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The Experiences of Sexually Abused Women with Disabilities Who Consulted Services in Zimbabwe: The Intersection of Disability, Gender, and Poverty

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Abstract

Women have experienced sexual abuse, and very few of them report to the police or seek other services, such as medical attention. This study aims to gain insight into the barriers women with disabilities face when accessing police, health, and counseling services after experiencing sexual abuse. Barriers such as long distances, physical barriers at service sites, communication barriers, gender issues, lack of confidence in the service providers, and an overall lack of resources were reported. In a study undertaken in Zimbabwe, women with disabilities encountered intersecting barriers such as the intersection of disability, and gender, poverty, unemployment, and low levels of education aggravated structural and social impediments for women with disabilities when seeking services after sexual abuse.

Keywords

Zimbabwe, disability, women, women with disabilities, sexual abuse, intersectionality, health services

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THE EXPERIENCES OF SEXUALLY ABUSED WOMEN WITH DISABILITIES WHO CONSULTED SERVICES IN ZIMBABWE: THE INTERSECTION OF DISABILITY, GENDER, AND POVERTY

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ABSTRACT

Women have experienced sexual abuse, and very few of them report to the police or seek other services, such as medical attention. This study aims to gain insight into the barriers women with disabilities face when accessing police, health, and counselling services after experiencing sexual abuse. Barriers such as long distances, physical barriers at service sites, communication barriers, gender issues, lack of confidence in the service providers, and an overall lack of resources were reported. In a study undertaken in Zimbabwe, women with disabilities encountered intersecting barriers such as the intersection of disability, and gender, poverty, unemployment, and low levels of education aggravated structural and social impediments for women with disabilities when seeking services after sexual abuse.

KEYWORDS

Zimbabwe, women, disability, women with disabilities, sexual abuse, intersectionality, health, services

Over 300 million women are estimated to have disabilities worldwide (WHO, 2011). The majority of women with disabilities face myriad barriers arising from an intersection of disadvantaging characteristics, including disability, and gender, poverty, lower education levels, isolation, and subordinated social status (Kabia et al., 2018). Collectively these disadvantages make women with disabilities especially vulnerable to sexual abuse (Humphrey, 2016; Gartrell, Baesel & Becker, 2017). Although no evidence-based data exist on women with disabilities and sexual abuse globally, researchers estimate that they are 1.5 times more likely than women without disabilities to become victims of sexual abuse (Hughes et al., 2012). Due to the poverty and unemployment that often accompany disability, women with disabilities are more likely to be left at home alone, increasing their vulnerability to sexual

predators (Addlakha, Price & Heidari, 2017; Rugoho & Maphosa, 2017). In addition, women with disabilities are often seen by predators as especially vulnerable and exploitable targets (Rugoho & Maphosa, 2017). The potential abusers of women with disabilities include family members and neighbors, as well as other individuals who can exert power over them, such as health care providers and personal assistance workers (Hughes et al., 2012). Dependency on caregivers especially exposes women with disabilities to sexual abuse (Nixon, 2009). Women with disabilities face additional and significant barriers after sexual abuse when seeking to report such abuse to the police or when seeking help from health care and social service providers (Rugoho & Maphosa, 2017; Benedet & Grant, 2014; Murray, Lombardi, Seely & Gerdes, 2014).

Sexual abuse of women with disabilities is prevalent, possibly because the perpetrators know that these women often lack the mental ability to either resist or report the crime (Barron, Allardyce, Young & Levit, 2019). While prevention strategies are important, the research in this paper explores the difficulties that sexual abuse survivors with disabilities encounter in reporting the crime and obtaining needed services. By hearing the voices of survivors with disabilities, we present important facts often hidden from non-disabled individuals in society. Indeed, if the barriers discussed in this paper could be ameliorated, disabled survivors in the long run might have better success in holding perpetrators accountable, as well as receiving the help they need.

INTERSECTIONALITY AND WOMEN WITH DISABILITIES

Intersectionality was first used by feminist groups to explain the oppression of women in patriarchal societies (Crenshaw, 1989; O'Connor, Bright & Bruner, 2019). Disabled feminists have since joined the discussion, noting that disability studies research focusing on males did not include the gendered dimensions of disability (Cleary, 2018). Intersectionality has helped to explain how the intersection of characteristics, such as geographic location, race, ethnicity, patriarchy, gender, sexual orientation, socioeconomic status, religion, and age, in conjunction with the characteristic of disability, result in greater inequalities and discrimination towards women with disabilities (Atewologun, & Sealy, 2011; Dhamoon, 2011). Intersectionality sees the unique experiences encountered by an individual as important in understanding how personal experiences interlock with societal structures resulting in marginalization and oppression (Crenshaw, 2016; Hirschmann, 2012).

Further, intersectionality theory can interrogate how various forms of discrimination, such as racism, sexism, and transphobia, reinforce each other to sustain discrimination (Collins, 2015). The goal of intersectionality is to identify the inequities, injustices, and unfair practices that interact to the disadvantage of the group under study. Demonstrating how the different characteristics work cumulatively to increase prejudicial problems opens the way to addressing them jointly to improve the situation. Intersectionality helps to describe a world where everyone, regardless of disability, gender, level of education, and employment status, can access affordable and good-quality services, such as health care (Simpson, 2009). This theory is important for understanding issues of power dynamics in societies. It is equally useful for locating persons at intersections that have often been invisible, where they experience a disproportionate level of oppression and/or privilege (Simpson, 2009). Intersectionality concerns the power relationships in social interactions and how power is obtained, maintained, and reproduced through these exchanges.

In most cases, for women with disabilities, hierarchically organized interactions result in accumulated disadvantages that create further inequalities. Negative attitudes towards women with disabilities, for example, create several barriers and leave these women with little power and few resources (Ballan, 2008; Hirschmann, 2012). Intersectionality and the social model of disability are in agreement that the way society views and interacts with women with disabilities creates barriers for women (Goethals, De Schauwer & Van Hove, 2015). The social model of disability argues that society's social constructions and artificial exclusions make individuals disabled, not their inherent medical conditions. For both intersectionality theory and the social model of disability provide clarity on how different members of societies interact with disability (Björnsdóttir & Traustadóttir, 2010). An intersectional approach is a tool with the potential to dissect the multiple oppressions experienced by women with disabilities, especially after collecting aggregated data. When the data is disaggregated, the issues identified may be able to be addressed by separate or common interventions.

METHODS

STUDY SETTING AND RECRUITMENT OF PARTICIPANTS

This qualitative study was conducted in Mashonaland Central Province, one of the ten provinces of Zimbabwe. To identify potential participants, five members of community social groups providing support to women with disabilities who experienced sexual abuse were consulted. They facilitated contact with women who fit the selection criteria. Caro, Turner, and Macdonald (2019) define sexual abuse victims as women who were physical touched, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing, and touching outside of clothing against their wishes. These individuals suggested 53 potential participants based on the following criteria: (1) having reported sexual abuse within the last five years to enable vivid recollection of events (we note that five years may be considered a long time for recall, but felt that sexual abuse is a significant and traumatic incident and thus not easily forgotten); (2) being 18 years and older, to be able to give informed consent; and (3) having a telephone number to enable direct communication.

Of the 53 participants, 19 were excluded from the research because they could not be contacted by telephone after repeated attempts. This may be attributable to a change in telephone number or technological barriers since most stayed in the rural areas where the communication infrastructure is still poorly developed. After contacting the remaining 34 women and explaining the objectives and purpose of the research, 26 expressed the desire to participate, while eight decided against it. The researchers did not pursue their reasons for declining. Among the 26 who finally participated, 11 had not gone to school, eight had achieved primary school education, four had attended secondary education, and three had vocational training. None had formal employment, and all were living in rural villages. Four were married with children, 11 had previously been married and had between 1 and 3 children, and the remaining 11 had never married and had no children.

To gain insights into the perspectives of the service providers as well, eight key informants from these services were interviewed by the first researcher. Key informants were purposively recruited, having had at least one previous encounter with women with disabilities reporting sexual abuse. Three key informants were male police officers, one of them being a senior police officer in charge of a police

station. Five were nurses (three males and two females) at community clinics who were responsible for medical and counselling services at their clinics. One of these nurses at a district hospital was in charge of supervising nurses in the district.

DATA COLLECTION METHODS

Due to the geographical distribution of the participants, face-to-face semi-structured interviews were considered the most suitable method for data collection.

It was not convenient for women with disabilities to convene for group discussions because it would involve too much travel, reduce their anonymity, and potentially violate their privacy. A female assistant researcher with extensive experience conducting research with women with disabilities undertook face-to-face interviews with the women. Because the assistant researcher also has a physical disability, she often identified with the participants, who appeared to be comfortable talking to her. The interview guidelines focused on their experiences in accessing police and health and counseling services. Interviews lasted 45 to 60 minutes each; comfort breaks were allowed.

The first author carried out face-to-face interviews with service providers. The interviews focused on challenges that are likely to be faced by women with disabilities when utilizing their services after sexual abuse. The interviews lasted between 35 and 45 minutes each.

All participants preferred to use their first language, Shona, one of the main languages spoken in Zimbabwe, during the interviews. Participants consented to the interviews to be recorded using a Dictaphone. Notes were taken to memorize important information.

DATA ANALYSIS

The first author and the assistant researcher joined in the thematic content analysis. Thematic content analysis is a qualitative method in which the researcher analyzes data to identify common themes – topics, ideas, and patterns (Braun & Clarke, 2006). It is a method for describing data that follows the following steps: (1) familiarization; (2) coding; (3) generating themes; (4) reviewing themes; (5) defining and naming themes; and (6) writing up. The first author worked with the assistant researcher to translate the raw data into English. The first author and research assistant performed back-to-back translations on selected transcripts to check the transcription quality. Both also checked for errors by repeatedly listening to the original recordings. Grammatical mistakes were edited out without altering original meanings. The first author and research assistant read the edited transcripts four times to understand the data. All transcripts (from women with disabilities and service providers) were imported into Excel software for data coding. The coding process involved a critical review of each transcript, followed by coding into emerging themes. Finally, themes were presented as narratives, and relevant quotes were used to support identified themes in reporting the results.

ETHICAL CONSIDERATIONS

The following ethical considerations were observed: (1) informed consent; (2) respect for anonymity and confidentiality;and (3) respect for privacy. Anonymity and confidentiality were achieved by giving participants pseudonyms. Verbal consent was sought prior to the start of the data collection. All participants were told that participation was voluntary and that they had the right to decline to answer any

question or to exit the research at any point without giving any reasons. Informed consent was obtained during the telephone discussions, and a hard copy of the consent form was signed prior to the interview's commencement. Women who could not read and write gave informed consent by signing with a thumbprint after hearing an explanation of what was on the paper.

RESULTS

Results showed that women with disabilities faced many barriers when seeking services after being sexually abused. The content analysis grouped the barriers into four themes, which were: (1) long distance; (2) physical barriers; (3) communication barriers; (4) gender issues; and (5) lack of confidence in the service providers, and lack of resources. The results are presented in more detail below.

LONG DISTANCE TO CLINICS AND POLICE STATIONS

Long distance to clinics and police stations was cited as a major challenge to women with disabilities seeking help after encountering sexual abuse. Participants reported travelling between five and 32 kilometers to the nearest police station or hospital to get support. Most rural areas reported not having public transportation, such as buses and taxis, meaning that walking was the only option. Sharon, 41, who has a physical disability, described her situation:

> After I was sexually abused, I told my aunt. We walked together to the police station, which is about 31 kilometers from our village. There are no buses connecting to the police station. It was very hard for me due to the nature of my disability.

A similar narrative was shared by Gremma, a 26-year-old with polio of the left leg, who added:

> I had to walk 16 kilometers to report to the police because I did not have the money to board a bus. The police continued summoning me several times. The case kept being postponed at the courts. Most of the time, I had to walk because I could not afford bus fare. I do not have a source of income to finance my travel.

Vimbai, a 33-year-old wheelchair user, failed to finish her prescribed counseling sessions after her wheelchair broke. She attributed the breakdown to the long distances travelled by saying:

> I encountered many barriers because of the long distance. If we decided to use small taxis operating in our area, I would have to pay extra fees for the wheelchair. One day I slept in the bush with my sister after my wheelchair had developed a problem. I could not afford to repair the wheelchair because I had no income. So, I had to quit the counselling sessions.

Chipo, 30, a double amputee using prosthetic legs, said:

> I live deep in the rural area. I do not have easy access to buses. I am not working. The majority of ways to make money here in the rural areas require a lot of energy… It's hard to walk using my artificial legs because they are now too old. If I walk long distances, I develop sores on my stumps. All

> these reasons mean I can't visit the clinic and police services that are eight kilometers from here.

Long distances were further cited as a barrier to the women who experienced sexual abuse and the relatives and friends who assisted them. Shami, a 21-year-old wheelchair user, explained:

> Some of us are assisted to go to the police stations and clinics by friends and relatives. For me, in particular, the police station is nine kilometers from where I live. When I first reported, every family member was eager to assist me; they would push me to the police station in my wheelchair. However, as the case dragged on, they showed little interest because of the long distance. As a family, we could not afford money for transport… We ended up not pursuing the case with the police.

Gremma, a 26-year-old with polio of the left leg, recounted her experience:

> In rural areas it is hard to travel long distances alone as a woman especially after you have been raped. I know men with disabilities who can travel to the hospital alone. But it is hard when you are a woman. The families will not allow you. Yet they will be discouraged to accompany you by having to walk long distances. We may have the desire to go to police and clinic, but this all depends on the willingness of the family to accompany you if you are a woman and on availability of bus fare.

Pamela, a visually impaired 29-year-old, pointed out that she was reluctant to walk long distances also because the outcome of her case was not going to change her circumstances. She explained:

> I did not see the advantage of continuing to walk such long distances. I do not have an income, and it is hard to ask for transport fares in rural areas. Even if the rapist was to be found guilty, I did not see how it would change the fact that I was raped.

Nomsa, 27, who had had polio in the left leg, also contributed:

> I just lost hope, travelling long distances with no progress. I felt like I was fighting a war in which circumstances had already made me a loser.

All key informants confirmed that people in rural areas had to travel long distances to access police and health services. Distance also affected travel in the opposite direction, for investigations by the police and home visits by nurses. The police officer in charge said:

> It is not only people with disabilities who have to endure walking long distances, though they are the most affected. Our police officers also do not have resources to cover these long distances.

Another police officer said:

> [W]hen you feel that there is missing information, you are supposed to go back and investigate further, but long walking distances discourage us. This affects the outcome of the case.

Also, nurses indicated experiencing barriers in this respect:

> We have outreach programs for victims of sexual abuse. We are unable to implement them due to the long distances. We don't have cars. (A male nurse)

> When someone stops attending counselling sessions, I am supposed to make a follow-up visit to see if there are barriers at home, but distance discourages me. (a female nurse)

PHYSICAL BARRIERS

Most participants noted that after they had walked the long distances to reach the needed services, they found an unfriendly physical environment at the clinics and police stations. Some of the physical barriers mentioned are steps, narrow corridors, and the absence of disability-friendly toilets. As Vimbai, a 33-year-old wheelchair user said:

> It is so hard that after travelling a long distance, you find it hard to maneuver at the police stations and clinics. There are a lot of steps at the doors to the police station and clinic. It is hard for me to maneuver using my wheelchair. People had to lift me to enter the police station. This made me uncomfortable to visit the police station and clinic, especially when I am alone.

Chipo, 30, a double amputee, mentioned:

> The corridors to the counseling room at the clinic are very narrow for a wheelchair so we ended up using a room which could not provide privacy. My discussion with the counselor almost ended up being public. This made me hate Counseling. You would always think of these barriers before your next visit.

Abigail, 39, who had polio in both legs, also noted:

> We usually spent many hours at the clinic or police station and their toilets are not disability friendly… how could you visit a place which would not allow you to relieve yourself? The ground around it is also not flat.

Some key informants, police officers, and nurses, agreed that the physical environment is not disability friendly. A female nurse said:

> In rural areas, facilities are not disability friendly. Most of the toilets are pit latrines, which are not convenient for wheelchair users. There are also steps, and you have to ask for extra help to lift wheelchair users up the steps.

COMMUNICATION BARRIERS

After walking long distances to find the police or health centers, some participants, especially those with communication challenges, pointed out that it was very

disheartening to find that the policy or health centers do not have the capacity to interact with them. Those with hearing impairment pointed to the unavailability of sign language translators, while those with speech barriers indicated that police and health centers staffs were not sensitive to their barriers. Tamari, who is 27 years old and has a hearing impairment, said:

> After walking 11 kilometers to make my report, the police could not relate to me. They did not understand [sign language]. They told me to wait until they had looked for a sign language translator. Even the [sign language] interpreter who was brought by the police had difficulty communicating with me because my [sign language] is not standardized. Poor communication weakened my case.

Marian, who is 30 years old and acquired a hearing impairment at the age of 12, had a similar story:

> As deaf people, we are greatly disadvantaged when reporting to the police. The police will delay dealing with your case while they look for a [sign language] interpreter. This discourages us to make follow-up visits, because if the translator is not there, you would have wasted money on transport. I did not have money for transport to make follow-up visits.

Conversations with women with disabilities and speech barriers require great patience. Jane, who is 33 years old and has cerebral palsy, said that the police officer investigating her case did not accommodate her disability. She felt that much of the information she wanted to give was not captured. Jane said:

> When we went to see the prosecutor, I heard him saying that the information that they had was not enough for a conviction. The police officer who interviewed me did not give me enough time to explain in detail, he was rushing me. Before I had finished explaining, he would have asked another question.

Portia, 44 years, with multiple disabilities, had the same experience:

> I am slow in speaking and words do not come out clearly when I am telling about bad experiences. I need listeners who can bear with me. The environment was also intimidating. And most times I would have been tired due to travelling long distances.

Blessing, a 19-year-old with severe cerebral palsy who stammers, said:

> Because of this, I struggle to pronounce words, and I require a good and patient listener. The police officers were not patient with me… I noted that most of the issues that I had raised were totally missing in the police report. The environment was intimidating, I feared to say it. And when you are a woman with a disability, it seems the police is not taking what you say seriously.

Some participants who went to hospitals experienced communication barriers. Health personnel were reported not to know sign language and had to rely on the assistance of helpers or parents brought by the women with disabilities.

All key informants from the police services confirmed that, in most cases, they lack the capacity to assist victims with hearing impairments. They noted that there are very few sign language interpreters in the police force. A course on sign language was provided for a few police officers, but it was inadequate. The police officer said:

> There are no [sign language] interpreters in the entire district, if not the whole province….. We rely on a non-governmental organization which provides us with [sign language] interpreters.

Another police officer added:

> I was trained in [sign language] for two weeks but to be honest, I cannot have a conversation in sign language.

These examples of barriers to communication between women with disabilities wanting to report or be treated after sexual abuse are added to any barriers that non-disabled women might feel.

DISCRIMINATION AGAINST WOMEN

Most participants reported experiencing negative attitudes from male family members and male staff at the services providers' centers. Males, in general, seem not to empathize with the women's situations, and the participants were not pleased with the support they received from males. Chipo, 30, a double amputee using prosthetic legs, was unhappy with the way her father approached the issue of her sexual abuse. She said:

> My father seemed not to care at all. He never supported me with anything even emotionally. He did not make an effort to help with bus fare. It was only my mother and sisters who would support me. I have seen him selling his goats to help when other siblings got ill. Mine was also a medical condition, so I expected his support.

Abigail, 39, who had polio in both legs, also recounted:

> Sometimes the attitude of family members, especially males, pains us as disabled women. They don't seem to believe what we say. Even male police officers don't seem to believe what we are saying. It is difficult to be listened to and trusted especially when you are a disabled woman.

Male staff run most rural police stations and health clinics. Participants pointed out that they were uncomfortable interacting with male police officers and nurses, especially because of their negative attitudes. Chipo, 30, a double amputee using prosthetic legs, and Otilia, who is 22 years years-old, with her left leg amputated above the knee, both mentioned that some of the questions asked by the police officers were embarrassing and indicated that male police officers did not regard them as reliable witnesses. Chipo said:

> The male police officer kept asking if I was quite sure of what I was saying. He seemed to doubt what I was saying.

Otilia pointed out:

> I overheard him discussing my case with other male police officers. He was saying that you need to be careful when dealing with disabled women because some of them report rape cases in an effort to force marriage after they had been rejected.

The negative attitudes at the male-operated stations created an intimidating environment, where the women did not feel they could freely express themselves. Some participants also added that the negative attitude of males in general made them uncomfortable discussing their experiences. Monalisa, 20 years old, with a physical disability, noted:

> I did not feel comfortable when I reported about sexual abuse to a male police officer. He was not friendly and accommodating to me. After walking a long distance, I expected someone friendly. The male officer did not empathize with me. Some of the questions he asked me, made it appear as if I was reporting falsehoods or I was the accused. I felt like he was protecting the man. I lost self-esteem and confidence due to his approach.

Rutendo, 19 years old, with spina bifida and a deformed left leg, mentioned:

> As someone who has not been to school and being a disabled woman, I expected much help from the police. I grew up in a poor polygamous family where, as a disabled girl, I was not given the opportunities given to other children. I did not complete my primary education. It was hard to talk to convince my father and the male police officers that I have been raped.

Martha, 24, who is physically disabled, summed it up very well when she said:

> The environment at the police station was intimidating for me. The male police officers seem to have a negative attitude towards me. This may have affected my responses… I am not educated, so with a male officer and with my low education … communication is difficult.

Otilia, who is 22 years old, with her left leg amputated above the knee, explained that cultural practices also make it hard for sexual abuse victims to deal with male officers:

> In our culture, you cannot explain explicitly to a male person. Both at the police station and health center, facing male staff inhibited my expression.

Some of the participants made similar observations about counseling sessions. They felt that the counseling sessions were not very helpful because of gender issues. Aganeta, 40, with deformed hands, said:

> My counseling sessions were provided by a male counsellor. I was not comfortable to discuss all issues. He referred me to the district hospital to get counseling from female nurses. Poverty and lack of income prevented me from going. I am not working.

Some key informants agreed that there were many cases where male police officers investigated cases of sexual abuse and that most male nurses were tasked with providing counseling sessions to females. The police officer said:

> Most of the police officers in rural areas are male, there are very few females. Experience, expertise, and availability are among the factors we consider in allocating a case to an investigating officer.

Another police officer pointed out that victims have the right to ask for another officer if they are not comfortable talking with the one allocated to them. Unfortunately, they are not educated to understand that they have that right. A nurse informant agreed with the observations of the participants and said that ideally, people should be able to select a person to whom they are confident talking, especially when the issues are related to sexual abuse.

LACK OF RESOURCES

The majority of participants pointed out that lack of resources is a challenge not only for them but also for the service providers; they may not be helped to their satisfaction because of resource deficiencies. Both participants and key informants from the services agreed that lack of resources was a problem. For example, it is very important to administer post-exposure drugs soon after sexual abuse to avoid unwanted pregnancy and sexually transmitted infections. Post-exposure drugs may be difficult to obtain. Shamia, 25 years old, with a short left leg, said:

> I arrived at the clinic 36 hours after I had been raped and they did not have the drugs. Volunteers had to take me to the district hospital using public transport. I did not have any money of my own to travel. This stressed me a lot, although I eventually managed to reach the hospital within 60 hours.

Mariam, 40 years old, born with hand deformities, also said:

> I had to find money to travel to the hospital because at the local clinic, they did not store the prophylactic drugs. It took me forever to find the money and by the time I arrived at the hospital it was already late.

The perceived or experienced lack of quality of the services caused participants to lose confidence in these services. It was often mentioned that service providers do not have the competencies to deal with disability issues—they were not sensitive to the disability and were not able to use sign language—or, more in general, seemed to lack communication and counseling skills. As Marian, 30 years old with an acquired hearing impairment, described:

> I am still feeling the trauma of sexual abuse because I was counselled by a nurse who did not understand sign language. The counseling was done through writing. The counseling sessions were useless. I wasted my time and money.

Chipo, 39 years old, with dwarfism, did not see the benefit of counseling after receiving little explanation:

> I don't see how counseling sessions were going to help me. During one counseling session that I attended, the nurse just asked me endless questions, and I thought it was a waste of time. No one explained what we were trying to achieve. For me continuing to go means paying for transport and food. I did not have the money. Walking was the only option. Why should I walk long distances only to talk?

In the health services, the nurse admitted that there was poor consciousness raising about the importance of counseling and the low quality of counseling services. She blamed it partly on factors such as understaffing and poor counselling skills:

> Clinics are understaffed. There may be one nurse running a clinic…offering clinical and counselling services. In some cases, nurses may not have been trained in counseling skills.

DISCUSSION

The results demonstrate that women with disabilities who are victims of sexual abuse face multiple layers of marginalization due to the intersection of many factors. When gender and disability interact, it usually results in poverty, as noted by (Humphrey, 2016). Women with disabilities reported having no money or access to means of production; the inability to pay for the limited means of transportation available to them resulted in their having to walk long distances to reach services. Some women had to quit counseling and follow-up visits to the police because they could not afford the hidden cost associated with the mobility they needed to seek justice or health care. As a result, their needs for care and counseling are unlikely to be met (World Health Organization, 2017). When disability and gender intersect, one result is extra costs that can create barriers to accessing health services because women, especially disabled women, often cannot safely use the same ways to move around as men can (Pinilla-Roncancio & Alkire, 2020). The women in this study, who could not get results from their visits, were often requested to return on several occasions, adding to the transport and related expenses. The extra cost and hardship create further marginalization when it comes to accessing justice as well as sexual and reproductive health.

The intersection of disability, poverty, and gender created a prejudicial environment, as shown by the results when women with disabilities engaged with the police services. In the current study, some women with disabilities reported not being treated as credible witnesses by both police, mostly male, and male members of their families. In Zimbabwe, persons with disabilities are treated as sick people (Rugoho & Maphosa, 2017). This attitude is seen among the police, who doubted the authenticity of what was being reported by women with disabilities. These findings show that equity before the law, which is demanded by the constitution of Zimbabwe and the Convention on the Rights of Persons with Disabilities, is still lacking in Zimbabwe (Rugoho & Maphosa, 2017). Results show that the support given to women with disabilities who have experienced sexual abuse is highly inadequate. They may lack the ability to clearly articulate their needs and obtain the services to which they have a right.

After travelling long distances, women with disabilities are further confronted by other barriers, such as the infrastructure at police and clinics that present obstacles to many people with disabilities. Narrow corridors, steps, and inaccessible sanitation facilities created further barriers for women with disabilities. Our results showed that some women with disabilities also felt their rights to privacy were violated (Ganle, 2016; Van Rooy, Amadhila, Mufune, Swartz, Mannan, & MacLachlan, 2012). The absence of ramps and the presence of narrow corridors can keep women with disabilities away from health centers and may demoralize them, leading them to give up on accessing services. When toilets are inaccessible to them, it is difficult for women with disabilities to relieve themselves at police stations or clinics, which

limits the length of time they are willing to wait at the station or clinic. These barriers, added to the feeling of not being believed by police and nurses, discouraged women with disabilities from seeking police and health services, with the result that many women with disabilities either do not go at all or do not return for follow-up or further care. These multiple disadvantages add more burden to women with disabilities.

The interaction between disability and poverty has been acknowledged in previous studies (Grech, 2016; Banks, 2018; Kabia et al., 2018). For those with limited funds for transportation, no vehicle, no money for a taxi, and having to travel long distances on bad roads in a wheelchair increases the possibility of it breaking down. Repair is expensive and time-consuming, and alternatives are too expensive for poor rural women with disabilities. Other research has shown that for those with amputations, walking long distances with prosthetics also brings health problems (Batten, Lamont, Kuys, McPhail, & Mandrusiak, 2020; Gallagher, O'Donovan, Doyle & Desmond, 2011). Women with disabilities are often asked to return at a later date, thereby adding more cost barriers. These factors impact the women's willingness and ability to visit police and health centers which are usually very far from their homes.

Further problems are experienced by women with hearing or speech impairments who face communication barriers at police stations and clinics. Police stations and health centers did not easily access sign language interpreters. These factors further jeopardize the cases of women with disabilities, as they are further delayed from accessing justice or necessary health care. Women with disabilities are requested to return on a later date when a translator might be available, which adds to the barriers of cost, time, and transportation.

Those with other disabilities affecting their speech highlighted that service providers were not patient listeners; service providers' impatience made their reports incomplete and reduced the quality of service that the women with disabilities received. Rugoho and Maphosa (2017) have demonstrated that communication barriers discourage deaf people and other people with disabilities from continuing to visit hospital or police services. Similarly, sign language users faced communication barriers when accessing services after experiencing sexual abuse in Nepal and Indonesia (Garibay, 2019; Devkota, Murray, Kett & Groce, 2017; Abou-Abdallah & Lamyman, 2021). Other research has shown that women with hearing impairments felt marginalized by service providers who could not communicate in sign language (Garibay, 2019; Devkota, Murray, Kett, & Groce, 2017). Smith and Pick (2015) observed that women with hearing impairments in the United States cited barriers in communication as their reason for not reporting sexual abuse to authorities. Poor communication by service providers also led to women with disabilities having low confidence in the services offered. Poor communication with clients by health professionals and police has been noted by others (Rathiram, Neilson, Kassim, Mokone, & Green, 2022; Hester & Lilley, 2018). The frustration resulting from poor communication also discourages women with disabilities from continuing to use the services. The additional communication problems experienced by women with disabilities added to any woman's burden when seeking assistance after sexual abuse.

From the discussion, the intersection of limited access to education and disability influenced women with disabilities' access to post-sexual abuse services. Most participants in the study had low education, often because of their being disabled, which in turn contributed to low income and high poverty levels. This finding supports others (Humphrey, 2016) who showed that low education and limited poverty

participation in political, social, and economic activities. Gender issues have affected the provision of justice because male officers and nurses operate most police stations and health clinics in rural areas. From a power dynamics analysis, this perpetuates the marginalization of women with disabilities because the male presence creates a tense and unfriendly environment that does not facilitate free expression by victims of sexual abuse about their experiences. A similar study in Australia, a high-income country (McCulloch, Maher, Walklate, McGowan, & Fitz-Gibbon, 2021; Dowse, Soldatic, Spangaro, & Van Toorn, 2016) found that women who were victims of sexual abuse were not comfortable dealing with male police officers. Gender and patriarchal practices make it difficult for women with disabilities to get good quality services from male staff. Again, the intersection of gender and disability leads to even greater barriers to the women receiving the services to which they have a right.

LIMITATIONS

The study used face-to-face semi-structured interviews. Although this was sufficient to explore the topic, focus group discussions might have added to the comparisons and sharing of different responses. We did not use focus group discussions because the women with disabilities were unwilling to join them, at least in part because their rural locations and barriers in transportation rendered that option unfeasible, and many might have been reluctant to engage in a group-based discussion. Nevertheless, future studies should consider the advantages of focus group discussions and weigh their viability ethically and with sensitivity. The participants in this study all live in rural areas. It would be important to compare their experiences with peers living in urban settings, where some barriers, such as distance and lack of female personnel, might be less inhibiting.

CONCLUSION AND RECOMMENDATIONS

Access to adequate post-sexual abuse services from police and health care is vital for the well-being of the victims. This research has shown that women with disabilities face a number of barriers in accessing police, health, and counseling services, because of the intersection and collective impact of a number of disadvantages affecting them. Police and nursing staff need training in disability issues, especially concerning gender-sensitive and disability-sensitive communication skills. Service providers able to communicate in sign language should be available in more locations. Financial support for women with disabilities seeking services to reimburse their expenses for travel is also recommended within the health and social care system. In the longer term, recruiting more women to the police force might help improve its capacity to deal fairly with women, including women with disabilities seeking assistance after sexual abuse.

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