing work priorities within the communities:

*“...people here depended on physical strength for survival, disabled people were not able to cope and people regarded them as liabilities, with the new era of education and lesser demanding work, people are starting to change the attitudes”* (Nurse, gender not recorded)

This quote suggests a level of inclusion into the workforce is possible and desired within some communities. Whether the same is true of all impairment groups is worth considering as in most cases where inclusion was discussed it was only those with physically impairments that were mentioned. Another healthcare worker, however, showed a lack of exposure to PWDs in ‘normal’ roles and the pervasiveness of discrimination by stating that she felt that PWDs were less able to do certain activities:

*“...for example you can’t just take a blind person to a school and tell him/her to*



*teach. The pupils might be even frightened at the first time they meet him in class”*  
(Nurse, Female)

#### Isolation of PWDs

The view of PWDs as cursed and as unproductive burdensome people can both be linked with the resulting isolation and treatment of these community members as ‘outcast’. Interview and FGD participants frequently discussed the segregation of PWDs within their communities, either deliberately through hiding of disabled children and adults or through overlooking the potential of PWDs to play a role within the community. This isolation, particularly where PWDs have little contact with members of their community and are frequently kept ‘behind closed doors’, increases vulnerability to abuse and decreases the social networks which can act as a protection against abuse or an avenue to report abuse when it does happen.

#### PWDs as ‘unmarriageable’

This view of PWDs as dependent and unproductive is particularly poignant in terms of views concerning the sexuality and marriageability of PWDs within Kenyan communities. In Kenyan culture there is a high degree of importance placed on the ability of a person to marry well and therefore the idea that a PWD does not have the right or the ability to marry carries great significance. One community nurse stated that the right to be married:

*“...varies from disability to disability and the severity of the disability. There are disabled people who are married and are taking care of their families, other disabled people have a disability that cannot allow them to marry and take care of their families”* (Nurse, Female)

This belief that the right to marry is tied to physical capabilities or the ability to bear and look after children, alongside a belief that certain PWDs are incapable of caring for a family, clearly highlights the impact of the belief that PWDs are an unproductive burden within the family.

A similar view was given by a district hospital nurse who while acknowledging the right of PWDs to marry linked the ability of a person to marry to their ability to play a ‘productive’ role in their society:

*“where we have a lot of work especially the farm work, so as much as they have a right to get married, when it comes to senses of going to the farm ... I don’t know how they might look at him/her...he/she might not be accepted fully”.* (Nurse, Female)

Views like these show that the exclusion of PWDs from work or education opportunities has a wide reaching impact on their ability to participate equally within their societies.

#### PWDs unable to have ‘normal’ relationships

Linked to the view that PWDs are ‘unmarriageable’ is the idea that they are incapable of experiencing normal sexual relationships. The views of PWDs as asexual or hypersexual described in the literature review were not widely expressed in the interviews, with the

exception of one health worker who showed a concerning lack of understanding by stating that:

*“I also believe those with epilepsy have high libido during ovulation” (Nurse, Female).*

The view, however, that PWDs could only have a relationship with a non-disabled person if that relationship was an exploitative one was echoed by members of both the criminal justice and healthcare workforces. One community nurse stated that while she believed that PWDs could have a relationship she would want to discuss this carefully with them:

*“...to know if the person is sure or not and will not change their mind later” (Nurse, Female)*

A similar concern was expressed by a police officer who stated that if the police:

*“...came across a man with a disabled girl like that (taking a ‘romantic stroll’), they would investigate if the man was abusing the girl or have the intention to use her to commit a crime.” (Senior Police, Male)*

The officer went on to explain that the same concern would not be taken with a non-disabled couple because:

*“That is normal, but for the disabled person and a non-disabled they would most likely have to prove that they are innocent”*

Although these views show that to some extent these interviewees are aware of the risk of sexual abuse of PWDs they can also be taken as patronising and as undermining the potential of PWDs to form healthy and non-abusive relationships. The view that a PWD can only experience sexual relationships through abuse was further emphasised by the same police officer who stated that:

*“The only way a disabled person learns about sexual relationship is through sexual abuse”*

This view is also linked with the idea expressed in the literature review by Phasha (2009) and others that sexual abuse of PWDs can be viewed as ‘a favour’, a view which was echoed in one interview with a member of the criminal justice workforce who stated that:

*“People see them as helpless and weak and thinks it is a favour to consider them as a sexual partner.” (Administration Police, Male)*

Responses to incidents of sexual abuse of PWDs

Sub-question 2 is: “How do or might these views affect the way they (key responders) deal

with reported incidents of sexual abuse of PWDs?”

When looking at the ways in which ‘key responders’ in the health and criminal justice workforce respond to incidents of sexual abuse it is clear that the views which have been explained above and the resultant negative treatment of PWDs also affect the way in which these cases are handled.

Underreporting and community responses

Echoing the literature, a key issue in the interviews and FGDs is the underreporting of sexual abuse of PWDs. Underreporting where a key caregiver or breadwinner within a family is the perpetrator of abuse was mentioned, as was a concern with ‘spoiling the cv’ of perpetrators with high standing in the community. More prominently mentioned, however, was the idea that abuse of PWDs was not considered to be a serious enough issue to report to the authorities. Again mirroring the view that PWDs are a burden on the community one nurse hypothesised that underreporting was down to the fact that the community:

*“...do not value the disabled and cannot waste resources following the abuse of a non-productive person” (Nurse, Female)*

Where cases of abuse are reported to family or community members it is common that this will go no further and community responses outweigh the number of cases brought to healthcare or criminal justice services. Two of the FGDs referred to the practice of perpetrators paying a fine of 1 or 2 goats to the victim or their family in order to “dismiss the case”. In fact the general preference for dealing with cases of sexual abuse of PWDs at a community level was expressed by both criminal justice and healthcare staff. Both groups referred to instances where abuse had been brought to their attention, only for community members to refuse to follow official procedures with the preference of returning to community level forms of ‘justice’. A member of the ‘Administration Police’ (responsible for community policing) said that when dealing with a report of sexual abuse of a PWD:

*“If the people involved are ready to settle it we can help facilitate and that is why we are based at community level. If people are willing to settle it and we refuse they will go ahead anyway or refuse to participate in the justice process” (Administration Police, Male)*

In the FGDs when asked who cases of abuse should be reported to, the PWDs or parents of disabled children commonly mentioned community and family structures showing that even for these individuals keeping the issue within the community may be seen as the best, correct, or only option. The importance of having family or community support in order to mediate the stigma and shame connected to this abuse and for the justice process to be successful was emphasised by several respondents. This suggests that even where there is individual will to pursue a case through official channels exists the case may not be strong enough without this wider support.

### Barriers after reporting

Even when there is a willingness to report and pursue a legal case at the individual, family or community level a number of barriers remain. As in the literature the issue of whether PWDs could be competent witnesses and to what extent the systems for pursuing a case could adjust to the needs of PWDs was questioned by a number of respondents. One of the respondents most closely involved at the court level, a probation officer, did however emphasise that in some cases adaptations such as sign language interpreters and video links for victims were available. A greater challenge seemed to be the costs associated with making a complaint and the associated processes. Several respondents in both the interviews and FGDs spoke of prohibitive costs associated with accessing a 'P3 form' at the police station to make a report; receiving medical treatment and tests following sexual abuse; and even paying for healthcare workers or police to attend court cases. To add even further to these costs the issue of corruption and bribery was mentioned as a considerable barrier to achieving justice as:

*"The investigation officer is sometimes bribed by the accused so that he makes a shoddy investigation which cannot sustain in a court of law and let me tell you that this is very common."* (Senior Police, Male)

On top of this the cost of transport to access these services, and of hiring a lawyer to represent the victim means that for the majority of Kenyan PWDs and their families pursuing a legal case against a perpetrator of sexual abuse is unlikely.

### Processes are not followed

Finally, while the majority of interviewees from both professional groups expressed when asked that they personally felt confident that they would handle cases of sexual abuse of PWDs correctly and professionally (a response open to potential acquiescence bias) there was an acknowledgement that this was not the case for all of their colleagues. A particularly candid statement was made by one member of the police forces on this issue:

*"...some of our officers especially the uniformed officers are not conversant with investigation procedures and may not be friendly to the victims. They sometimes cover their ignorance by using derogatory language or intimidation... most sexual abuse cases are thrown out at the appeal stage due to lack of evidence or shoddy investigations, evidence will have since disappeared or expired due to poor handling and witnesses and the victims already tired of the case, but what can we do."* (Senior Police, Male)

Responses like this show that there is need to ensure staff are trained on these issues across all levels of the workforce and that the correct procedures for dealing with victims and referrals are understood.

### Impact of inadequate responses

The inadequacy of the official responses to cases of sexual abuse of PWDs was cited by a number of respondents as a factor in increasing and perpetuating high rates of sexual abuse.

According to these respondents perpetrators of abuse do not fear recrimination and therefore continue to see PWDs as 'easy targets'. This is summarised in a comment by one nurse:

*"...since disabled people are not highly regarded the dispute resolution structures are seen to favour the perpetrator and do not help in deterring sexual abuse" (Nurse, gender not recorded)*

It is clear from the analysis of this data that the knowledge, attitudes, beliefs and practices which staff in the healthcare and criminal justice sector have of disability and PWDs in Kenya has a significant negative impact on both rates of, and responses to incidents of sexual abuse.

Responses from the two professional groups were largely similar, with no identifiable pattern of difference between the two groups, suggesting a pervasiveness of these negative views and responses across the different workforces. The following section will outline a number of recommendations which were either highlighted by respondents within the data collection or have come out of the analysis.

Recommendations for improving responses to sexual abuse of PWDs

The emphasis of these recommendations is on actions which can be taken by Advantage Africa, the INGO which led this research process, because the original motivation for the data collection was to help to inform their practice on dealing with an issue which had been brought to their attention by service users. In addition there are recommendations for areas of development for criminal justice and healthcare service providers and the Kenyan government more broadly.

Recommendation 1: Increase the value placed on PWDs within their community.

A central finding in this research is the negative view of PWDs, and the way that this view affects their treatment in their community, rates of sexual abuse and the way key responders deal with reports of sexual abuse. A key area for interventions therefore is in building the worth which a community places on PWDs with an aim of creating an inclusive society. Partly this can be done through education and awareness programmes which can be aimed at communities; parents of disabled children; and providers of key services including the criminal justice and healthcare workers which are the focus of this paper. As one healthcare worker stated:

*“...because some parents lack exposure and education, they don’t know that these people can be positive to the community if they are given the chance”* (Nurse, Female)

Education sessions on the rights and capabilities of PWDs can be further enhanced by increasing their work and education opportunities in order to develop their abilities to participate in their communities and to increase their visibility and acceptance as equal members of society. Work on disability awareness and the promotion of disability as a human rights issue generally would therefore help with the specific issues of recognition of PWDs as community members with equal rights including to relationships and sexual lives free from abuse.

Recommendation 2: Raise awareness of the laws and processes relating to sexual abuse of PWDs

The current emphasis on community responses to incidents of sexual abuse of PWDs is not effective in delivering justice to victims or creating a deterrent for future abuse. Therefore initiatives that encourage PWDs and their communities to access formal interventions through attending healthcare services and following up with criminal justice services should be encouraged.

Advantage Africa is well placed to run these types of trainings through partners in local Disabled People’s Organisations (DPOs) and other groups highlighted through the process of conducting this research. Dissemination of these approaches to other IGNOs, and other local, national, international forums would also allow for a greater reach of this work.

Recommendation 3: Provide training and support for healthcare and criminal justice staff  
Healthcare and criminal justice staff should be included in the education programmes mentioned in recommendations 1 and 2. This research has shown, however, that there is a need for specific training directed towards these groups about sexual abuse and the correct

procedures which should be followed following an incident of sexual abuse of a PWD. It is important that these key responders are able to provide appropriate comprehensive support to victims of abuse and to ensure that conviction of perpetrators is achieved wherever possible. This recommendation was emphasised by one healthcare worker who recommended that:

*“all service providers should be given some training about sexual abuse also where possible train different kinds of service providers together so that they can share their challenges and learn how each group deals with sexual abuse”* (Nurse, Female)

Recommendation 4: Provide support to PWDs who are survivors of sexual abuse

Interviewees were asked whether they were aware of any support available to PWDs who were survivors of sexual abuse. None were aware of any such support. This support needs to cover a number of areas including psychological / emotional support to deal with the trauma of sexual abuse; financial or practical support (i.e. through transport provision or access to legal advisors); and support to tackle the stigma of sexual abuse within the community. It is also necessary to improve the chains of communication after an incident of abuse, as described by one healthcare worker:

*“When a disabled person has been abused, we should have a special way of communicating in order for the victim to get his/her right quickly. You may find a disabled is unable to walk to a police station. If the communication is good he/she can be picked and be taken where he/she needs to go”* (Hospital Staff, Male)

Recommendation 5: Remove financial barriers to pursuing criminal cases and tackle corruption

As one respondent from the criminal justice system stated often:

*“...families are very poor to raise money for transportation to police, to hospital and the court. The process is expensive and time consuming to such poor families. The police have a form called p3 which is provided on payment, as some of the victims have complained; the hospital treatment and laboratory test require some payment; it is followed by many days/months of court hearings (which are located far in big towns).”* (Probation Officer, Female)

This entire process is costly both in terms of direct payments and in time spent travelling to and from the various services and appointments. More needs to be done to streamline this process and reduce the financial burden it places on the victim and their family. Corruption in the form of bribes or additional ‘unofficial’ payments further adds to this burden. This should be actioned at the level of central and provincial government in Kenya to ensure that both the official protocol and the actual practice in instigating and following a report of sexual abuse is made as simple and stress-free as possible. Ensuring that effective whistleblowing and complaints procedures are in place, visible and followed up will also help to improve this process.

## Limitations of the research

There are a number of potential limitations in any study. The purpose of this section is not to present every possible limitation to this paper, but to look at the key points which may have had an impact on the findings presented above.

In terms of the data collection the key limitations relate to the limited research experience of the Kenyan researchers, which was dealt with in the methodology section, and the issue of potential acquiescence bias. The individual interview participants were selected as a result of their occupation in positions which would be expected to have knowledge and understanding of dealing with cases of sexual abuse of PWDs. The potential for bias lies in the possibility of embarrassment or concern relating to professionalism if they were to present negative views of PWDs or a lack of understanding of their professional role. This was mediated for through ensuring that each participant was aware of their anonymity in participating in the role, and through asking them to describe the views of others within their community or occupation and using these responses as proxy measures for their own views. It is accepted, however, that some bias may remain and therefore I was conscious of looking for this during the analysis of the data.

During the analysis stage a limitation existed due to the nature of the dissertation which meant that analysis of the data could only be done by one person, myself. It is widely accepted that independent analysis by a second research is preferable in the case of qualitative research in order to reduce researcher bias and subjectivity (Mays and Pope, 1995). This was dealt with through consultation with the dissertation supervisor regarding emerging codes and themes and through triangulation across the data in order to check for agreement or difference on particular points and to ensure that the interpretations presented above accurately represent the data.

It is also important to note that there is limitation in the extent to which these findings can be generalised as the data were collected from two regions of Kenya and do not represent a statistically representative sample, therefore findings may not be applicable to other areas of Kenya or East Africa. The findings from this study do, however, echo data from other studies in the region which suggest that some level of conceptual generalisation is possible.

## Recommendations for future research

The literature review for this dissertation revealed a serious deficiency in research into sexual abuse of PWDs across Africa. In particular there is very little data available regarding population level incidence of abuse. Future research into this area could be a useful advocacy tool to encourage African governments and others working in the area to prioritise prevention of abuse and improve responses when abuse does occur. Particular to Kenya the data revealed a general lack of services and support for PWD and their families. Further research into how best to support the full inclusion of PWDs into their communities across sectors, for example through improving education and employment opportunities and through community education programmes to reduce stigma and isolation, is highly recommended. Kenya is also a signatory to the United Nations Convention on the Rights of



Persons with Disabilities (UNCPRD) and therefore research into the extent to which this convention is implemented is also recommended.

## Conclusion

This dissertation aimed to answer the research question “How do staff in the health care and criminal justice sector in Kenya understand and respond to the sexual abuse of people with disabilities and how could changes to their practice help to reduce rates of sexual abuse?”

The literature review revealed that relatively little research has been conducted in this area and in particular there is no reliable data concerning rates of sexual abuse of PWDs in Africa. More research into this area is vital to increase the visibility of the issue and to push for action from African governments and other bodies working in the region.

The analysis of data from this research largely reflected that which has been highlighted in previous studies across Africa, that societal stigma towards PWDs which means they are viewed as cursed individuals and burdens on society perpetuates an environment in which sexual abuse of PWDs is allowed to continue and is often not considered to be a serious issue. As well as these being the beliefs and attitudes held by the majority of the general public many of these views appear to be held by those ‘key responders’ who are meant to act as the first point of contact for a victim of abuse. The negative views of PWDs expressed by these ‘key responders’ has a direct link to the inadequate or negative responses to cases of abuse, which further perpetuates abuse due to the lack of fear of punishment or repercussions.

Kenya is a signatory to the UNCPRD and as such has a legal obligation to protect the rights of her disabled citizens, including ensuring that they live their lives free from abuse. Currently this obligation is not being met. Kenyan citizens must be educated to understand that PWDs have equal rights as non-disabled persons and the government must be held to account for ensuring that this equality is realised. This can be done through working towards full inclusion of PWDs in their communities and tackling long-standing stigmas against these groups.

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## Appendix - Topic guide

### Topic guide for individual semi-structured interviews

**Intro** – recap on aims of the research, ethics, consent, anonymity etc. The interview will last about 1 hour.

**I am interested in your views and experiences in your role as a (Doctor, Teacher, Lawyer, Faith Leader, DPO Leader etc.)** There are no right or wrong answers so please feel free to tell me your thoughts.

There will be 8 sections that we will discuss and then a chance for you to add anything else you think of at the end. Then I will ask you to fill in a short questionnaire.

**1. I'm interested in your thoughts about how people with disabilities are generally viewed around here.**

Prompts:

- What are the main attitudes and beliefs about them?
- Do you think disabled people are regarded as equal members of the community or as different? If different in what ways?

**How do you think people in your work setting/group (e.g. hospital/police station etc.) regard disabled people?**

**2. Now let's think about local Ideas about disabled people and sexuality in this community**

Prompts:

- Are disabled people seen to have the same rights to a married life and to be sexually active as other people? Why or why not?
- What are the ideas of the community about this kind of issue?

**What do you think people in your profession think about this issue?**

**3. Now, how common is it for disabled people to suffer sexual violence or other kinds of violence or abuse?**

Prompts:

- You can think about adults and children and also males and females
- Do you think disabled people are more at risk of sexual abuse than other people?  
If yes – why is that? If not, why not?
- Is it different for boys/men vs girls/women?

- What about comparing people with different types of disability? E.g. people with physical difficulties, or slow learners, deaf or blind or having mental illness (madness), or epilepsy or albinism for instance?

**4. Do you think there is anything generally about society round here that makes sexual abuse of disabled people more or less common?**

Prompts:

- E.g. people's beliefs or attitudes or behaviours

**5. What usually happens in (your workplace) if a case is brought/reported involving a disabled person and some kind of sexual abuse?**

Prompts:

- Who would deal with this kind of situation? (is there one person responsible for such cases or could it be any of you?) Is it dealt with by someone of a particular seniority?
- Is it different for men vs women, children vs adults?
- Have you or any of your colleagues had any special training about this at all?
- Do you think dealing with this kind of thing needs any specialist skills? If yes – what kind of skills?
- Would you feel confident and comfortable with dealing with this kind of thing or not?
- Do you usually refer on to any other organisations/agencies/groups to help deal with this? if so who? Under what circumstances would you contact other people?

**6. Are there any special information (guidelines) about what you should do in this situation? If yes what do you think of them? Necessary/not necessary, Helpful/ not helpful? Are they used?**

Prompts:

- If no guidelines – what do you think of that idea? Do you think some should be developed?
- Do you know if there are any national or international guidelines about this topic for your profession? Do you think there should be?
- Have you ever seen or heard any advice/guidelines for victims of abuse

**7. Do you think any organisations/agencies/individuals are particularly good or bad at dealing with this issue?**

Prompts:

- Are you aware that anyone (e.g. doctors, teachers, police, preachers, government officials or anyone) has special training in this area of work? If not do you think they should?
- Have you ever seen or heard any advice/guidelines for victims of abuse?

**8. Is there anything better or different that you think should happen in the situation when someone who is disabled experiences sexual abuse?**

Prompts:

- For example by your organisation/agency or others?
- Which other organisations/agencies/individuals do you think should be involved with this issue?
- Do you think there are things to be done locally or at a regional or national level?

**9. Is there anything else you would like to tell me about this topic?** Anything we haven't covered?

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**Close** – Thanks for participating

**Now here is a quick reminder about what will happen to the information you have given me.** Your real name and details will be removed and we will look at what you said alongside what other people we have talked to said and make a summary of it all. **Is there is anything that you have said today that you don't want us to use in the report?**

**At the end of the study** a written report will be produced and some suggestions for training and interventions and possibly changes in practice maybe made. If you would like a copy of this report or a short summary please tell me.

**Many thanks again for taking part in our study!**