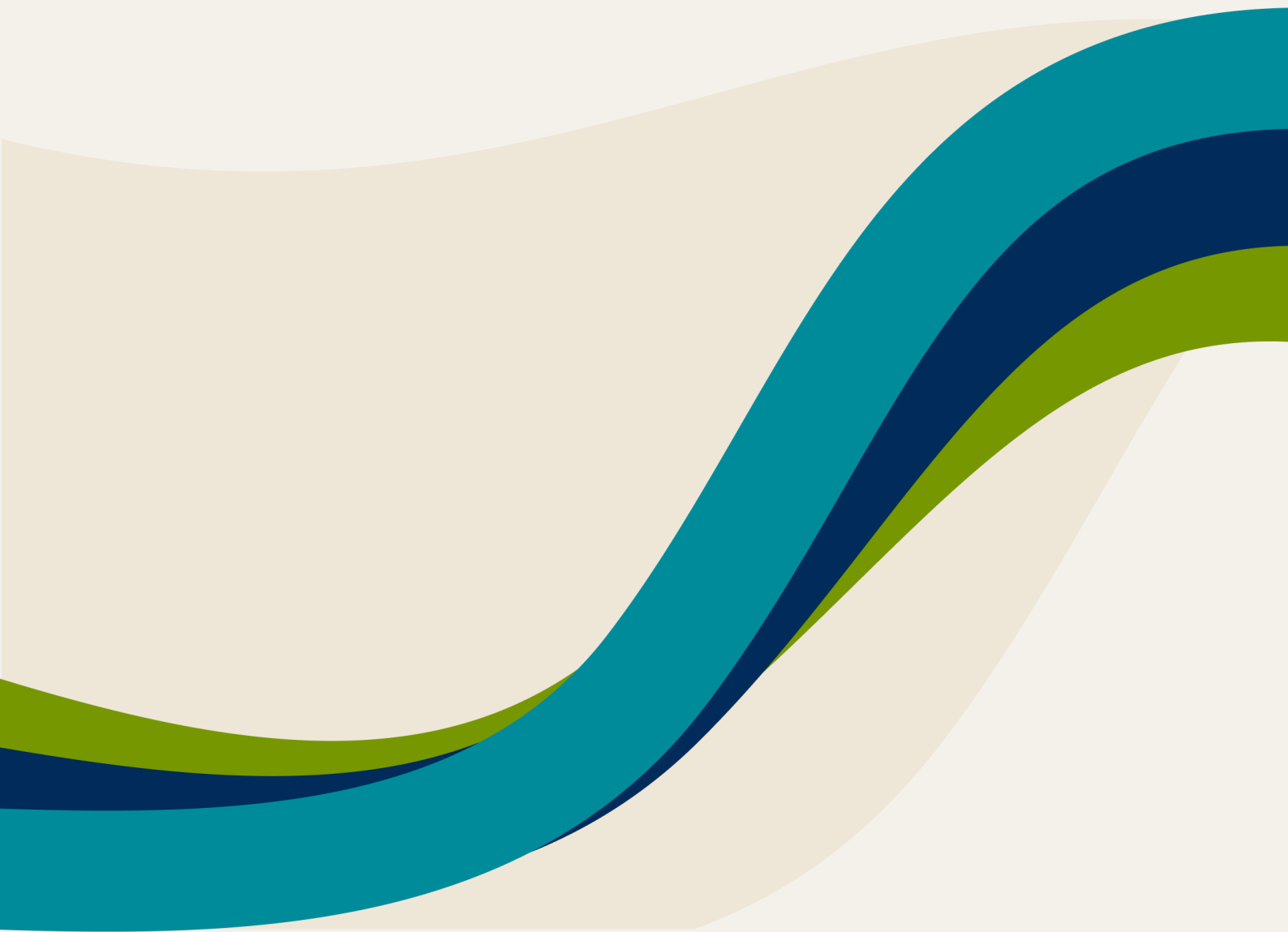


Factors Influencing Violence Against Women with Disabilities

A Formative Research Report

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Contents

Executive Summary.....	3
1. Introduction	8
2. Research Questions.....	8
3. Methodology.....	10
Limitations.....	11
4. Key Findings.....	12
Risk and Protective Factors	12
Risk Factors.....	12
Protective Factors.....	17
Barriers to help-seeking.....	17
Previous experience of VAW Prevention and Response programming	19
VAW Prevention Programming.....	19
VAW Response Programming	19
5. Discussion and Implications	20
Discussion	20
Implications	20
Annex 1: Ethics and Safeguarding.....	23
Annex 2: Data Management and Protection.....	28

Executive Summary

Introduction

In response to the greater risk of violence against women (VAW) faced by women with disabilities, coupled with the lack of evidence on the specific factors that increase the risk of violence for women with disabilities, WAG-Disability Rights and SDDirect worked in partnership to undertake formative research to understand the factors that influence violence against women with disabilities.

The purpose of this study is to

- contribute to a deeper understanding of violence against women with disabilities, how violence against women with disabilities manifests,
- and to generate recommendations on how programmes should be designed to prevent and respond to the specific drivers of violence against women with disabilities.

Research questions

The key research questions for this study are:

1. What are the specific drivers and risk factors that place women with disabilities at risk of VAW? Are unsupportive family members an important risk factor that places women with disabilities at risk of VAW?
2. What are the protective factors and mitigating factors for women with disabilities that present opportunities for prevention programming? Are supportive family members an important protective factor that mitigates the risk of VAW for women with disabilities?
3. What are the specific barriers to help-seeking for women with disabilities who experience VAW?

Methodology

The study used a peer-led qualitative methodology using focus group discussions (FGDs) and key informant interviews (KIIs). People with disabilities led the study design, data collection and analysis processes, providing deeper insights and enabling more meaningful interactions with respondents with disabilities, particularly when discussing sensitive topics related to VAW¹.

The study conducted 41 focus group discussions (FGDs) and 53 key informant interviews (KIIs) with respondent groups including women with disabilities, men with disabilities, women and men community members, women and men community leaders, service providers, and

¹ Peer-led research methodologies can enhance the relevance, credibility, and depth of findings by drawing on researchers' lived experience and fostering greater trust and openness among participants

representatives of Organisations of People with Disabilities (OPDs) and Women's Rights Organisations (WROs). The research took place in rural and peri-urban Lilongwe.

Ethics

The study adopted a stringent ethical framework, including SDDirect's Protection against Sexual Exploitation, Abuse and Harassment (PSEAH) policy and procedures, as outlined in Annex 1.

Limitations

The limitations of the study are:

- The study did not include young people under 18, as there were insufficient resources to manage the additional safeguarding requirements for this particularly vulnerable group.
- The research is qualitative, focusing on *why* things happen, rather than *what* happens. It is not possible, therefore, to generate robust findings relating to the types of violence experienced by women with various disabilities.
- The vignettes did not explore ritualistic practices directly, so data in this regard are limited.
- The vignettes generally depicted women with visible disabilities with significant functional limitations. The data therefore reflect views and perceptions of women with significant functional limitations and does not relate as closely to women with invisible disabilities.

Intended Audience

This report is intended for GBV practitioners and specialists with an existing understanding of VAW prevention and response who seek to strengthen their knowledge of the specific risk factors, experiences, and barriers faced by women with disabilities, and to design programmes and interventions that are more meaningfully inclusive, accessible, and responsive to their needs.

Key Findings

Risk Factors

There are multiple known risk factors for violence against women, including gendered power imbalances, the normalisation of violence, the hidden nature of violence, norms that promote physical punishment as discipline among others (World Health Organisation, 2024). Whilst these risk factors are relevant to violence against women with disabilities, this section seeks to move beyond these known risk factors to identify specific drivers that increase the risk of violence for women with disabilities.

- **Stigmatisation and stereotyping** which result in women with disabilities being placed in a position of economic dependence, being ignored or avoided, and being discredited increase the risk of violence for women with disabilities.
- **Family members who feel internalised shame associated with their relative's disability** are more likely to perpetrate neglect or abuse of their family member with disabilities.

Relatedly, family members who experience stigmatisation or a lack of social support, which the data suggests is common, are more likely to feel internalised shame associated with their family members' disability. High levels of stereotyping and stigmatisation of disability among the general community are likely, therefore, to increase risks of caregiver violence and neglect.

- **Lack of social protection and wider social support** exacerbate the challenges faced by women with disabilities and their families to adapt to, and accommodate, needs relating to disability. This increases risks of violence for women with disabilities. Women with disabilities are also vulnerable to exploitation by local leaders and are frequently asked for payment by frontline service providers for services such as justice and health services meaning, particularly where they are economically dependent, they are excluded from reporting violence or seeking help.
- **Lack of recognition of the various forms of violence²** increases risks of violent behaviour or neglect. For example, it was found that caregivers sometimes lock women with disabilities alone in their homes whilst the caregiver works, considering this to be a form of protection rather than neglect or harmful behaviour.

Protective Factors

- **Supportive family members and community support** emerged as a significant protective factor, with focus group participants stating that community and family members should intervene or protect women with disabilities experiencing abuse.
- **Women supporting one another through collective care** was highlighted as a valuable form of protection from, prevention of, and response to violence.
- **Financial independence** was also noted as a protective factor against violence; however, there was broad recognition that women with disabilities face greater challenges in achieving financial independence largely due to the stereotypes and lack of accessible, safe and dignified income-generating opportunities discussed above, making this factor less accessible to them.

Barriers to help-seeking

Barriers to help-seeking are very closely linked to the **discrimination and stereotyping** that increases women with disabilities' risk of experiencing violence in the first place. The data included numerous examples of victim-blaming and discrediting victim-survivors with disabilities who report their experiences and seek help. The expectation of such treatment, based on widespread knowledge of discrimination against women with disabilities, is a strong barrier to help-seeking and reporting for women with disabilities who experience violence, abuse and neglect.

² All forms of violence refers to physical, sexual, emotional and financial violence.

The findings suggest that religious belief functions as a significant coping mechanism supporting emotional resilience among women with disabilities who experience violence, abuse, and neglect. However, the findings suggest that some religious beliefs may **also operate as a maladaptive or constraining coping mechanism**, particularly where reliance on divine intervention discourages help-seeking or engagement with formal accountability processes. Respondents reported that, having experienced violence, they are frequently told to leave the matter with God, rather than to take action to seek help or report their experiences.

Previous experience of VAW Prevention and Response programming

When asked about experiences of VAW Prevention and Response programming, respondents typically cited acts of charity to women with disabilities, highlighting the strong inclination toward the charitable model of disability³, rather than the rights-based model.⁴ There were very few references in the primary data to strategic, evidence-based interventions that are designed to prevent violence against women with disabilities or improve response services for victim-survivors with disabilities.

Discussion and implications

Discussion

The stigmatisation, stereotyping, discrimination and social exclusion faced by women with disabilities all create pathways toward increased risk of violence for this group. The research found evidence that family members internalise the shame associated with disability, which can affect their treatment of and support for family members with disabilities. Furthermore, the lack of social support and protection for people with disabilities and their families increases the risk of neglect and violence for women with disabilities.

Implications

Mainstream VAW prevention and response programming increasingly recognises the intersectional nature of violence and the uneven distribution of risk across different groups of women. However, limited attention has been given to the design and implementation of interventions that are explicitly informed by the lived experiences of women with disabilities, who face heightened vulnerability and varied risks. In the absence of such targeted interventions, women with disabilities are often incorporated into generic VAW programming that addresses broad drivers of violence—such as gendered power imbalances and the

³ The charitable model of disability views persons with disabilities primarily as recipients of care, protection, and benevolence, positioning disability as an individual tragedy that requires charity rather than addressing the social, structural, and rights-based barriers that contribute to exclusion and vulnerability.

⁴ The rights-based model of disability views persons with disabilities as rights-holders and emphasises that disability arises from barriers in society rather than an individual's impairment, requiring action to ensure equality, inclusion, and full participation.

normalisation of violence against women—while failing to engage with disability-specific risk factors, including internalised shame within caregiving families, pervasive stigmatisation and stereotyping, and discrimination in service delivery.

Those seeking to design and deliver VAW prevention and response programmes that are meaningfully inclusive of women with disabilities and which address the root causes of violence against women with disabilities, should consider the following implications:

1. **Design and deliver more disability-transformative programming**, that challenges the specific harmful norms, stereotypes and stigmatisation that increase risks of violence for women with disabilities, as discussed in this report.
2. **Design and deliver family-focused interventions** which address caregiver stress, shame, stigmatisation and inability to cover the additional costs to adapt and accommodate disability-related needs.
3. **Engage Faith Leaders** to encourage faith-informed responses to violence that emphasise compassion, responsibility and protective action as expressions of religious belief.
4. **Integrate disability inclusion into VAW response programmes** that work with frontline service providers within the referral pathway. Building on interventions which seek to increase the application of the survivor-centred approach and improve referrals within institutions, VAW response programmes should also address the intersection of gender inequality and ableism, and should dismantle the “charity” model of disability in favour of a rights-based approach.
5. **Ensure more meaningful inclusion of women with disabilities in programming**, centring the voices of those with lived experience of violence in programme design, policy and implementation.

1. Introduction

In response to the greater risk of violence against women (VAW) faced by women with disabilities, coupled with the lack of evidence on the specific factors that increase the risk of violence for women with disabilities, WAG-Disability Rights and SDDirect worked in partnership to undertake formative research to understand the factors that influence violence against women with disabilities.

The research was co-led by a women-led organisation of People with Disabilities (OPD), and a technical consultancy firm and aimed both to understand the drivers, risk factors and protective factors of violence against women with disabilities, and the barriers and enablers of help-seeking specific to women with disabilities, and to provide research evidence to facilitate adaptation and improvement of programming to prevent and respond to violence against women with disabilities.

The study aimed to generate evidence to support the design and implementation of VAW prevention and response programmes that address the specific factors that increase risks of violence for women with disabilities in Malawi and will contribute toward the global evidence base on how best to prevent and respond to violence against women with disabilities.

2. Research Questions

The purpose of this study is to contribute to a deeper understanding of violence against women with disabilities, how violence against women with disabilities manifests and to generate recommendations on how programmes should be designed to prevent and respond to the specific drivers of violence against women with disabilities. The research further seeks to investigate what is required for VAW prevention and response programmes to be fully inclusive⁵ of women with disabilities.

Specifically, this study aimed to respond to the following research questions:

1. What are the specific drivers and risk factors that place women with disabilities at risk of VAW? Are unsupportive family members an important risk factor that places women with disabilities at risk of VAW?
2. What are the protective factors and mitigating factors for women with disabilities that present opportunities for prevention programming? Are supportive family members an important protective factor that mitigates the risk of VAW for women with disabilities?

⁵ SDDirect and WAG-Disability Rights adopt a holistic interpretation of 'inclusion' to mean that excluded groups participate in, lead and benefit from development programmes that transform the structures, systems and social norms that maintain their exclusion.

3. What are the specific barriers to help-seeking for women with disabilities who experience VAW?
4. What have been the experiences of women with disabilities of VAW prevention and response programming to date? What has worked well for them and what have been the gaps from their perspective? How can future programming build on this?

For the purpose of this report, the research questions have been grouped under the following main headings:

- Risk and protective factors
- Barriers to help-seeking
- Previous experience of prevention and response programming

3. Methodology

To address the research objectives, the study used a peer-led qualitative methodology using focus group discussions (FGDs) and key informant interviews (KIIs). People with disabilities led the study design, data collection and analysis processes, providing deeper insights and enabling more meaningful interactions with respondents with disabilities, particularly when discussing sensitive topics related to VAW⁶.

The study design and implementation considered risks of harm to both researchers and respondents, which required a stringent ethical framework, including SDDirect's Protection against Sexual Exploitation, Abuse and Harassment (PSEAH) policy and procedures, as outlined in Annex 1.

The study conducted 41 focus group discussions (FGDs) and 53 key informant interviews (KIIs) as detailed in Table 1. The research took place in rural and peri-urban Lilongwe.

Respondent Group	Total number of interviews undertaken	Total number of participants
Women with Disabilities KII	13	13
Women with Disabilities FGD	5	35
Men with Disabilities FGD	6	36
Men Community Members FGD	6	36
Women Community members FGD	6	36
Women Community Leaders KII	10	10
Men Community Leaders FGD	7	7
Mixed Gender Community Leaders FGD	2	10
Men Community Leader with Disability KII	1	1
Service Providers KIIs	23	23

⁶ Peer-led research methodologies can enhance the relevance, credibility, and depth of findings by drawing on researchers' lived experience and fostering greater trust and openness among participants

Organisations of People with Disabilities (OPD) representatives KIs	10	10
Women's Rights Organisations (WRO) representatives KIs	5	5
Total		222

Table 1 Number of respondents

Interviews and focus group discussions were recorded, translated and transcribed in English. Qualitative Data Analysis software (Dedoose) was used to code the transcripts using an a priori coding framework, which was developed through a review of 10% of the transcripts, and through reflection on the research questions. A group of seven data coders with disabilities worked together to code all transcripts.

Following coding, coded excerpts were categorised and distributed to a group of data analysts including people with disabilities, who then read through and identified themes and trends emerging from the data. A data analysis workshop was then held with all data analysts to agree on the key findings of the study, and the key recommendations.

Data was managed as outlined in Annex 2.

Limitations

While this qualitative study provides in-depth insights into participants' lived experiences and perspectives, several limitations must be acknowledged, as outlined in this report.

- The study did not include young people in respondent groups as there were insufficient resources to manage the additional safeguarding requirements for this particularly vulnerable group. The study focuses, therefore, primarily on lived experiences and perspectives of violence against women with disabilities
- The research is qualitative, focusing on *why* things happen, rather than *what* happens. It is not possible, therefore, to generate robust findings relating to the types of violence experienced by women with various disabilities.
- The vignettes did not explore ritualistic practices directly, so data in this regard are limited, resulting in an inability to draw conclusions in this regard. Further research into the harms inflicted against women and girls with disabilities through ritualistic practices is required.
- The vignettes generally depicted women with visible disabilities with significant functional limitations. The data therefore reflect views and perceptions of women with significant functional limitations and does not relate as closely to women with invisible disabilities, such as women with neurological or cognitive disabilities, or those who have invisible chronic medical conditions.

4. Key Findings

Risk and Protective Factors

Risk Factors

There are multiple known risk factors⁷ for violence against women, including gendered power imbalances, the normalisation of violence, the hidden nature of violence, norms that promote physical punishment as discipline among others (World Health Organisation, 2024). Whilst these risk factors are relevant to violence against women with disabilities, this section seeks to move beyond these known risk factors to identify specific drivers that increase the risk of violence for women with disabilities.

Stigmatisation and stereotyping of women with disabilities

The data demonstrates that the widespread stigmatisation and stereotyping of women with disabilities, which was acknowledged by all respondent groups, created pathways towards a greater risk of violence. The relationships between this stigmatisation and stereotyping and increased risks of violence are demonstrated in Figure 1.

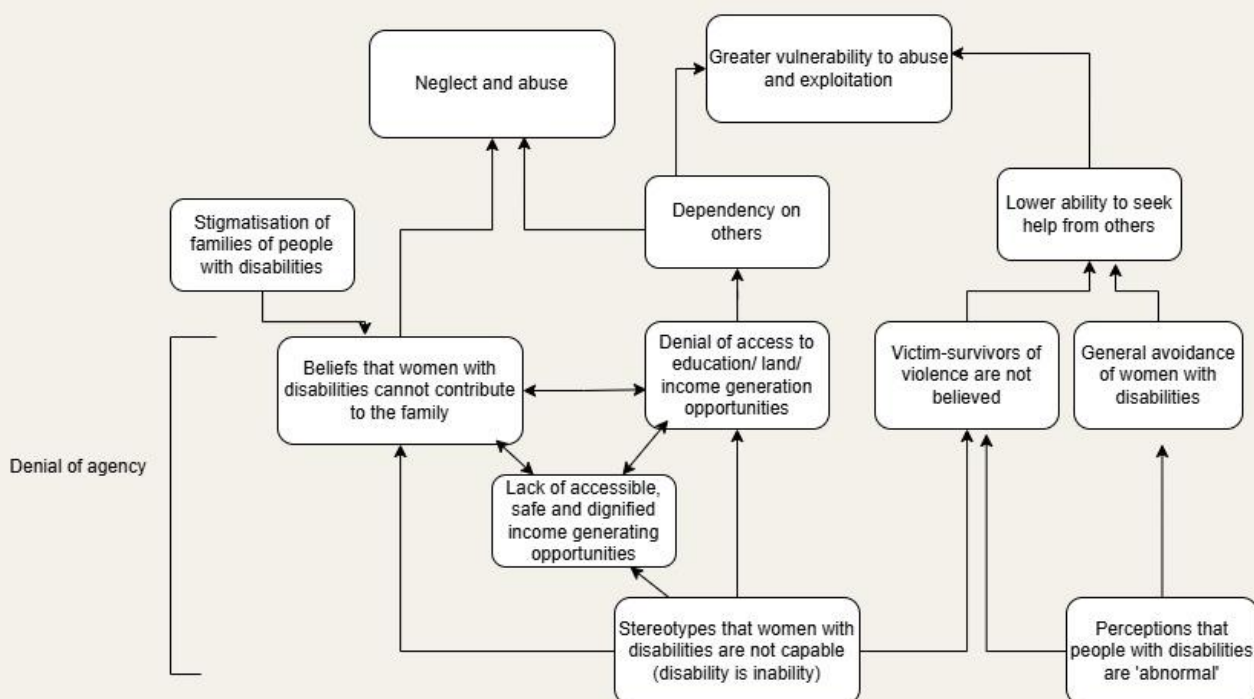


Figure 1: Pathways from stereotypes and stigmatisation towards greater risks of violence

⁷ Risk factors are characteristics, relationships, social norms, and structural conditions that increase the likelihood of violence against women and girls occurring or being tolerated within a given context.

Stereotypes that disability means 'inability'

The stereotype that women with disabilities are incapable was consistently present across all respondent groups, and was linked to a number of harmful perceptions and behaviours that may increase risks of violence, abuse and neglect of women with disabilities.

Mutually reinforcing beliefs and practices contribute to placing many women with disabilities in the position of economic dependence, thereby increasing their vulnerability to violence, neglect, exploitation and abuse. Patterns evident across the data indicated that the pervasive stereotype of disability as inability underpins a triad of interrelated harmful beliefs and practices. These include: (1) the disproportionate denial of access to education, land, and income-generating opportunities for women with disabilities; (2) the limited availability of accessible, safe, and dignified income-generating opportunities for this group; and (3) widely held assumptions that women with disabilities are unable to contribute to household or family livelihoods in a dignified manner.

One woman with disabilities respondent shared her own experience:

'I am blind, I grew up till 1997 when my mother passed away. I desired to know how to farm because farming is productive, but the one I was living with was saying that 'if I taught her how to farm they would be saying I am a violent person, why am I teaching a visually impaired woman how to farm'... Then my brother was blocking me from [school]... when we went begging he was also depending on the same income [from begging] so he thought that things would not work out for him when I got educated.' (woman with disability, key informant interview).

Findings further demonstrate that the stereotype of disability as inability feeds into harmful practices of **discrediting victim-survivors with disabilities** who report their experiences of violence. For example, when discussing the issue of women with disabilities such as visual impairments being sexually abused, participants often assumed they wouldn't be able to identify the man, and they wouldn't be believed at the police station due to their disability. For women with disabilities who become pregnant, there is an assumption that they wouldn't be able to care for the child. A service-provider respondent shared *"Since she has a visual impairment...[her parents] will be the ones to have the burden of looking after the baby because she cannot do it herself."*

Often these sentiments were expressed as concern, however they appear to mask deep-rooted, unconscious bias, and limited understanding of the rights-based approach to understanding disabilities and the barriers that exist for persons with disabilities to exercise their rights. Many respondents appeared to overlook or dismiss the idea that women with disabilities have agency over their own lives, regardless of the severity of their impairments.

Stereotypes that disability is 'abnormality'

There were numerous instances within the dataset which characterised disability as abnormality, a stereotype which appears to limit the ability of women with disabilities who experience violence from seeking help, as they are **ignored or avoided**. One Front Line Service Provider, for example, stated *'a lot of people come to the defence of someone normal while they watch those with disabilities suffer.'*

This sentiment was further exemplified by a male respondent with disabilities, who stated that *'People in the community do not want to be closer to persons with disabilities. So, I doubt very much that they can help her [the character in the vignette] in any way'.*

The data further includes examples of **discrimination against women with disabilities by service providers**, including health services, police, and social services.

'We have another case of a woman with a disability who went to the hospital for maternity ... she was ill-treated and delivered her baby on the floor... on the cement... because of the disability... people were not attending to her when she tried to ask... and the kind of responses she was getting showed that they do not care because she has a disability and they didn't think she should be doing whatever she did [which resulted in pregnancy]. She can't sleep with a man... have babies and everything like that.' (Women's Rights Organisation Representative, Key Informant Interview).

A male respondent with disabilities suggested that stigmatisation is worse for women who develop a disability later in life, noting that *'when you develop a disability later in life, people assume you must have done something wrong somewhere. People ridicule you for asking for support. They can even laugh at you'.*

Finally, the lack of visibility of women with disabilities in public life was also highlighted as a potential reason for shame and misunderstanding around persons with disabilities.

"I see MBC TV programmes only feature women who can hear but not those with hearing impairment...in short...those who have disabilities are not included." (women with disabilities, focus group)

Family members who feel internalised shame associated with their relative's disability are a risk factor for neglect and abuse

The data suggest that where family members feel shame associated with their relative's disability, this is a key risk factor for caregiver neglect and violence against women with disabilities.

All respondent groups shared instances in their communities of **neglect and abuse of women and children with disabilities** by caregiving family members, which was consistently attributed to the shame the family member is perceived to feel due to their relative's disability. A male respondent with a disability noted *'it happens because other parents who have children with disabilities feel ashamed, so they don't want to let them out and associate with other children. They can try either way to hide him/her from the outside world.'*

All respondent groups shared views that families *should* support their relatives with disabilities, particularly children, yet frequently **did not acknowledge the challenges** facing caregiving families in the context of low social support, stigmatisation and low household income. One mother of a man with disabilities articulated the judgemental attitudes she encounters, stating *'they say I just keep my child on free range [the child is not adequately cared for]. When this happens, I usually tell them that I did not ask for this situation from God.'*

Relatedly, the data includes numerous instances of **abandonment of mothers of children with disabilities**. One community leader respondent said: *'In our community there was this man who had married a woman without any disability, but she would give birth to children with disabilities. The man abandoned her and left.'*

Conversely, while instances of neglect and abuse of women and children with disabilities by caregiving family members were shared by all respondents, women with disabilities more frequently cited examples of care and support they received from their own families. This contrast suggests the **presence of stigmatising attitudes and stereotypical assumptions regarding caregivers**, which may then act in a vicious circle to feed into internalised shame and self-stigmatisation (Čolić et al, 2021). The relationship between caregiver internalised shame, stigmatisation of families of women with disabilities, and stereotyping appears to be complex and nuanced. Čolić et al (2021) note that parents of people with disabilities are more likely to feel internalised shame where they have experienced stigmatisation from others. This suggests,

therefore, that stigmatisation of caregivers by wider community members may increase the risk of caregiver violence and neglect, as depicted in Figure 2.

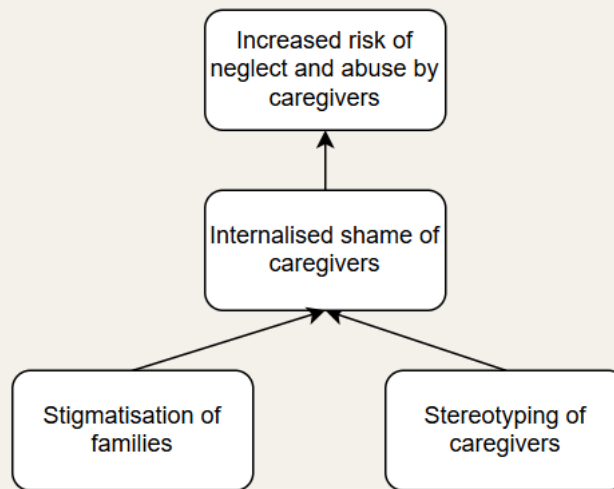


Figure 2: Drivers of caregiver internalised shame and links with risks of violence

Lack of social protection and wider social support

The lack of social protection and wider social support for persons with disabilities and their caregivers, which is typical in the study sites, also emerged as a risk factor for violence. Respondents with disabilities typically acknowledged that a **family's inability to cover costs** associated with adaptations, accommodations and caregiving may lead to neglect and abuse of women with disabilities. For example, a woman with a disability shared *'They do not take care of the disabled because they do not have the resources to take care of them'*.

Respondents frequently cited **limited social protection to support disability-related costs**. The data suggests that in some cases this is due to corruption across leadership structures. Examples shared by respondents with disabilities suggest that in some instances Community Leaders submit the names of people with disabilities for social support programmes, such as food distribution or provision of agricultural inputs, but that the intended recipient then does not receive the support. A female respondent with a disability shared that *'it's because chiefs look down on people living with disabilities and sometimes mismanage support made for people living with disabilities'*.

Financial barriers to accessing frontline services further increase costs and reduce access to social protection. Women with disabilities reported that they are often asked for payment for services, which when understood in connection to the finding that women with disabilities are often placed into the position of economic dependence, severely limits a victim-survivor's ability to access support, particularly when they are economically dependent on their abuser as in the case of intimate partner violence or caregiver violence. For example, one woman respondent with a disability stated that *'the police want us to pay some amount of money for us to get the help we need, so if you do not have money, you will not get help'*.

Lack of recognition of all forms of violence

Certain forms of violence are not always recognised as such. Locking women with disabilities alone in their homes as a form of protection whilst caregivers work outside the house was frequently discussed as reasonable by community members, community leaders and frontline service providers. In some cases, physical punishment was justified by respondents as necessary to correct certain behaviours, including when discussing stories of young women with severe learning difficulties, though this was not frequent within the dataset.

Protective Factors

Respondents identified several protective factors⁸ that could support violence prevention against women and girls with disabilities.

- **Supportive family members and community support** emerged as a significant protective factor, with focus group participants stating that community members should intervene or protect women with disabilities experiencing abuse.
- **Women coming together to support each other through collective care** was highlighted by respondents as another valuable form of protection.
- While marriage was frequently perceived as a protective factor by respondents, many discussions acknowledged that it can also be a source of violence and abuse for women with disabilities.
- **Financial independence** was also noted as a protective factor against violence; however, there was broad recognition that women with disabilities face greater challenges in achieving financial independence largely due to the stereotypes and lack of accessible, safe and dignified income-generating opportunities discussed above, making this factor less accessible to them.

Barriers to help-seeking

Barriers to help-seeking for women with disabilities are multifaceted and deeply rooted in societal attitudes and structural challenges. Violence against women is often normalised, particularly in communities with high prevalence of violence (Mannell et al, 2021) by both survivors and perpetrators, leaving survivors to view this as part of their lives rather than something to challenge, and perpetrators to see this as accepted, and justified behaviour.

⁸ **Protective factors** are individual, family, community, or societal characteristics and conditions that reduce the likelihood of violence occurring, mitigate its impacts when it does occur, or strengthen people's ability to prevent, resist, and recover from violence

Discrimination and stigmatisation

The data indicates that discriminatory attitudes and practices among service providers and within the broader community function as a substantial barrier to help-seeking for women with disabilities experiencing violence, particularly due to fears that exiting abusive households may result in heightened vulnerability or adverse outcomes.

The expectation of discrimination and poor treatment by service providers, based on widespread knowledge of discrimination against women with disabilities, is a strong barrier to help-seeking and reporting for women with disabilities who experience violence, abuse and neglect. As noted above, the data includes numerous examples of victim-survivors with disabilities being discredited by community leaders and service providers, being asked for payment for services which they have no means to fulfil, and being denied services to which they have a right.

Widespread misunderstandings about violence against women further exacerbate these barriers. Service providing respondents often described leaving abusive relationships as a straightforward process, overlooking the significant social, emotional, financial, and safety challenges that prevent many women from doing so.

The data also revealed a **tendency toward victim-blaming**, particularly by community members, community leaders and service providers, a dynamic that further discourages women with disabilities from seeking and receiving the support they need. For example,

“But if she was not disabled she would have been handling her situations better. Like relocating for better environments, she can leave the house and find piecework in fear of what happens at home. She would know that what the parents are doing is wrong.” (female community member, focus group)

“Maybe if she was not disabled she would have fought back her parents.” (female community member, focus group)

Religious Beliefs

A prominent trend in the data indicates that **religious belief functions as a significant coping mechanism supporting emotional resilience among women with disabilities** who experience violence, abuse, and neglect. Across all respondent groups, faith was consistently identified as a source of strength, with participants commonly expressing beliefs that God offers protection to victim-survivors, ensures justice for perpetrators, and provides material and emotional support.

However, religious belief may, in some contexts, also operate as a maladaptive or constraining coping mechanism, particularly where reliance on divine intervention discourages help-seeking

or engagement with formal accountability processes. For example, one community leader, when reflecting on a perpetrator whose whereabouts were unknown, stated: *"We will thank God for bringing him to us... for it can only be God's spirit who has softly whispered to him so that he can come and show himself to us."* Similarly, a community member advised that a woman with a disability experiencing violence *should "be praying because God can handle everything rather than worrying,"*. While such beliefs may offer comfort and hope, they may also inadvertently reinforce passivity by framing intervention and justice as matters of divine action rather than collective or individual responsibility. In these circumstances, faith-based coping may function as a deterrent to help-seeking and the pursuit of due process, thereby limiting pathways to protection and accountability.

Previous experience of VAW Prevention and Response programming

VAW Prevention Programming

VAW prevention interventions are those that address the root causes of violence, such as the social norms, stereotypes and stigmatisation against women with disabilities that have been discussed in this report.

Even though respondents were directly asked about their experiences of VAW prevention programming, the data does not include substantive information in this regard. When asked, respondents typically cited acts of charity to women with disabilities, where an organisation or individual might offer clothing or food. One Women's Rights Organisation representative respondent shared an example of a programme team that produced policy documents that were irrelevant to their lived experiences of violence, as they were not adequately consulted. Frontline service providers more typically noted that they are not invited to participate in VAW prevention programming, whilst other frontline service providers noted that they provide counselling services to families affected by violence.

VAW Response Programming

GBV response interventions aim to provide victim-survivors with survivor-centred, timely, high-quality, and protective support that addresses their immediate needs and risks, offers longer-term assistance and referrals, and better enables them to pursue justice as they define it. Strengthening GBV response services through response programming can involve improving access to existing support services or creating new, safe ways for survivors to seek help.

When asked about response programming, respondents typically referenced examples of responding to specific cases through mediation, provision of food or shelter, or through referrals. No respondents cited examples of programmes that aimed to improve response services for women with disabilities who experience violence.

5. Discussion and Implications

Discussion

Women with disabilities are generally not viewed as having agency, which the findings show increases their risk of violence, exploitation, abuse and neglect. The research findings align with global evidence that women and girls with disabilities are boxed into stereotypes that deny their agency, autonomy, and right to make decisions about their own lives. This lack of recognition contributes to pathways that increase their invisibility and vulnerability to violence, and often excludes them from community engagement, access to supportive services, and protection mechanisms.

Women with disabilities are less likely to report this abuse and violence as they frequently don't have access to support services and face significant social barriers to reporting, as outlined in this report. Many services are not designed with disability inclusion in mind, and service providers often lack skills and knowledge on how to engage with survivors with diverse impairments, and frequently hold discriminatory views against people with disabilities.

Mainstream VAW prevention and response programming increasingly recognises the intersectional nature of violence and the uneven distribution of risk across different groups of women. However, limited attention has been given to the design and implementation of interventions that are explicitly informed by the lived experiences of women facing heightened vulnerability, particularly women with disabilities. In the Malawian context, this has resulted in insufficient application of tailored approaches that address the specific risk factors and drivers of violence affecting women with disabilities, including those identified in this report. In the absence of such targeted interventions, women with disabilities are often incorporated into generic VAW programming that addresses broad drivers of violence—such as gendered power imbalances and the normalisation of violence against women—while failing to engage with disability-specific risk factors, including internalised shame within caregiving families, pervasive stigmatisation and stereotyping, and discrimination in service delivery.

Within mainstream VAW prevention programming, interventions that address harmful social norms, such as gendered power imbalances and the normalisation of violence, have demonstrated effectiveness in reducing the prevalence of violence. These approaches provide a valuable foundation from which contextually appropriate adaptations can be developed to address the specific risk factors identified in this report.

Implications

Those seeking to design and deliver meaningfully inclusive VAW prevention and response programmes, which address the root causes of violence against women with disabilities should consider the following implications:

1. Design and deliver more disability-transformative programming

Many VAW prevention programmes aspire to be gender-transformative to address the root causes of gender-based violence and gendered power imbalances (Fulu et al., 2014, UN Women). However, violence prevention interventions that seek to reduce the prevalence of violence against women with disabilities should challenge the specific harmful norms, stereotypes and stigmatisation that increase the risk of violence experienced by women with disabilities. Specifically, violence against women with disabilities prevention programming should address:

- Stereotypes that disability means inability, and that women with disabilities lack agency and capability to participate meaningfully in their lives, families and communities
- Stereotypes that disability means abnormality, and people with disabilities should be avoided or ignored
- Stigmatisation of caregiving families of women with disabilities
- Discrimination of women with disabilities amongst response service providers
- Barriers to access to education and income-generating opportunities for women with disabilities

2. Design and deliver family-focused interventions

Findings indicate that internal family dynamics, and socioeconomic context shape both risk and protective factors. Caregiver stress, shame, stigmatisation and inability to cover the additional costs to adapt and accommodate disability-related needs, all increase the risk of violence and neglect of women with disabilities.

Violence against women with disabilities prevention programming should include family-based interventions that seek to address the following risk factors:

- Inability of women with disabilities and caregiving families to cover the additional costs related to disability-related needs
- Lack of social support services for women with disabilities and their family members
- Internalised shame associated with disability

3. Engage Faith Leaders

The findings suggest that women with disabilities who experience violence, and those who offer encouragement and support, often defer to their religious beliefs as an explanatory factor or coping mechanism. Whilst this can offer emotional resilience, the findings suggest that this may also operate as a maladaptive or constraining coping mechanism, particularly where reliance on divine intervention discourages help-seeking or engagement with formal accountability and safety processes.

Violence against women with disabilities prevention programming should **engage faith leaders to encourage faith-informed responses that emphasise compassion, responsibility, and protective action as expressions of religious belief.**

4. Integrate disability inclusion into VAW response programmes.

To meaningfully address violence against women with disabilities, interventions with response service providers should be explicitly designed to address the intersection of gender inequality and ableism, and to dismantle the “charity” model of disability in favour of a rights-based approach (IDA, 2021). VAW response programmes that seek to improve survivor-centred approaches and referrals amongst frontline service providers should be adapted to include disability transformative processes that facilitate critical reflection and peer-group solidarity on issues pertaining to disability rights.

5. Ensure more meaningful inclusion of women with disabilities in programming

Programmes should adopt the principle of “Nothing About Us Without Us” by involving women with disabilities in the design, implementation and evaluation of VAW prevention and response programmes that seek to address the specific factors and drivers that increase the risk of violence for women with disabilities.

The CRPD (Convention on the Rights of Persons with Disabilities, Article 6) emphasises the right to participate fully and equally in society. Research from the Global Women’s Institute (2021) shows that co-designing programmes with women with disabilities increases their effectiveness and responsiveness.

Funders and implementing partners must prioritise participatory approaches, invest in building leadership of women with disabilities, and partner with Organisations of People with Disabilities (OPDs) and Women with Disabilities Organisations (WWDOS).

Annexes

Annex 1: Ethics and Safeguarding

Given the sensitive nature of this study, and to ensure we minimise any risk of harm to participants, the following stringent ethical principles and procedures were applied consistently throughout the research process.

Risk assessment | A full risk assessment and mitigation strategy was undertaken. This risk assessment was reviewed and updated during data collection as needed.

Sensitive Interviewing | Researchers were fully trained in sensitive interviewing approaches in Chichewa, providing researchers with the skills to gently probe respondents and reduce the risk of causing harm.

Disability-friendly interviewing tools and techniques | WAG-Disability Rights and Bonface Massah, the Disability Inclusion Technical Advisor led the process of ensuring all data collection, analysis and reporting processes are disability-friendly. This included co-design of the data collection tools and interview techniques, and analysis and findings review discussions to ensure they are acceptable, accessible, adaptable and available to people with disabilities with various impairments and needs. The research used formats such as sign language and large print as appropriate and required by the participants.

Informed consent and assent | The research required informed consent and assent and guardian consent for all participants.

Right to withdraw | Informed consent, assent and guardian consent forms noted that all research participants have the right to withdraw from the study at any time, and provided respondents with the contact details of the Research Manager if they wished to withdraw after the data collector left their location.

Privacy and confidentiality | Privacy and confidentiality was assured for participants in the following ways:

1. All interviews and focus groups took place in private, accessible and safe spaces, where conversations could not be overheard. Ground rules were set and made clear to all participants in the focus groups to ensure privacy and confidentiality of all participants.
2. Questions and discussions were about third-party examples to ensure no one was required to disclose any personal data that they do not wish to.
3. All discussions were kept confidential between the researcher and the participants, and transcripts were anonymised so participants' identities could not be identified.

4. All research participants were given a unique identifier code. The names and identities of research participants were not shared with other community or family members unless requested by the participant.
5. All audio files were assigned file names before being sent for translation and transcription by the Research Manager, who kept a record of the file name, and the description of the data (i.e. FGD, KII reference number, GVH name, date etc.) in a file that was only accessible to the Research Manager. All transcripts were redacted of names and personally identifying information before coding took place, to remove any risks that such information accidentally becomes included in a draft or final publication. As noted above, personally identifying information was not stored alongside research transcripts or notes.

Reducing inconvenience to respondents | While respondents were not remunerated for their participation, the research sought to eliminate undue cost or inconvenience on participants. For this reason, the research interactions were held in respondents' homes, or a location selected by respondents. Respondents were compensated appropriately for transport or childcare costs incurred related to their participation and were provided a drink and/or snack during interactions.

Respondent family groups | The study did not engage respondents from within one family. For example, if a woman with disabilities participated in the study then members of her family (intimate partner, children, in-laws etc.) were ruled out from participating. This reduced the risk that respondents will deduce the topic of conversation held with a woman with disabilities on the basis of conversations they themselves have participated in, and thus put women with disabilities at greater risk of harm by other family members.

Access to referrals | In the case where a member of the research team is made aware of a survivor of violence who requires support, the following measures were in place. All data collectors:

1. had full knowledge of the National Referral Pathways for survivors of VAWG
2. were fully trained in survivor-centred approaches
3. were fully trained in mandatory reporting laws of Malawi
4. were provided service directory cards that include all types of services (e.g. agricultural services) such that they do not signal that a survivor has reached out for help relating to their experience of violence, in case the card is found by the perpetrator, or others.

These measures enabled members of the research team to make adequate and appropriate referrals for services where necessary.

Access to psychosocial support | Researchers were trained on the risks, signs and symptoms of trauma (including secondary and vicarious trauma) and were provided guidance on skills to reduce the risk of trauma, as well as response mechanisms if a researcher or participant does experience trauma.

Safeguarding against Sexual Exploitation, Abuse and Harassment (SEAH) | The research was implemented in accordance with the SDDirect Safeguarding Policy. The research team was trained in the Safeguarding Policy and signed the SDDirect Code of Conduct.

Risks and mitigations

Risk	Risk rating likelihood (low/ medium/ high)	Risk rating impact (low/ medium / high)	Mitigation
Communities, and research participants expectations of support and programming are raised and are not met	Low	Medium	The research was introduced to the community before respondents were selected, to avoid rumours, and misconceptions relating to the content of discussions, and the benefits to those participating. The research team was available to address any wider concerns or questions from the community about the research.
Researchers abuse their power to subject research participants, or other community members to abuse, exploitation, harassment or other forms of harm including fraud or corruption	Low	High	The research team was trained in, and required to sign, the SDDirect Safeguarding policy and Code of Conduct, which prohibits all behaviours that could result in abuse, exploitation, harassment or any other form of harm of anyone. The Steering Committee held overall responsibility to ensure compliance with the Safeguarding policy and Code of Conduct, which was delegated to Co-PIs and Co-Research Managers as relevant, who oversaw their direct reports.
Harm and abuse perpetrated by researchers, partners, service providers not being reported to the organisation	Low	High	Clear and accessible reporting mechanisms were established, offering at least 4 methods through which reports can be made, to enable research participants or wider community members to report any breach of the code of conduct by anyone engaged in the research. SDDirect has qualified investigators who would have led a full, safe and ethical investigation into every report made, centred on the survivor of the incident and ensuring that their needs and wishes were fully addressed.

			Reporting and referral pathways were well understood by researchers and communicated clearly to research participants. Researchers were selected based on their values and beliefs related to inclusion, human rights and gender equity, and were trained on Social Development Direct's code of conduct and ethical behavioural, and those expectations were communicated to all participants and community members
Participants and communities are harmed in the course of travelling to or from an interview	Medium	Medium	Researchers mapped the safety of spaces or places in which interviews and discussions took place, including travel to and from those spaces and places, to ensure a safe and confidential space for research process and appropriate safeguards was implemented. No one was expected to travel after dark. For FGD participants, care was taken to recommend that any travel to reach the interview site was conducted in groups. For KII participants, the researchers (who always operated in pairs) accompanied the participant when travelling to the interview site.
Participants and researchers experience re-traumatisation, secondary traumatisation or vicarious traumatisation as a result of their participation in the research.	Medium	High	Researchers were provided information about the signs and symptoms of trauma and ways to reduce risks of experiencing trauma. Researchers were also provided access to trauma response services, and were trained in providing referrals to research participants who may require trauma response services. Frequent and regular supervision and check-in with research team provided support to researchers, identified any support needs and ensured researchers were supported as needed.
Psychosocial, and other, support needs for researchers and respondents are unmet	Low	Medium	The research team drew on the Survivor Support Fund to ensure all respondents and researchers were referred, and costs covered, to services as per their need. Data collectors were trained in the mandatory reporting laws of Malawi, which stipulate that abuse experienced by

			anyone under 18, or anyone without the mental functioning to make decisions in their own best interest, is required to be reported to the police on behalf of the survivor. Data collectors comprehension of these laws was assessed before they began data collection.
Participants put at risk by breach of confidentiality or other aspects of code of conduct	Low	High	Detailed informed consent, assent and guardian consent forms were drafted, and translated, which provide all relevant information relating to the research, including where to report concerns or feedback. Commitments to confidentiality are included in the Code of Conduct that all researchers were required to sign and adhere to.
Researchers experience burnout, stress and/or trauma	Medium	Medium	Researchers were provided information about the signs and symptoms of stress, burnout and trauma and ways to reduce risks of experiencing these symptoms. Frequent and regular supervision and check-in with research team provided support to researchers, identified any support needs and ensured researchers were supported as needed.

Annex 2: Data Management and Protection

Qualitative data were audio-recorded using Kobo Collect, which is an encrypted open-source software, and later transcribed and translated into English in MS Word processing software. All respondents in the study were assigned unique identifiers that link the respondent to the transcript and the complete consent/assent/parental consent forms. The respondents' identifying information and unique identifier were entered into a separate Kobo Collect form, the database for which was only downloaded in the event that a respondent needed to be identified for data protection purposes. Any personally identifying information that was present in transcripts due to the nature of the conversation was removed from all the transcripts.

Data security and protection

Access to data collected as part of this research was restricted to members of the research team. Each researcher was responsible for keeping primary data (i.e. notes, audio recordings, chat conversations, transcriptions) safe on their electronic devices and hard copies were stored in a lockable cabinet at the WAG-Disability Rights office, which was accessible only by the Research Managers and Principal Investigators. Data stored on individuals' devices was password protected. All recordings and data that were stored on individual electronic devices were deleted as soon as transcripts and recordings had been uploaded to secure cloud storage through end-to-end encrypted software. After the report has been finalised and approved, all interview and focus group notes and recordings will be deleted.

No photos or videos of research respondents were captured during the course of this research study.