Preventing Violence against Women and Girls with Disabilities in Botswana

Situation Analysis
March 2018

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List of Abbreviations

AIDS	-	Acquired Immune Deficiency Syndrome
ALIGHT	-	Actions Linking Inclusive Development, GBV, and HIV Together
ALIV[H]E	-	Action Linking Initiatives on Violence Against Women and HIV Everywhere
ART	-	Antiretroviral Therapy
ASRH	-	Adolescent Sexual Reproductive Health
BCD	-	Botswana Council for the Disabled
CSE	-	Comprehensive Sexuality Education
DPO	-	Disabled Peoples Organisations
GBV	-	Gender-Based Violence
HIV	-	Human Immunodeficiency Virus
IDM	-	Institute of Development Management
IEC	-	Information Education and Communication
MDG	-	Millennium Development Goals
NDP	-	National Development Plan
NSF	-	National Strategic Framework
PVT	-	Prevention of Vertical Transmission
PrEP	-	Pre-exposure Prophylaxis
SAMRC	-	South African Medical Research Council
SDG	-	Sustainable Development Goals
SRH	-	Sexual and Reproductive Health
SRHR	-	Sexual and Reproductive Health and Rights
STI	-	Sexually Transmitted Infections
TB	-	Tuberculosis
USAID	-	United States Agency for International Development
UNCRPD	-	United Nation Convention on the Rights of Persons with Disabilities
UNFPA	-	United Nations Population Fund
VCT	-	Voluntary HIV Counselling and Testing

Acknowledgements

We would like to acknowledge the support and contributions of the advisory committee members Mussa Chiwaula; Dr Godisang B Mookodi, Dr Boitumelo Mangope, Dr. Alice Welbourn, Dr. Andrew Gibbs, Norma Msebele, Moffat Louis, Jacques Lloyd, Ingrid van der Heijden and Sokwe Monametsi who reviewed and commented on this report.

We would also like to acknowledge the generous support of the American people through the United States Agency for International Development (USAID) as well as their representative staff in the Botswana office, who made this project possible. The authors' views expressed in this report do not necessarily reflect the views of USAID or the United States Government.

Executive Summary

Global evidence indicates that the prevalence of violence among people with disabilities is higher than among those without disabilities. This particularly affects women and girls with disabilities who also experience all forms of violence including gender-based violence (GBV). However, in Southern Africa evidence on the prevalence and causes of violence against women and girls with disabilities is very scattered. Literature from the region reveals that violence against this group is driven by harmful individual attitudes and values, negative cultural and social norms related to gender and disability, and a lack of access to services and public resources. The evidence also shows that violence is interlinked with worse outcomes of sexual and reproductive health and rights (SRHR) and greater risk of HIV acquisition. The literature highlights that disability stigma and exclusion is connected with gender inequality and poverty, creating a toxic cocktail and triple burden for women and girls with disabilities in resource poor settings (disability, gender, poverty). In societies where violence against women and girls is rampant, women and girls with disabilities may therefore have an even greater risk of all forms of violence (physical, emotional, psychological, financial, structural). In Botswana, evidence shows that violence against women is endemic, but there is no empirical evidence on the experiences of women and girls with disabilities.

Not surprisingly, in Botswana policies and programmes addressing violence (incl. SRHR, HIV and GBV) are not interlinked with policies or programmes focusing on disability. In fact, policies and strategic programmes related to disability are silent on the issues of SRHR and violence. In contrast, some policies and programmes on SRHR, HIV and GBV recognise the vulnerability of people with disabilities and a few recognise specific vulnerability to violence of women and girls with disabilities. However, they fail to provide data on people with disabilities or information on their vulnerabilities, needs and desires. They also do not include specific measures to protect or promote the rights of people with disabilities and fail to provide guidance on how services need to be adapted so that they are accessible to people with disabilities. Disability inclusive monitoring and surveillance is also lacking.

This report is the first piece of evidence from the ALIGHT Botswana project, which aims to increase the participation and inclusion of women and girls with disabilities in GBV and HIV programmes. The report provides the first piece of evidence for this project through a scoping literature review and systematic policy analysis. It is designed to inform key stakeholders, people with disabilities and their representative organisations, and organisations working in the fields of violence prevention, SRHR and HIV. It aims to inform policy and practice development towards more inclusive programmes and implementation. It also acts as a stepping stone towards an evidence-based training and a sensitisation intervention.

In addition, the report highlights specific actions that can be taken to change cultural norms and individual attitudes and values, improve access to services and resources and develop more disability inclusive policies and programmes. It also highlights the need for better disability related data collection, both in general and on violence specific outcomes, as well as research into what works to prevent violence against women and girls with disabilities. Furthermore, it highlights that some of the suggested actions can be implemented immediately without extra resources, while others may need minor additional investment or long-term planning and resource allocations.

Background to this Report

Worldwide people with disabilities (particularly women and girls) have a higher risk of experiencing violence, including gender-based violence (GBV), than people without disabilities (1, 2). This human rights violation negatively affects the health and wellbeing of people with disabilities, especially women and girls with disabilities (3). In addition, sexual violence, sexual exploitation and negligence of sexual and reproductive health rights (SRHR) increases their vulnerability to SRH issues including unwanted pregnancies, HIV and other sexually transmitted diseases (STIs) (3). The increased risk of women and girls with disabilities to violence (including GBV), HIV and STIs is an issue affecting countries across Southern Africa. Nevertheless, people with disabilities have been left behind in research and key interventions targeting violence, GBV, SRHR and HIV in the region, including in Botswana. As a result, countries like Botswana lack data and information on disability as well as inclusive programmes and policies focusing on GBV, SRHR or HIV (4, 5).

Responding to these gaps, the ALIGHT Botswana project was developed to advance the participation and inclusion of women and girls with disabilities in programmes related to the prevention of and response to gender-based and other forms of violence in Botswana (http://www.mrc.ac.za/hiv/Alight.htm). ALIGHT Botswana is a collaborative project between the Botswana Council for the Disabled (BCD), the South African Medical Research Council (SAMRC) and the Institute of Development Management (IDM). The report presented here has been developed as one of the outputs from this project. It also serves as a first step towards providing evidence for the development of a disability inclusive violence prevention framework and training intervention for Botswana.

The ALIGHT project has been inspired by the ALIV[H]E Framework (6), also known as Action Linking Initiatives on Violence Against Women and HIV Everywhere. ALIV[H]E is an applied research implementation framework that draws on evidence of 'what works' to prevent violence against and exposure to HIV for women and girls. The framework takes into account the intersectional nature of gender and other social and economic inequalities (e.g. disability, sexual orientation and HIV status) as well as the need to link HIV, SRHR and violence prevention interventions (6). It includes a specific focus on women and girls with disabilities. Most importantly, the ALIV[H]E Framework provides a practical tool for analysing, tracking, measuring and monitoring progress and for providing evidence for promising and effective interventions. Building on the WHO and UNAIDS 16 ideas for addressing violence against women in the context of HIV, the framework charts the programmatic approaches and areas for change that have guided this report (see figure 1).
We used the framework's change matrix (figure 2) which identifies four areas for potential transformation to prevent violence (middle ring in figure 1 and figure 2).

These include:

- Laws, policies and resource allocation (programmes/strategic plans)
- Socio-cultural norms, beliefs and practices
- Internalised attitudes, values and practices
- Access to control over public and private resources and services

Figure 1 The 16 Idea Wheel (source ALIV[H]E Framework 2017)

The framework emphasises the need to build successful programmes based on evidence (6). For the ALIGHT project, this report provides the first piece of evidence through analysing and synthesising the existing empirical literature from Southern Africa and the policy and strategic documents from Botswana, allowing the report to cover all four change matrix areas. For this purpose, we used a scoping literature review and systematic policy and strategic programme analysis.

The literature review applied systematic review techniques to locate empirical evidence and appraised the related scientific papers or reports (see attachment 2). At the time of this research, two global systematic reviews on prevalence of violence against adults and children with disabilities were already available, but there was little evidence for Botswana. We therefore focused our literature search on papers providing empirical evidence on the causes of violence against women and girls with disabilities in Southern Africa.

For the policy, strategy and programme analysis we applied the UNFPA's SRHR and disability policy analysis tool (developed by UNFPA in 2017). This tool was developed on the basis of the principals and articles laid out in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). It assesses policies and programmes with regards to their linkages, rights' protection, inclusion of disability, SRHR elements (including HIV and violence), and their guidance on implementing accessibility and disability inclusive monitoring and evaluation. It also assesses to what extent disability-focused policies and programmes consider and address SRHR, HIV, violence and GBV.

Evidence on Violence against Women and Girls with Disability

Prevalence of Violence against Women and Girls with Disabilities
Worldwide, women and girls with disabilities are at increased risk of all forms of violence, including physical, emotional, economic and sexual violence, compared to men and women without disabilities (1, 2, 7). Two systematic reviews published in the Lancet reveal that people with disabilities have 50% greater odds of experiencing violence (1, 2). Literature also shows that girls and women with disabilities, people with intellectual impairments and people with mental health disorders are at higher risk (8-13).

Although we know that the prevalence of violence against this group is high globally, the Lancet articles also highlight that evidence from lower and middle-income countries such as Southern Africa is lacking. In all Southern African countries national prevalence data on violence against women and girls with disabilities is not available as disability indictors are not inserted in routine data collection and surveillance focusing on violence. We therefore often have to rely on estimates, case reports or the opinions of advocates rather than national representative prevalence studies. For instance, the Zimbabwean book, *Singing to the Lions* (2013) estimates that "81 children with disabilities are raped in Zimbabwe every day" and bases this estimate on care reports (14). The authors argue that the silence surrounding sexual violence due to fear and lack of voice makes it very difficult to deal with this subject (14). Similar high numbers are claimed in the media based on a report from Save the Children Norway in 2010, which claims that 87.4 percent of girls with disabilities are sexually violated (15). Again, this media report does not provide the link towards the evidence nor on what these numbers are based.

In Botswana, the 2012 GBV Indicator Study (16) revealed that 67% of women in Botswana have experienced some form of violence in their lifetime, including both partner and non-partner violence. The most commonly reported form of GBV was emotional intimate partner violence (IPV), followed by physical IPV, sexual IPV and economic IPV. Child sexual abuse is reported as a significant risk factor for GBV in adulthood. However, the study does not include disability indicators and therefore is silent on women and girls with disabilities. Nevertheless, opinion pieces about violence appear in Botswana's media indicating that there are diverse issues of violence against people with disabilities, including women and girls. For instance, in August 2017 the Sunday Standard Reporter claimed that people with Albinism fear being hunted down for *muti* (17). The article refers to a regional Amnesty International Conference in which Botswana's country representatives shared their fears of being "slaughtered and harvested for *muti*". Evidence was not provided in this article.

The most rigorous evidence around disability in Botswana comes from the 2016 study on the living conditions among people with disabilities in Botswana (18). Using a national representative household survey carried out in Botswana between 2012 and 2014, the study provided detailed evidence on disability prevalence, causes of disability and the living conditions of households with people with disabilities compared to those without disabilities. The report revealed that households with people with disabilities scored lower on indicators relating to standard of living (access to health, education, employment, household assets etc.) than those who did not have people with disabilities. The report also includes a paragraph about experiences of beatings and

scolding (18). It is stated that "a total of 13.7% of the respondents reported to have been beaten or scolded because of their disability, dropping to 7.6% when concerning family members only. Discrimination by public service providers due to disability was reported by 11.9%" (18). Gender differences with regards to violence were not observed in this study. However, the study only prompted beatings and scolding and did not inquire about violence with its physical, economic, emotional and psychological dimensions. It also did not prompt IPV or sexual violence.

Intersection of Disability, Gender, Violence and SRHR

The increased risk of violence for women and girls with disabilities has been linked to double discrimination based on disability and its intersection with gendered norms and attitudes (7-9, 19, 20). In societies where gender inequality and violence against women is common practice, the likelihood of women and girls with disabilities being victims of violence is even greater (7, 21). Furthermore gendered norms and expectation may directly facilitate the acceptance of violence. For instance, Chappell's study with young people with disabilities in KwaZulu-Natal revealed that his participants downplayed their disability when it came to intimate relationships and accentuated their experience rather within a discourse of gender and sexual identity. Furthermore the young women with disabilities in his study reported to "accept a cheating partner and most female participants 'normalised' intimate partner violence as an acceptable component of married life" (22). This acceptance or expectation emerged from cultural believes that a man who loves his woman would hit her and a man who doesn't love his woman doesn't hit her (22).

Violence against women and girls with disabilities is also seen as intersecting with other developmental areas such as SRHR and HIV. For instance, De Beaudrap et al.'s cross-sectional study in Cameroon found that women with disabilities were at higher risk of HIV and that this was associated with higher rates of sexual abuse, exploitation and sex work in this population (23). Similarly, Hanass-Hancock's (10) ethnographic study in South Africa and Yoshida et al.'s (24) paper on the SEPO study in Zambia point towards the intersection of gender, disability and SRHR/HIV, revealing higher risk of violence for women with disabilities but also linkages to worse SRHR and HIV outcomes for women with disabilities as a result of violence.

In addition, violence has been linked to the causes of disability (25, 26). In Botswana, the 2012 GBV indicator study report (16) revealed that GBV leads to physical injuries, sexual and reproductive health issues (STIs, HIV) and poor mental health outcomes. Hence, the level of GBV in Botswana is not only alarmingly high but has also been contributing to the occurrence of disabilities (21, 27).

Global Evidence on Causes of Violence

Globally, the literature has shown that girls and women with disabilities are often more accessible to potential perpetrators, as they may need help with personal care; are more likely to be isolated (13, 28); have lower self-confidence and fewer assertiveness skills (9); and are less likely to disclose violence because of communication barriers, lack of rights awareness, lack of knowledge, lack of sexual vocabulary and difficulties in accessing services (29-31). Thus, seen from the perpetrator's point of view, girls or women with disabilities are easy targets. In addition, research shows that violence against these girls and women with disabilities is often not reported (30, 32, 33). The literature reveals that this is partly a result of low levels of knowledge about acceptable

behaviours and rights (e.g. what is inappropriate sexual contact) and how to report violence (34, 35), but can also be related to a lack of rights protection and enabling environments that accommodate disability when reporting violence. This under-reporting reinforces the perpetrators' perception of them being easy targets.

Causes of Violence against Women and Girls with disabilities in Southern Africa

Empirical evidence on the prevalence and causes of violence against women and girls with disabilities in Botswana is not available. We therefore expanded our search to the whole of Southern Africa. In order to understand the current stage of evidence in Southern Africa we use the ALIV[H]E change matrix as a reporting tool. The change matrix has been developed to illustrate how intersecting fields create four areas for potential change to prevent and mitigate outcomes of violence. In order to assess change this report provides a baseline of the current state of knowledge through analysing existing empirical literature, policy and programme documents.

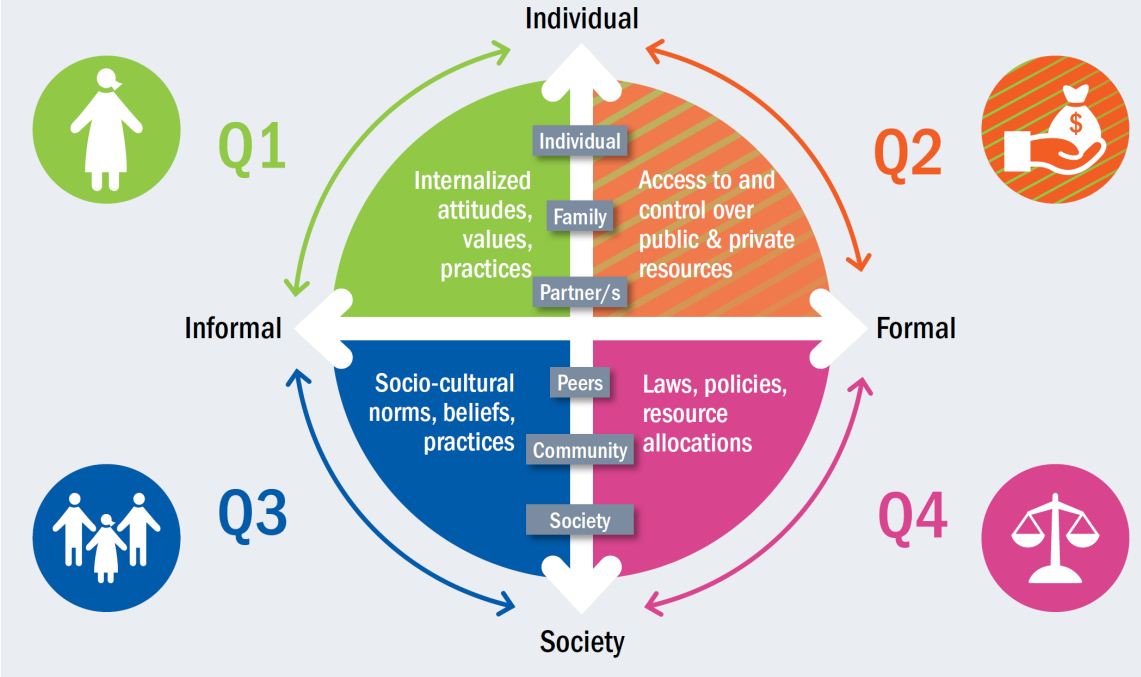

Figure 2 The Change Matrix (source ALIV[H]E framework 2017)

The following section uses the results from our scoping literature review and provides evidence for quadrants one to three. It specifically focuses on evidence about causes of violence against women and girls with disabilities in Southern Africa. The section thereafter will provide evidence for quadrant four through a detailed policy and programme analysis for Botswana.

Internalised Attitudes, Values and Practices as a Cause of Violence

The ALIV[H]E framework for this area covers individual "beliefs and values and how these are expressed through the attitudes, practices and behaviours of individuals, between couples and within families". For instance, in Botswana

patriarchal attitudes are an underlying factor driving the incidence of violence against women and girls (16). Acts of violence therefore are a manifestation of unequal power relations between men and women in relationships, with men using violent behaviour to establish power and control over women through fear and intimidation (36).

Disability stigma and negative attitudes are seen as increasing the vulnerability of women and girls with disabilities (3). Stigma and attitudes may lead to low self-esteem, compromised psychological wellbeing, and lowered ability to uphold their rights and form equal relationships with others. This includes intimate partnerships and safer sexual practice (37, 38).

Generally, evidence from Southern Africa focuses more on the structural and cultural causes of violence and provides fewer details about the internalised attitudes and values of people with disabilities and the perpetrators of violence against them. The available evidence from Southern Africa suggests that women and girls with disabilities are a "minority group" that experiences disability related stigma, discrimination and isolation (39, 40). For instance, a study from Malawi describes women with disabilities as having lower self-esteem and perceiving themselves as less attractive, leading to their acceptance of sexual advances and even violence (8, 9). Similarly, Neille (41, 42) links violence against women with disabilities in South Africa to increased dependency, discrimination and social exclusion, which are seen as facilitating the acceptance of violence. The most detailed description of individual experiences and facilitators of violence has been provided by van der Heijden (40). Her work with women experiencing physical disabilities in South Africa reveals that these women's unique experience of violence is shaped by social stereotypes, which label them as being unable to perform daily tasks, dependent on others for personal assistance and asexual. Van der Heijden states that disability stigma shapes the types of violence that these women experience, with some women being blamed for being a burden or feeling that they are a drain on others and therefore having to tolerate physical, financial or sexual violence in return for assistance (40). Furthermore her work reveals that participants experienced themselves as "inadequate, undesirable and pitied". Though this embodiment's disability stigma may not only lower self-esteem but also "hamper attainment of normative womanhood and intimate partnerships"(43). Similar evidence from Botswana could not be located for this review.

Socio-cultural Norms, Beliefs and Attitudes as a Cause of Violence

Within the ALIV[H]E Framework, the area of socio-cultural norms, beliefs attitudes, norms and practices, including customary or traditional, religious and cultural". In relation to this area, the 2012 GBV Indicator study reveals that "violence against women in Botswana has its roots in culturally-based perceptions which subordinate women to men as well as gender stereotyped roles that perpetuate and tolerate the use of violence against women" (16). For instance, culturally, a man may be seen as superior to his wife or partner and physical violence against his partner/wife may be seen as exercising his authority or even as an expression of love (16, 22).

Gender-related cultural stereotypes often overlap with perceptions and misconceptions about disability. A variety of misconceptions about disability have been described and some of them have been linked to violence against women and girls with disabilities in

Southern Africa. Socio-cultural interpretations of disability may include the perception of disability as a curse of god, neglect from the ancestors, or as a result of sin/adultery (10, 31). Such negative perceptions may be used to justify the isolation and neglect by the mother of a child with disability or the child itself. Social isolation and lack of access to social situations has been shown to reduce women with disabilities opportunities to meet suitable caring partners (43). In addition even if women with disabilities find a partner they are less likely to be accepted as a wife, hence they are less likely to find stable long term partnerships (43). With limited opportunities (related to stigma and isolation) women with disabilities have therefore reported that they "have to be grateful" and must tolerate physical or sexual violations in return for assistance or attention (10, 31, 40).

Misconceptions about the mental capacity of people with disabilities to report violence and identify perpetrators has also been reported as negatively impacting reporting and prosecution of violence against people with disabilities (10, 30-33, 44). Sicking's work in South Africa, for instance, shows that, besides accessibility issues, misconceptions about people with disabilities as not being able to stand as a witness, not being able to recall events and identify perpetrators, the practice of bribes and a lack of motivation and willingness to deal with "family matters" lead to underreporting and lack of prosecution and convictions (30). Her work also shows that the low reporting and conviction rate is connected to increased risk of violence and abuse (30). Nevertheless, Dickman et al.'s work shows that reporting and prosecution can be considerably improved through accommodating people with disabilities appropriately at the police station or in court and through sensitisation and training of staff in the judicial system (32, 33). This also applies to people with learning and intellectual disabilities. In South Africa, both Pillay and Dickman provide evidence of people with these types of disabilities being able to provide accounts of events, relate details of abuse and stand as a witness (32, 33, 44). Pillay's work highlights that for survivors with learning and intellectual disabilities, provisions need to be made through: applying a developmentally sensitive interview approach, allowing them to explain events in simple terms and the provision of an intermediary system if the adversarial court procedures are too complex (44).

In addition, in Southern Africa misconceptions about disability intersect with those about sexuality, increasing the risk of sexual violence (10, 45). For instance, a number of papers assert that people with disabilities might be perceived as being asexual and that girls and women with disabilities may therefore be seen as virgins. This misconception of them being virgins may expose them to the cultural practice of 'virgin cleansing', in which the perpetrator believes that intercourse with a virgin will 'cleanse [him] of diseases, such as HIV' (10, 45-48). How common this misconception is in Southern Africa is not clear. Most reports base their evidence on the perceptions of their interviewed participants and only a few include actual case reports.

Literature also reports that some people with disabilities are perceived as being oversexed or unable to understand sexual matters. Hence, exploitation is seen as difficult to prevent and not necessarily a violation, as the affected person is seen as "asking for it" (10). While this calls for intensified efforts to provide sexuality education and rights awareness, educators and parents may be reluctant to provide sexuality education as cultural and social perceptions prevent them from acknowledging the sexuality and potential agency of young people with disabilities (49-

51). Additionally, educators and parents may hold the belief that these young people do not have the capacity to understand sexual matters or engage in consensual relationships as adults (10, 52, 53).

These misconceptions intersect with cultural concepts around gender in the Southern African region (10, 54). Women with disabilities may therefore not only be seen as less "important" but also less able to fulfil the role of a partner/wife. Hence, if women with disabilities are accepted in these roles, they are expected to be grateful and not challenge the status quo (9, 10, 55).

Lack of access to Resources and Services as a Cause of Violence

Within the ALIV[H]E Framework, this area is understood as the "individual's or family's ability to access and use resources. Resources can be food, land, money or services, such as healthcare, education or legal." The framework emphasizes that it is important to look at both the availability and accessibility of services and resources for diverse groups of people.

Numerous papers globally and in Southern Africa have described the challenges of people with disabilities in accessing public and private services and resources (56-60). Accessibility is often discussed with regards to public services (health, education, transport and social protection), communication and information, employment and financial resources and assets, with individuals and households of people with disabilities generally facing less accessibility. An extensive report on access to resources and services for people with disabilities in Botswana can be found in the Botswana Living Condition Survey (18). This nationally representative survey was carried out in Botswana between 2012 and 2014. It revealed that households with people with disabilities scored lower on most indicators used in this survey. This includes lower household possession (assets), worse dietary diversity, less access to information and health care and a higher dependency ratio (18). At the individual level, this survey revealed that people with disabilities generally had more health issues (poor physical and mental health), lower wellbeing and less access to health information as compared to individuals without disabilities (18). Participants with disabilities were also less likely to access the formal education system and those who did access the education system tended to spend a shorter time in the system (18). Not surprisingly, people with disabilities experienced higher unemployment and tended to depend more on others in their households (18).

Research on violence and disability in the Southern Africa suggests that perpetuation and underreporting of violence against women and girls with disabilities is related to worse living conditions, in particular with regards to the inaccessibility of living spaces, houses and services, as well as to an increased level of poverty and dependency. Charowa's anecdotal account states that women and children with disabilities in Zimbabwe may be denied basic rights, such as access to food, in the context of limited resources (12). Poverty is a driver of vulnerability. In fact, some authors see poverty as a key driver of violence against people with disabilities and here in particular women and girls. For instance, Neille's study in South Africa concluded that in the "context of poverty it is impossible to separate the experience of disability from the experience of violence" (61). The study revealed that structural violence (lack of access to economic and structural resources) underpinned all other forms of interpersonal violence "making

persons with disabilities vulnerable to additional forms of exploitation and serve[d] to further isolate people with disabilities" (61). Similarly, van der Heijden's work in South Africa revealed that the dependency of women with physical disabilities on assistive devices and support from others provided opportunities for "men to manipulate and exploit them … making them feel they were a burden to others", including sexual exploitation in return for assistance (40). In addition, her study revealed that poor women with disabilities, who lived in informal settlements, faced additional challenges in these settlements as they had to use inaccessible public toilet facilities exposing them to intrusions of privacy, exploitation and violence (40). Her work also revealed that the degree and type of disability matters, with women facing more severe disabilities experiencing greater risks (40). Hence, the lack of access to economic resources and worse living conditions increases these women's dependency and exposure to violence.

Similarly, several papers from the region describe the denial of or exclusion from education, which particularly affects girls with disabilities (59, 62, 63). In addition, even where education can be accessed, young people with disabilities may be excluded from specific sections of education, such as sexuality education (64). As a result, people with disabilities have lower assertiveness skills, self-confidence and knowledge about rights, making them easier targets for sexual violence (9, 50, 64, 65).
A number of papers also explore access to the law and justice once women with disabilities had experienced violence. Throughout these studies, reporting, prosecution and conviction of perpetrators of violence against people with disabilities is hampered by lack of access to services and facilities (30, 32, 33, 44). This included the lack of sign-language interpretation; information in Braille; breaches of confidentiality; complicated adversarial court procedures that do not accommodate disability; and physical and financial inaccessibility of police stations, court facilities and support services (e.g. transport). Hence, even when girls and women with disabilities have the knowledge and courage to seek justice, they will encounter multiple barriers to receiving justice.

Gaps in the Evidence Base

The empirical evidence on violence against women and girls with disabilities in Southern Africa is still scattered. In Botswana, we currently have only rudimentary evidence. However, what is available indicates that violence against women and girls is an issue of scale in the region and that the risk of violence is most likely significantly increased for women and girls with disabilities.

Considering the available literature, we found that the evidence available from Southern Africa is predominately based on anecdotes, case reports, case studies, qualitative interviews, and surveys without validated scales (see annexure 2). Evidence mainly describes the type and experience of violence against people with disabilities and the causes of such violence. With the exception of two studies focusing on the prosecution of the perpetrators of violence, no other studies provide evidence of what works to prevent violence. Hence, there are no case-control, cohorts or randomised control trials available in the region to provide more rigorous evidence (figure 3).

Therefore, although we have some evidence on the causes of violence against women and girls with disabilities there is a lack of empirical data from Botswana (so far mainly opinion pieces and anecdotal reports) and there is no empirical evidence of what works

to prevent or mitigate violence against women and girls with disabilities. While anecdotal reports and opinion pieces can be rich in their descriptions, they are unfortunately seldom formally recognised and therefore Botswana needs more formal disability data collection and analysis including case, cross-sectional, cohort studies and randomised control trials (see figure 3).

Figure 3 Hierarchy of Scientific Evidence (Source: ALIV[H]E framework 2017)

Policies, Laws and Strategic Plans and Programmes in Botswana

The ALIV[H]E framework fourth area in the change matrix includes a focus on policies, laws and programmes. In order to protect the rights of vulnerable populations, such as people with disabilities, a country's legal framework and programmatic plans need to specifically ensure that these groups' rights are protected and promoted. This includes specific legislation and procedures that include vulnerable populations, such as people with disabilities, as well as disability specific acts, policies and programmes. Inclusion in such documents needs to go beyond the lip-service of mentioning people with disabilities to identifying prevalence and causes (evidence), describing reasons for vulnerability, listing the rights of vulnerable groups including people with disabilities, identifying specific accommodation measures, providing specific guidance implementation and guiding the monitoring and evaluation of inclusion.

The following review includes sections that describe firstly Botswana's legal and policy framework more generally. Secondly it undertakes a focused analysis of policies and programmatic plans that are relevant to violence/GBV, HIV and SRHR. It assesses if these policies and plans are linked to other acts, policies or plans, what data they provide, how they describe service delivery and disability accommodation measures and if they provide monitoring and evaluation approaches that ensure data collection of people with disability and violence, HIV, SRHR and GBV. Thirdly the review assesses the inclusion of HIV, SRHR and violence/GBV in disability policies and country programmatic plans.

The Botswana Legal and Policy Framework

Constitutional Rights

The *Botswana Constitution* (1966) protects fundamental rights and freedoms of individuals living in Botswana. This includes the right to life, personal liberty, privacy and freedom of movement among other rights. The list of fundamental rights does not include the right to health or sexual and reproductive health. The Constitutional rights are enshrined as "fundamental rights and freedoms of the individual … whatever his race, place of origin, political opinions, colour, creed or sex". The latter does not mention disability or sexual orientation. However, the general outline of anti-discrimination in sections 3 and 15 of the Constitution can be read as protecting also the rights of people with disabilities. Section 15 of the Constitution protects "from discrimination on the grounds of race etc.". It states that "no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority." Furthermore the Constitution defines 'discriminatory' as "affording different treatment to different persons, attributable wholly or mainly to their respective descriptions by race, tribe, place of origin, political opinions, colour or creed whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description." In other words the Constitution forbids discrimination (which is seen as disabling or restricting people) on the basis of race, tribe, place of origin, political opinion, colour or creed but does not specifically mention discrimination on the basis of disability. Apart from this the Constitution is silent on disability.

General Health Policies and Plans

Botswana's policy framework includes several health policies (see table 1) that are relevant in the context of SRHR, HIV, violence prevention and GBV. The two guiding national health policy documents include the *National Health Policy 2011 of Botswana (draft)* and its implementation framework of the *Integrated Health Service Plan: A Strategy for Changing the Health Sector for a Healthy Botswana 2010-2020.* The National Health Policy identifies the major causes of diseases, gaps in the health system structure and human resources and focuses on six building blocks of the country's health system (Leadership and Governance; Health Service Delivery; Human Resources; Health Financing; Health Information; and Health Technologies and Medicines and Vaccines). It provides specific directions to each building block. In addition, it provides a platform for coordinated planning, financing, monitoring and evaluation. In the policy health is recognised as "a right to be enjoyed by all Batswana". The policy also mentions people with disabilities and estimates that Botswana includes 96125 people with disabilities (prior 2010 data). It states that these people "may experience social exclusion". Furthermore, it identifies the need to extend the "existing safety nets" for "the poor and vulnerable" and that "health facility buildings have the provision for the special needs of users with disabilities". The policy does however not specify how vulnerable populations or people with disabilities need to be accommodated or how facilities need to be adjusted to meet their needs (see appendix 1 definitions). Similarly, the implementation framework of the *Integrated Health Service Plan* is very detailed with regards to its general response to building the country's health system. The Plan particularly focuses on harmonising and integration of health services. It also identifies the need to "ensure that financial incentives and

systems are in place to deliver services efficiently and with particular focus on the needs of vulnerable populations". It does not identify these vulnerable populations but ensures that "financial incentives and systems are in place to deliver services efficiently and with a particular focus on the needs of the vulnerable groups". Again these comments are generic and do not specify how to provide access to vulnerable groups. The Plan does not include any specific information on sexual reproductive health. It includes information on access to rehabilitation and GBV services, but does not include information on how people with disabilities will be enabled to access health services in general or those related to SRHR specifically.

Legislation around Violence

The legal framework of Botswana also includes a *Domestic Violence Act (2008)* which regulates protection against domestic violence, including physical, sexual, emotional psychological and economic abuse, intimidation, harassment, damage to property, unlawful entry in the property, unlawful detainment and stalking. The Law does not specifically mention people with disabilities but makes some provision for support of people with intellectual disabilities through allowing support of "submission on behalf of minors, mentally challenged, unconscious or intoxicated persons". It does not regulate support for accessing justice for people with disabilities who may need support such as assistance, transport, sign language interpretation, Braille or juristic assistance (or financial support). However, the law allows that parties "may request the presence of any specified person during the proceedings", which means if people with disabilities can afford disability-related assistance they could bring this to court themselves. The law also defines economic abuse and damage to property. Theoretically the denial of assistive devices and withholding of economic opportunities could be discussed under this clause as types of violence that people with disabilities experience.

Educational Plans and Policies

Botswana's Education Act was adopted in 1967. It aims to ensure the development of education and the provision of education to all people in Botswana. The Act provides for the establishment/registration and control/management of schools in Botswana but does not provide specific information about learners with disabilities nor how schools or materials will be made accessible. This information is provided in the revised version of the National Policy on Education 1994. The revision focuses on increasing educational opportunities for young people in Botswana, reducing inequalities and improving quality and accessibility of education for all. The policy highlights that the provision of education to children with disabilities remains limited. It focuses on special education, and makes specific provisions for the inclusion of people with disabilities in the education system. The policy obliges educationists to "(i) ensure that all Batswana, including those with special needs, have equality of educational opportunities; (ii) as much as possible integrate children with special needs into ordinary schools; (iii) establish special classes in primary schools in major villages and towns; (iv) develop standards for the construction of all educational buildings to make them accessible to disabled people; (v) employ adequate numbers of appropriately trained special education teachers; and (vi) ensure support and participation of children's parents and their community through an education and information campaign". Furthermore the education sector has a draft *Inclusive Education Policy (2011*) which has not yet been adopted. The overall goal of this draft policy "is the achievement of an inclusive education system in Botswana which provides children, young people and adults with

access to relevant, high quality education which will enable them to learn effectively, whatever their gender, age, life circumstances, health, disability, stage of development, capacity to learn or socio-economic status." The policy is not specifically about disability inclusion, but has particular sections that address the educational needs of people with disabilities.

Legal Acts and Polices targeting Populations Groups
Botswana's legal framework also includes the *Children's Act 2009*. This Act guarantees the rights of all children in Botswana and identifies children with disabilities as experiencing discrimination and "needing protection". Hence the Act specifically provides for the protection of children with disabilities and specifies that all children should be allowed to participate in social, cultural, religious and educational activities.

In addition, the *Revised National Population Policy* (2010) is a tool that can be used to understand Botswana's general legal and policy position and how it speaks to disability. The goal of the *National Population Policy* is to improve the quality of life and standard of living of all people within Botswana through reduced population growth rate, low fertility, low morbidity, low mortality and a balanced population distribution. Among other things the policy is explicit on the support and care for people with disabilities and aims at integrating people with disabilities into the economy and society. It speaks of improving physical access to buildings, reviewing policies and acts to address discrimination on the basis of disability, building institutions for rehabilitation, ensuring the right to education regardless of disability and the promotion of social acceptance. Hence, in general Botswana applies a mainstreaming and linking policy approach.

Apart from the guiding laws and polices described above, Botswana has developed specific policies and programmatic plans/strategies that are related to disability, SRHR, HIV or GBV (see table 1). These will be further discussed in the next sections.

Table 1 Current Botswana's SRHR, GBV and Disability Policies and Strategic Frameworks

Constitution and relevant Acts or General Policies	**National SRHR, HIV and GBV Policies**	**National Disability Policies**	**National SRHR, HIV and GBV Strategic Plans or Frameworks**	**National Strategic Plans on Disability**
Constitution of Botswana 1966	Policy Guidelines and Service Standards: sexual and reproductive health 2001 (also SRH Service Standards)	National Policy on care for people with Disabilities 1996	Sexual and Reproductive Health Rights and HIV and AIDS Linkages Integration Strategy and Implementation Plan	Botswana Council for the Disabled (BCD) Strategy Plan 2011-2016
Botswana Domestic Violence Act, 2008; Sexual Offences Act 2007; Protection from Harassment Act 2011); SAPS National Policy Guidelines for Victims of Sexual Offences	Botswana National Policy on HIV and AIDS 2012	Revised National Policy on Disability draft 2013 (not available in public domain)	A two year Costed scale up Plan for Sexual and Reproductive Health and Rights and HIV Linkages in Botswana 2015	
National Health Policy 2011 (draft) of Botswana	Handbook of Botswana HIV Treatment Guidelines, 2016		National SRH Programme Framework (2001) - document could not be located for this review	
Integrated Health Service Plan: A Strategy for Changing the Health Sector for a Healthy Botswana 2010-2020	National Guidelines on HIV Counselling and Testing 2009 National Guidelines HIV Testing and Counselling for Children and Adolescents 2010		Adolescent SRH Implementation Strategy revised 2011	
Education Act 1967; Revised National Policy on Education 1994 and the draft Inclusive Education Policy 2011	Policy Guidance to Male Involvement in SRH, HIV/AIDS GBV Prevention and Management : An Addendum to SRH Policy Guidelines and Service Standards 2008		Draft Third National HIV and AIDS Strategic Framework (NSF III) 2018/9- 2022/3	
Children's Act 2009	National Policy Framework for the Management of Sexual Offences (2013) - document could not be located for this review		National Gender-Based Violence Strategy 2016-2020	
Revised National Population Policy 2010				

Inclusion of People with Disabilities in SRHR, HIV and GBV Policy and Programmes

General

Current policies, guidelines and programmatic plans relevant to SRHR, HIV, violence and GBV can be found in several documents in Botswana (table 1). With regards to SRHR the country has developed *Policy Guidelines and Service Standards on Sexual and Reproductive Health* and two general implementation frameworks namely the *Sexual and Reproductive Health Rights and HIV and AIDS Linkages Integration Strategy and Implementation Plan* and a *Two Year Costed Reproductive Health Rights and Linkages* plan (adding to the national SRH Programme Framework 2001). The SRHR policy and implementation plans include adolescent sexual reproductive health (ASRH), family planning, safe motherhood, sexual transmitted diseases (including HIV, PVT, ART and VCT), gender-based violence, fertility management, male and female reproductive health, maternal and new-born health and post-abortion care. In addition the country has an *Adolescent SRH Implementations Strategy (revised version 2011)* and *Family Planning Policy Guidelines and Service Standards*.

HIV is one of the major burdens of diseases in Botswana and the country has developed several guiding documents to address this disease. This includes the *Botswana National Policy on HIV and AIDS* (2012), the *National Guidelines on HIV Counselling and Testing* (2009) and the new *Handbook of Botswana Treatment Guidelines* (2016). In addition, the country has two policies related to HIV counselling and testing (2009 & 2010), *Policy Guidelines to Male Involvement in SRH, HIV/AIDS and Gender-Based Violence Prevention Management* (2008). Implementation is guided through the *National HIV and AIDS Response Strategic Framework (NSF III)*, which is currently drafted in its third edition for 2018/19-2022/3. GBV is an additional challenge identified by the Botswana Government and addressed through the *NSF III* and the *National Gender-Based Violence Strategy 2016-2020*. This strategy specifically focuses on the provision of GBV prevention, protection, care and support services and additional services strengthening prevention of violence and support for victims.

Most of the reviewed documents recognise the need to promote "gender equality" or a "gender-sensitive approach" (see appendix 1 definitions). For instance, the *SRHR and HIV Linkages Integration Strategy and Implementation Plans* states that "gender-sensitive policy to establish gender equality and eliminate gender-based violence are additional requirements" for the success of SRHR programmes, while the *National Strategy towards Ending Gender-Based Violence in Botswana 2016-2020* list "gender sensitivity" as a guiding principal. In addition, the *Adolescent SRH Implementations Strategy* (2011) includes a specific section that focuses on gender, diversity and development with emphasis on addressing "gender inequalities in ASRH programming".
Hence Botswana's policy framework is focused on SRH, HIV, GBV and specific groups (youth, men, vulnerable women) and the integration of responses in these areas, while applying an overarching "gender-sensitive" approach that focuses on primary violence prevention.

Linkages

Ideally policies and plans focusing on SRHR, HIV and violence/GBV should be interlinked and be written from a human rights perspective. They should also link to disability policies or plans. In Botswana SRHR, HIV and GBV policies and their strategic plans have been developed over the last 18 years. Depending on their developmental date they link into the Millennium Development Goals (MDGs) and Botswana's Vision 2016 (prior 2013) or more recently (post 2015) into the National Vision 2036, the National Development Plan, the Sustainable Development Goals (SDGs), several acts (e.g. Child Protection, Domestic Violence, Abolition of Marital Power Acts) and several health and gender related regional and international treaties (e.g Maputo Plan of Action 2006, Abuja call towards universal access to HIV, TB and malaria treatment, African Health Strategy 2007, AU Campaign on Accelerated Reduction of Maternal Mortality 2009, National Youth Policy 1995, Policy on Women in Development 1995, National Health Policy 1996, National School Health Policy 1996). The SRHR policies and strategies are also interlinked with each other and integrated into the national health policy and implementation plan. The *Policy Guidelines on Service Standards on SRH* (2001) and the *ASRH Implementation Strategy 2011* also highlight a paradigm shift from "demographic driven focus on family planning to a health driven focus on sexual and reproductive health". Furthermore, the later developed *SRHR and HIV Linkages Integration Strategy and Implementation Plans* undertake a concerted effort to integrate and harmonise SRHR and HIV programmatic areas.

None of the SRHR, HIV or GBV policies and strategic plans link to the *National Policy on Care for People with Disabilities* or international conventions such as the *Convention on the Rights of Persons with Disabilities* or earlier guiding documents such as the *Standard Rules*.

Disability Data

The situation analysis and/or background sections of policies or strategic plans often include data and information about the general population. They should also include data on vulnerable populations, and for the purpose of this review on people with disabilities. This should include statistical information, prevalence of disabilities and factors of vulnerability (behavioural, social, cultural and structural). If this is not available, documents should identify this as a gap and drive towards better data collection.

The *Policy Guidelines and Service Standards on SRH* include detailed data on the general population and specific data on adolescents and women. The Policy provides data on contraceptive prevalence rates, maternal health and pregnancy rates including teenage pregnancy, age of sexual debut, mortality and detailed information on STIs and HIV and AIDS. It highlights that the age group 15-29 has the highest rates of HIV acquisition, "teenage pregnancy rate is 16% with contraceptive use being only 29% among this age group". The *SRHR & HIV Linkages Integration Strategy and Implementation Plan* refer to the data from this policy as well as a rapid assessment on SRH and HIV linkages. Data provided here is generic but provides information on gaps in access to services (not disability specific). The Plan identifies the SRH needs for men, youth and the aged population and the need to link services and interventions. It includes a detailed linkages matrix but does not identify how services will be delivered to vulnerable populations other than adolescents. Similarly, the *Two Year Costed Scale*

up Plan for SRHR and HIV Linkages provides general data as well as data on service usage in a pilot implementation phase. It acknowledges that "social determinants of health such as poverty, equity and access issues still need to be addressed", but does not speak to disability. The complimenting *Policy Guidance to Male Involvement in SRH, HIV and GBV Prevention and Management* does not include any specific data. In addition, the *ASRH Implementation Strategy 2011* provides detailed situation analyses of SRH of adolescents and young people providing demographics, pregnancies including teenage pregnancy, HIV and STI prevalence, barriers and access to services and the socio-cultural context of ASRH. This data is broken down via age and gender but does not disaggregate via disability.

Similarly, the *Botswana National Policy on HIV and AIDS 2012* provides general epidemiological data, including national HIV prevalence and incidence. It does not provide data on people with disability or the disabling effects of living with HIV. Similarly, the *Handbook of the Botswana 2016 Integrated HIV Clinical Care Guidelines* and the *National Guidelines on HIV Testing and Counselling* do not include such data.

The new and *Third National HIV and AIDS Response Strategic Framework (NSF III*) and the *National Strategy towards Ending Gender-Based Violence* provide epidemiological data as well as data from the Botswana Gender Indicator Survey (2012). Both Strategies identify 67.3% of women in Botswana as having experienced some form of GBV and acknowledges that factors hindering "the achievement of Botswana's vision of ending all forms of GBV include: lack of male engagement and participation in GBV interventions, inadequate and ineffective strategies to address negative social and cultural practices, lack of GBV surveillance system and inadequate capacity for evidence-based and human rights programming and implementation" (NSF III) to inform policy. The NSF provides data on key populations which include female sex workers, men who have sex with men but lacks data on other vulnerable populations. Although it does not include data on people with disabilities it states that "the lack of service providers who are proficient in areas of sign language or Braille is a gap in the promotion of access and utilisation of HIV services". The *National Strategy towards Ending Gender-Based Violence in Botswana 2016-2020* does not provide information on people with disabilities.
Hence, none of the policies or programmes include data or information on the diverse groups of people with disabilities that could be used to inform policies and programmes.

Factors of Vulnerability

Ideally policies and plans identify and prioritise the needs of vulnerable populations and specifically identify people with disabilities and their needs. Despite the lack of data on the vulnerability of different groups of people with disabilities, several policies and plans in Botswana mention people with disabilities or identify them as vulnerable or at risk (without specifying why). The *Policy Guidelines and Service Standards on SRH* mention adolescents with disabilities under the groups that are eligible for adolescents' sexual reproductive health services and identifies "physically disabled women" and "women with mental health problems" as "at higher risk of gender-based violence". The *SRHR and HIV Linkages Integration Strategy and Implementation Plan* and its *Two Year Costed Scale up Plan* state that "SRH and HIV services will be provided to the entire population with due attention also to special population targets and vulnerable groups that require more dedicated attention such as people with

disabilities, sex workers, young people …". Furthermore, the *SRHR and HIV Linkages Integration Strategy and Implementation Plan* states that for "people with disabilities …. their institutions should be included in training and orientation sessions planned at the pilot phase of the project. The disabilities include hearing impaired, sight impaired and mentally and physically challenged. Furthermore, material development process should consider their special needs e.g. material in Braille format for the sight impaired."

However, neither document transfers these statements into its linkages and implementation matrices, which are explicit to populations such as adolescents and young people but not for people with disabilities. The complimentary *Policy Guidance to Male Involvement in SRH, HIV and GBV* does not identify people with disabilities as a vulnerable group (but identifies women and adolescents/youth). In addition, the *ASRH Implementation Strategy 2011* identifies that marginalized groups "face barriers accessing services to include legal and judgmental attitudes of some service providers and individuals comprising the circle of support". It identifies "vulnerable groups such as sexual minorities, commercial sex workers, the differently abled, orphans, AIDS orphans, street children and hard to reach populations as well as children missing from school". The term "differently abled" seems to be used here as a synonym for people with disabilities.

Within the context of HIV and AIDS the *Botswana National Policy on HIV and AIDS* takes "cognizance of the fact that due to age, gender, socio-economic-status, sexual orientation or disability, some Batswana are more vulnerable to the devastating effects of HIV and AIDS than others". Going further the new draft *NSF III* builds on the principal of "not leaving any one behind" and states that the NSF III "shall prioritise a comprehensive response to the special needs of sub-populations with different forms of disability". It also specifies that "the population groups targeted by the NSF III include adolescents, girls and young women, infants and children, men, people with disabilities, sex workers, prisoners, non-citizens and men who have sex with men". Similarly, in the *National Strategy towards Ending Gender-Based Violence in Botswana 2016-2020* people with disabilities are twice listed among the vulnerable group. In the specific vulnerability of people with disabilities, and here women and girls with disabilities is not explained or discussed, there is no contextual understanding of why women and girls with disabilities are vulnerable.

Hence most policies and programmes manage to identify people with disabilities as vulnerable. However, they do not describe this vulnerability nor do they identify the drivers of vulnerability for this population. In addition, people with disabilities are forgotten in the implementation matrices, which results in the fact that no practical actions are taken to address violence against people with disabilities and here women and girls with disabilities in particular.

Protection and Promotion of Rights of People with Disabilities

Polices and Plans often include measures to protect and promote human rights in the context of SRHR, HIV and violence/GBV. This should include the protection of the rights of people with disabilities. Furthermore, these documents should make efforts to promote the rights of people with disabilities through active steps such as disability accommodation, support and sensitisation.

Indirectly, policies and plans in Botswana protect fundamental constitutional rights through their alignment with the *Constitution* (which includes provision against discrimination). However, the *Constitution* does not directly protect sexual and reproductive health and rights or specifically mentions persons with disabilities. Some policies and frameworks identify SRH as a human right such as the *Policy Guidance to Male Involvement in SRH, HIV/AIDS and Gender-Based Violence Prevention & Management 2008*, the *Policy Guidelines and Service Standards on SRH 2001*, the *ASRH Implementation Strategy 2011*, the *NSF III 2018/9- 2022/3,* the *SRHR and HIV/AIDS Linkages Integration Strategy and Implementation Plan*. However most of these policies and plans fall short in protecting sexual rights and access to justice.
For instance, the *Policy Guidelines and Service Standards on SRH* recognises the "fundamental human rights and freedoms enshrined in the Constitution" and interprets these as "sexual and reproductive rights derived from the fundamental human rights and freedoms that are already enshrined in the *Constitution* of Botswana and are included in several international agreements and treaties to which the Government of Botswana is a signatory".

Several SRHR and HIV documents claim to use a human rights-based approach. However, not all of the documents specify these rights in the context of SRHR and HIV, hence they are unclear on which rights they protect. In addition, while some of these documents specify the protection and promotion of rights for vulnerable groups most of them fail to do so for people with disabilities. For instance, the *Policy Guidelines and Service Standards on SRH* lists the right to highest standards of SRH including the number and spacing of children, access to information and education to make informed choices, respect of privacy, confidentiality, dignity, continuity, opinion, choice and safety. The guidelines also discuss access and specifies how this will be achieved for adolescents and youth, post-partum women, family planning clients, but does not specify this for people with disabilities. Similarly, the *SRHR and HIV Linkages Integration Strategy and Implementation Plan* lists the same SRH rights and these rights are related to "access regardless of social status, economic situation, religious affiliation, ethnic origin, marital status or geographic location", but does not speak to rights protection or promotion based on disability. The *Two Year Scale up Plan*, the *Policy on Male Involvement in SRH, HIV and GBV Prevention* and the *National Guidelines on HIV Counselling and Testing* speak generally to non-discrimination, but do not specifically mention rights of people with disabilities.

Going a little further the *ASRH Implementation Strategy 2011* protects the rights of all youth to privacy, dignity, access to information and SRH services and violence protection. The right to access SRH services is specified with the statement that "every adolescent is unique and has different needs, to include access to and benefit from SRH information and services based on her/his developmental levels, gender, culture, social situation, life experiences, mental and physical ability/disability." Similarly, the *National Strategy towards Ending Gender-Based Violence in Botswana 2016-2020* identifies the need to "ensure respect and fulfil human rights especially for women and girls and other vulnerable groups such as people with disability,…". This Strategy also identifies "human rights" as one of its core principles.

The *National Policy on HIV and AIDS* identifies the need to reduce HIV and AIDS related stigma and discrimination towards persons living with or affected by HIV. The policy does not discuss the right to access services nor how this right will be achieved

for vulnerable populations including those with disability. Similarly, the Handbook of the *Botswana 2016 Integrated HIV Clinical Care Guidelines* does not speak to rights (service orientated). The new *draft NSF III* identifies priority interventions and that "those will be implemented using rights-based and people-centred approaches". It also refers to the Constitution stating that "Botswana's Constitution guarantees the rights of all people to equality and non-discrimination, which would include people living with HIV and key and vulnerable populations". However, the term vulnerable populations is not defined in the *NSF III*, hence this statement is unclear with regards to people with disabilities. Nevertheless, the *draft NSF III* identifies that "some populations may experience double or triple stigma (based on HIV, gender, sexual orientation, disability) and that interventions need to consider this multiple vulnerability and stigma". It is not specified how to do so.

Although most policies and programmes include a generic approach to rights protection, they fail to promote the rights of people with disabilities to access SRH, HIV and GBV services. Where rights protection appears it seems to be sporadic and isolated and is not taken forward into the implementation and service delivery formulations.

Access to Services

Policies and plans often identify a set of services and how these should be delivered and through doing this they guide implementation. This needs to include the concept of universal access and specific provision for vulnerable groups including people with disabilities through reasonable accommodation (see appendix 1 for definitions). Such provision needs to specify how services will be adapted or how people will be accommodated to meet their needs or respond to their vulnerabilities. For people with disabilities this would include the identification of the need to make buildings physically accessible, accommodate communication needs (Sign language or Braille), and provide knowledge and information in accessible formats (e.g. simplified tools for people with intellectual disabilities). Where a policy or plan does not specify "what is needed to ensure access" it does not provide meaningful instructions of the 'provision of accessible services'. Hence, it is possible that a policy or plan discusses 'access' in principal but does not ensure access for people with disabilities.

In Botswana all policies and programmes focus in part on service delivery. These target general or specific populations (adolescents or men). For instance, the *Policy Guidelines and Service Standard on SRH* focuses on providing access to maternal health, family planning, contraceptives, prevention and treatment of STIs and HIV and post-abortion care. It has a very specific section on the SRH services that need to be provided to adolescents (IEC, counselling, advocacy, family planning, antenatal care, post-abortion care, STI and HIV prevention and care and family life education). It does not include sexuality education or access to justice. In the adolescent section adolescents/youth with disabilities are included but even this section does not specify how to provide access to services for this group. Nevertheless, the policy does specifically mention that vasectomy, tubal ligation and hysterectomy for men/women with severe mental and/or physical disabilities "is legally possible if recommended by a psychiatrist/physician and with consent of family members" (while in general only the person him/herself can agree to that). Hence although the policy is not specific on how to provide access for people with disability to services, it is specific on third party authorisation of invasive procedures. Similarly, *SRHR and HIV Linkages Integration*

Strategy and Implementation Plan lists most relevant SRH services (not sexuality education or access to justice) and is specific to adolescents and youth. It does not make specific provision to provide access to services for people with disabilities. Similarly, the *ASRH Implementation Strategy 2011* aims to provide "universal access" to SRH services and to "create and enabling environment for the delivery of adolescent quality ASRH services for the successful implementation of the strategy". Again this strategy lists all SRH services excluding sexuality education and access to justice. It also does not identify that adolescents with disabilities may need specific accommodation to access services nor does it describe how services will be made accessible to this group. The *Two Year Costed Scale up Plan* and the *Policy Guidance on Male involvement in SRH, HIV and GBV Prevention* also do not provide any guidance or information on how to provide access to or include people with disabilities.

The *Botswana National Policy on HIV and AIDS* is driven by providing "universal access to comprehensive HIV and AIDS treatment, care and support services" and does also identify the need for "survivors of sexual crime to be counselled and offered a test for HIV". Similarly, the *National Guidelines on HIV Testing and Counselling* does identify the need to provide testing and counselling to those with "hearing and visual impairments or those who are discharged" (from care), while the *National Strategy toward ending Gender Based Violence* "advocates" for the development of interventions for specific groups including for people with disabilities. All three documents do not provide guidelines on how these services need to be adjusted or delivered in order to be accessible to people with disabilities. The *Handbook on the Botswana 2016 Integrated HIV Clinical Care Guidelines* is very detailed on how to provide services for HIV-prevention (VCT, PrEP etc), SRH, PVT, ART, TB, meningitis and cervical cancers. It also provides detailed implementation guidelines specifying service delivery for adolescents, zero-discordant couples and children. It does not provide guidance on accommodation of people with disabilities and how services need to be adapted to be accessible to them. The only document that speaks to some degree to disability accessibility is the *draft NSF III*, which states that "services need to be universally accessible and provide reasonable accommodation to people with disabilities where this is not possible". It also acknowledges that there is "limited access to integrated quality services across a continuum of care among infants, children, adolescents and youth as well as men and people with disabilities". The document appears to assume that integration would solve access issues hence it does not provide guidance on how to adapt services so that they are accessible to people with disabilities (but does provide details for other populations such as adolescents). As the only document, the *draft NSF III* commits to "scale up the provision of comprehensive sexuality education (CSE) and youth friendly services for in and out adolescents, girls and young women" and specifies the need to "assess the extent of GBV among vulnerable populations such as people with disabilities".

Despite all of the reviewed policies and plans highlighting elements of accessibility of SRHR services, some even using the terms of universal access, none of these polices and plans provide any guidance on how to make SRH services accessible to people with disabilities.

Overall Impression

All relevant SRHR policies and frameworks have been developed within the last 18 years. Overall the reviewed policies and frameworks make mention of people with

disabilities and to some extent acknowledge their vulnerability. However they fall short on providing data and information relevant to disability, protection and promotion of rights of people with disabilities and guidance on how to provide accessible services to this population (table 2 scoring). The specific needs and vulnerabilities of women and girls with disabilities are only discussed in general outlines. This is despite the fact that a number of these documents claim to use a human rights approach. Hence despite the acknowledgement of vulnerability there is little evidence of specific rights promotion for people with disabilities.

In addition, these documents do not identify disability specific indicators for monitoring and evaluation of policies and plans. It is therefore likely that disability will be further neglected if there is no additional data collection or a concise disability sensitisation and advocacy programme. Out of all the documents the *draft NSF III 2018/9-2022/3* appears the most inclusive plan so far. To our knowledge a submission for more specific inclusion of disability was made by the Botswana Council for the Disabled in January 2018.

Table 2: Level of Inclusion of Vulnerable Groups and Disability in SRHR Policies and Strategic Plans or Frameworks

	Policy Guide-lines and Service standards : SRH 2001	National Policy on HIV and AIDS 2012	Policy Guidance to Male Involvem ent in SRH, HIV GBV 2008	Hand-book of Botswana HIV Treatmen t 2016	HIV Counsel-ling and testing guideline s 2001	SRH and HIV/ AIDS Linkages Strategy and Impleme ntation Plan (2012)	A two year costed scale up plan for SRH 2015	ASRH Impleme ntations Strategy 2011	NSF 3 2018/9 - 2022/3	National GBV Strategy 2015-2020
Total out of 84	17	14	12	1	11	16	13	31	29	18
Perce ntage	20	17	14	1	13	19	15	36	35	21

Red – no inclusion, orange – limited inclusion, yellow – concerted efforts of inclusion, green-plan or policy includes detailed inclusion data, rights protection and service delivery

Inclusion of SRHR, HIV and GBV in Disability Policies and Programmes

General

Currently Botswana has two instruments that are thought to support the development of legal and policy instruments and programmatic areas directed at providing equal opportunities and rights to people with disabilities. This includes the 1996 *National Policy on Care for People with Disabilities* and the strategy of the coordinating body the *Botswana Council for the Disabled (BCD) Strategy and Implementation Plan*. The *National Policy on Care for People with Disabilities* sets out to "combat the incidence of disability and to promote the quality of life of people with disabilities". It was released in 1996 and a potential replacement policy is currently under review with government but not yet adopted by parliament (Revised National Policy on Disability 2013). As a broad framework the *Policy* can be read as recognising the need for accommodation and altering infrastructure to improve access for people with disabilities. It does not, however, discuss access in detail nor the needs or risks of specific subgroups of people with disabilities (e.g women with disabilities). In addition, it is not specific on implementing services and has no law designated to enforce its

implementation. The policy does, however, identify responsibilities of government ministries to uphold certain rights (e.g Ministry of Labour, assistance in the workplace, social schemes etc.). It also identifies the Botswana Council for the Disabled (BCD) as the central coordinating body of NGOs and DPOs and the formation of a Coordinating Committee on Disability which will "in collaboration with BCD evaluate, activate and make recommendations for appropriate actions to the Ministries concerned".

While the Coordinating Committee appears to have a short set of Terms of References the BCD has a Strategy and Implementation Plan covering 2011-2016 (no new strategy is in place as yet). The *BCD Strategy and Implementation Plan* mainly focuses on organisational structure building and has its limitation with regards to programmatic directions. The *BCD Plan* states that BCD is "recognised by the NGO Policy for Botswana as the sectoral coordinating body for people with disabilities". Being a plan that focuses on organisational building and capacity it identifies a number of organisational gaps, challenges and needed activities. It identifies six goals namely: 1) Strengthen the governance of BCD; 2) Enhance Coordination of all Organisations for People with Disabilities; 3) Raise Awareness, Advocacy & Visibility of the Council; 4) Strengthen Internal Controls, Monitoring & Reporting Systems; 5) Build Management and Implementation Capacity of BCD Secretariat and 6) Mobilise resources for Sustainability. The *BCD Plan* is critical with regards to BCD's governance, communication and dissemination approaches laying out a variety of activities to: change the Constitution to allow more variety of board members and additional skills and capacity, to develop capacity of BCD staff and develop programmatic approaches, financial systems and communication strategies. At the point of writing this report some of these activities have not been finalised or undertaken and it is therefore still a current guiding tool. The *BCD Plan* can also not be complimented with additional programmatic documents as yet and information on programmatic directions is therefore limited.

Linkages to Health, SRHR and GBV Policies and Plans

Ideally disability policies and plans should link to relevant SRHR, HIV and violence/GBV plans and polices. Both the *Policy* and the *BCD Plan* link to the Constitution of Botswana and the National Development Plan 10. Hence fundamental constitutional rights are protected indirectly through this linkage. The *Policy* also links to a number of Ministries, while the *BCD Plan* links to Vision 2016, the National Policy for NGOs and the National Policy on Care for People with Disabilities.

Neither the *Policy* nor the *BCD Plan* link to health, GBV or SRHR policies or programmatic plans (either older or current versions).

Factors and Data of Vulnerability to SRHR, HIV and GBV

Disability policies and plans usually include data on disability and other sectors (e.g. poverty). They should also include data on SRHR, HIV and violence/GBV issues. These policies and plans often also identify factors of vulnerability. This needs to include factors that increase vulnerability to SRHR, HIV and violence/GBV and information of which the group of people with disabilities is particularly at risk (e.g gender, age, type of disability).

The *National Policy on Care for People with Disabilities* provides some information on people with disabilities. It includes general information from other countries, refers

to a study conducted in the 1970s (no SRHR or GBV content) and states that 2.2% (1991 census) of people in Botswana have a disability. There is no information on health, SRHR or GBV. The Policy does however recognise factors that are "responsible for the inability of persons with disability to undergo rehabilitation in order to integrate in society" such as weakness in infrastructure, social services, health, education and vocational training and placement. It also recognises the "far-reaching consequences, at household and society levels" which are seen as an increase in the burden of care at the family level, impact on social relationships, increase economic burden and poverty and lower education prospects and outcomes.

The *BCD Strategy and Implementation Plan* does not include any data on people with disabilities. It does however recognise that there are "changing culture and traditions which discriminate against people with disabilities". In both documents vulnerabilities of specific sub-groups (etc. women, children) are not discussed. There is also no discussion of vulnerability to SRHR, HIV or GBV.

Protection and Promotion of Rights

Disability policies and plans are usually strong on disability rights protection. This should include direct references to the protection and promotion of rights in the context of SRHR, HIV and violence/GBV.

Through their alignment with the Constitution both the disability policy and the BCD strategy are indirectly upholding fundamental Constitutional rights. In addition, the *National Policy on Care for People with Disabilities* identifies the need to: protect the human dignity of every individual, work towards equal opportunities and ensure that people with disabilities are not disadvantaged. The *BCD Plan* also identifies the need to ensure equal opportunities for people with disabilities. The vision of the *BCD Plan* includes the statement to be "recognised nationally and internationally for promoting quality rehabilitation, education, skills training, services and advocacy for the rights of and promotion of equal opportunities for people with disabilities". The *Plan* identifies as one of its values to have "optimal service delivery through observing customer expectations and needs at all levels including: protect the rights of people with disabilities in relation to policy and legislation, protect the dignity and integrity of people with disabilities in relation to the changing culture and traditions which discriminate against people with disabilities". The *BCD Plan* does not include programmatic areas in its strategic plan as yet. It however list as an activity to "create a rights-based awareness programme for people with disabilities".

SRHR or GBV related rights are not mentioned in either document. Hence potential rights such as privacy, family life, choice of amount and spacing of children and access SRHR information, products and services are not discussed in these documents.

SRHR Services and Access

Disability policies and plans often speak to accessibility of services. The documents should also identify SRHR, HIV and violence/GBV services and specify how people with disabilities need to be accommodated in order to access these services.

Both the *Policy* and the *BCD Plan* speak generally to accessibility but are not specific on what needs to be done to adjust services, infrastructure and programmes so they are

inclusive of and accessible to people with disabilities. The policy identifies departments and ministries and their responsibilities. Further, the policy recognizes the principle of accommodation concerning altering infrastructure of training centres and workplaces in order to improve access for people with disabilities (not SRHR specific).

The *BCD Plan* identifies that "a vison of an all-inclusive community requires proactive advocacy with policy and legislative provisions to ensure universal access for people with disabilities", but does not say how to do so. The *BCD Plan* has no programmatic areas in its strategy; however it lists an activity to "develop a mainstream rehabilitation health, safety and wellness programme for BCD".
Hence both documents fail to discuss access to SRHR, HIV or violence /GBV programmes for women and girls with disabilities.

Overall Impression

Overall the current guiding *Policy* and *BCD Plan* are outdated and therefore very limited as guiding tools to promote the rights of people with disabilities. Both documents envision the creation of equal opportunities for people with disabilities but lack specific guidance on how to achieve this vision and which programmes need to be implemented. Neither document is based on disability data and research and is therefore not informed by evidence nor promotes data collection and mainstreaming of disability across research in Botswana. This is likely a major shortfall in order to inform disability specific and other key programmatic policies and programmes in Botswana.

Table 3: Level of Inclusion of SRHR issues in Disability Policies and Frameworks

	National Policy on care for People with Disabilities 1996	Botswana Council for the Disabled (BCD) Strategy (2011-2016)
Total out of 38	3	2
Percentage	8	5

Red – no inclusion or SRHR, orange – limited inclusion SRHR, yellow – concerted efforts to include SRHR, green-plan or policy includes detailed measures to uphold SRHR rights and deliver services to people with disabilities

It is therefore not surprising that there is very limited guidance on how to uphold the rights of people with disabilities with regard to SRHR, HIV and GBV in either document or the disability policies and programmes. Some of the discussions around rights and implementation can however be informed by existing human rights treaties and conventions most notably the Convention on the Rights of Persons with Disabilities (CRPD). This would allow Botswana to move forward with its disability agenda despite the lack of national data and information. It would also drive research and data collection in this area as this is enshrined in the CRPD.

Recommendations for Botswana

Botswana has to take considerable steps to ensure that women and girls are protected from violence and have access to SRHR, HIV and violence prevention, and GBV programmes. Actions to be taken include increasing research on these issues and policy and programme adaptation. As a first step, a number of potential actions can be recommended. Considering that Botswana had not signed the Convention on the Rights of Persons with Disabilities (CRPD) and had not yet updated its Disability Policy at the ALIGHT project onset, it can be assumed that needed actions and resource allocation for disability are still a matter of debate in the country. We have therefore organised our recommendations in terms of their potential need for resources. In table four we consolidate these ideas using the theme of resources and the ALIV[H]E change matrix (table 4):

Actions not needing any extra resources

The following actions can be taken immediately as they do not require any additional resources and link into processes that are already under way in Botswana. Firstly, Botswana has already developed a draft Disability Policy (2011/13). The information from the presented ALIGHT report can be used to improve this policy further before it is signed off by parliament. Secondly, Botswana will soon be updating its strategic plan for health for the era past 2020. This provides a timely opportunity for the disability sector to participate in its development and ensure better integration of disability within this plan.
Thirdly, government is already funding BCD to run the current coordinating mechanism for the disability sector in Botswana. BCD's strategy is not aligned to Botswana's present circumstances and the organisation's strategic approach needs to be strengthened, both in terms of organisational and programmatic development. Ideally, a new strategic plan should be developed which includes organisational development, communication and networking strategies, and programmatic areas of focus. This new strategic plan should ensure among other things the mainstreaming of disability into SRHR, HIV, and violence/GBV programmes as well as disability specific interventions (twin-track approach). An effective coordinating mechanism can be used to ensure that people with disabilities and their representative organisations are enabled to take part in all new policy and programme development (this may include reasonable accommodation, support for them to take part in these meetings and developments and creating awareness about the need for disability organisations to engage in these processes).

Fourthly, government, civil society and funders can actively support the current ALIGHT Botswana project and BCD's advocacy efforts focusing on raising awareness about violence against women and girls with disabilities. This includes supporting the dissemination of research and participation in advocacy campaigns. For instance, government officials who participate in advocacy events against violence or other key events (e.g. HIV) can highlight the issue of violence against women and girls with disabilities. In addition, people with disabilities and their representative organisations should be included in these campaigns and be provided with a meaningful platform for engagement with their communities and the public. Funders (national, bilateral and international) can require that programmes focusing on violence/GBV, HIV or SRHR include and report on the inclusion of people with disabilities.

Actions needing minimal extra recourses

Some actions can be implemented within a short period of time as they may only need a minimal amount of extra resources and some time for planning. For instance, data and information on disability are largely absent in Botswana; this is partially due to a lack of inclusion of disability indicators in existing national surveys and surveillance. Botswana is currently undertaking a number of studies focusing on SRH, GBV and HIV and could integrate disability indicators (e.g. the Washington Set of Disability Questions) into these studies/surveys to address this gap. In this way, the costs involved in acquiring national disability data would be minimal. Conducting a detailed analysis of this data could add minor cost.
Furthermore, Botswana can conduct a disability audit of its current key programmes and services in terms of their inclusion and targeting of women and girls with disabilities (as well as people with disabilities more generally). Tools for such audits already exist and only need slight adaptation and some funding for researchers to conduct this audit. Such an activity would provide crucial pointers towards existing gaps but would also identify feasible opportunities for change.

In addition, Botswana's general health programme already discusses feasible approaches towards healthcare for all which can be utilised here. For instance, the 'kiosk model', as identified in the SRHR policy guidelines, could potentially serve as a 'one stop centre' as proposed in the ALIGHT inception workshop. Similar to the kiosk model for outreach healthcare, the 'one stop centre' is envisaged to be a local point of care in which people with disabilities will receive access to a number of linked services. A pilot project could establish if such a linkage is feasible.

Actions needing long term planning and resource allocations

Some actions may require considerable extra resources and therefore require careful planning. This is generally the case if the adaptation for disability is costly or if new materials and interventions have to be developed. Long-term planning can assure that these costs can be incorporated throughout programme development. Ensuring that disability is a compulsory element during the development of all programmes will also make sure that costs are spread across different sources of funding.

For instance, to better understand what works to prevent violence against women and girls with disabilities, new programmes may have to be developed or adapted. New research also needs to be conducted in specific areas, including more expensive research such as randomised control trials. Government, researchers, funders and civil society need to collaborate on this to ensure the success of long term projects.

Apart from the need to increase the evidence base through research, disability accommodation has to be implemented within existing SRHR/HIV/GBV programmes. This could include costs relating to the provision of sign language interpretation, Braille, audio recordings, assistance and support, extra transport costs and costs for the training of staff. It may also include adaptations to building structures (ramps) or changes in the mode of service provision (mobile clinic) to ensure physical accessibility.

Table 4 Potential Actions for Change in Botswana

	No extra resources needed	Little extra resources needed	Additional resources needed
Formal and empirical evidence base 	Support ALIGHT Botswana research component	Mandatory disability data collection in all national surveys and surveillance	Collaborate with national and international funders to fund research projects into what works to prevent violence against women and girls with disabilities
	Systematic collect and support the dissemination of results from disability focused work	Fund disability specific analysis of existing data	Conduct a study on the economic and financial costs of disabilities
	Recognise and systematically collect the voices of women with disabilities (anecdotal data and opinion pieces)		
Individual attitudes and values 	Support advocates with disabilities in their communities and provide them with a public platform to raise issues of violence against them	Employ people with disabilities (particularly women) in programmes addressing HIV/SRHR/GBV	Take advantage of existing innovations and programmes that have evidence of what works and adapt them for implementation in Botswana (e.g. sexuality education for learners with disabilities)
Socio-cultural change 	Include SRHR/HIV/GBV and its link to disability in their existing programmes and community engagement strategies (Civil society; NGOs and DPOs)	Support collaboration between DPOs and NGOs in the field or SRHR/HIV/GBV to help sensitise communities about disability	Ensure that all public events and services are inclusive of people of all types of disabilities and enable their active participation
Access to services and resources 	Make inclusion of people with disabilities in funded SRHR/HIV/GBV and violence programmes mandatory	Adapt existing IEC-material so that it is accessible to people with diverse disabilities	Conduct a disability audit of public service facilities and plan adjustments and accommodation relevant to diverse forms of disability
	Specifically target women and girls with disabilities in existing poverty alleviation programmes	Train and sensitise healthcare workers, care workers, educators, and law enforcement officers on SRHR/HIV/GBV/violence and its link to disability	Improve people with disabilities' access to justice through supporting extra costs and reasonable accommodation
		Assess if SRHR's kiosk model can be used to link to a disability accessible centre ('one stop shop')	Assess appropriate approaches to disability related cash transfers to mitigate poverty and facilitate access
			Fund interventions identified in the NSF III to provide access to sexuality education and address GBV among people with disabilities
Disability inclusive policies and programmes 	Include SRHR, violence/ GBV, and HIV in new disability policy	Civil Society (DPOs) to actively engage in policy and programme development	Develop a Disability Policy and implementation staretgy and/or sign the CRPD
	Design the new health strategic plan (post 2020) disability inclusive (as well as any upcoming new plan or policy)	Adapt strategies in existing NGOs/DPOs and other implementation groups so that they include	Develop guidelines specifying how to accommodate people with disabilities in SRHR/HIV/GBV and violence prevention programmes

		SRHR/HIV/GBV and its link to disability	

Current policies and programmes acknowledge the vulnerability of people with disabilities but provide no guidelines on how to make services accessible to them. Guidelines for inclusion and accessibility have to be developed to clarify how to provide access to SRHR, HIV and GBV services for the diverse groups of people with disabilities. Such guidelines can also identify feasible adaptations that are affordable for implementers. In addition, Botswana can take advantage of innovations from other countries in the region, which provide guiding tools on how to provide access to some SRHR, HIV and GBV services. For instance, the Breaking the Silence approach in South Africa which was developed to adapt sexuality education lessons to be accessible to learners with disabilities. It may also take advantage of the new UNFPA regional strategy to increase access to SRHR for young people with disabilities.

In addition, government can embark on a long-term planning process on how to finance adaptations in key health, educational and transport services as well as how to improve employment equity for people affected by disabilities, especially women with disabilities and parents/caregivers of children with disabilities. A study to understand the economic and financial costs of disability, similar to that conducted by the South African Department of Social Development would be a suitable first step towards understanding how to finance disability inclusion and accessibility.

Attachments

Attachment 1 Key Concepts on SRHR, Violence and Disability

Disability is an evolving concept that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. Persons with Disabilities are defined as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. (CRPD, 2006)

Universal Design: means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. "Universal design" shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.

Reasonable Accommodation means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms (CRPD)

Box 1 Definitions of Key Concepts in Disability (Source CRPD)

Violence against women (VAW): Violence against women (VAW): Any public or private act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty with the family or general community. It includes sexual, physical, or emotional abuse by an intimate partner (known as 'intimate partner violence'), family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers or employers); sexual trafficking; forced marriage; dowry-related violence; honour killings; female genital mutilation; and sexual violence in conflict situations.

Gender-based violence (GBV): It describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with 'violence against women'. The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they do not conform to or challenge prevailing gender norms and expectations (e.g. may have a feminine appearance) or heterosexual norms.

Intimate partner violence: Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Sexual violence including rape: Any sexual act, attempt to obtain a sexual act, unwanted sexual comment or advance, or acts or attempt to traffic, or acts otherwise directed against a person's sexuality using force or coercion, by any person regardless of their relationship to the victim, in any setting including, but not limited to, home and work.

Gender inequality: Refers to gender norms and roles, cultural practices, policies and laws, economic factors, and institutional practices that collectively contribute to and perpetuate unequal power relations between women and men. This inequality disproportionately disadvantages women in most societies. It plays out in women's intimate relationships with men as well as at family, household, community, societal, institutional and political levels. Many women lack access to and control over economic and other resources (e.g. land property, access to credit, education) and decision-making power (e.g. in sexual relations, healthcare, spending household resources, making decisions about marriage). This lack of power makes it difficult for women to negotiate within, or leave abusive relationships or those where they know they could be at risk for HIV and/or other STIs.

Gender-transformative approaches: these encourage critical awareness of gender roles and norms and include ways to change harmful to more equitable gender norms in order to foster more equitable power relationships between women and men, and between women and others in the community. They promote women's right and dignity; challenge unfair and unequal distribution of resources and allocation of duties between men and women; and consider specific needs of women and men. Such approaches can be implemented separately with women and girls and with men and boys. However, they are also being increasingly implemented with both women and girls and men and boys together and across generations – either simultaneously, or in a coordinated way in order to challenge harmful masculine and feminine.

Box 2 Definitions of Violence and Gender Concepts (source ALIV[H]E Framework 2017)

Reproductive health is defined by the ICPD Programme of Action as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant." (ICPD, UNFPA)

Sexual health, in turn, is defined as "a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence." (ICPD, UNFPA)

Reproductive rights arise out of "established human rights protections; they are also essential to the realization of a wide range of fundamental rights. In particular, the following rights cannot be protected without ensuring that women and adolescents can determine when and whether to bear children, control their bodies and sexuality, access essential sexual and reproductive health information and services, and live lives free from violence" (ICPD, UNFPA).

Vulnerable Populations are subject to societal pressures or social circumstance that make them more vulnerable to poverty, disease (e.g. STIs, HIV), or violence. They are different from key populations, who are understood as being at highest risk of specific disease such as HIV and are 'key' to combating this disease. In the context of HIV for instance key populations are often groups such as sex-workers, men who have sex with men and intravenous drug users. Vulnerable populations depending on context can be women and girls, orphans, children, adolescents, migrants and people with disabilities among others.

Sexual and Reproductive Health (SRH) Services are services that include family planning, maternal health, preventing and treating sexually transmitted infections including HIV and AIDS, abortion and health information sharing.

Sexual and Reproductive Health and Rights (SRHR) Services include SRH Service as well services focusing on rights based approaches, violence prevention and management, access to justice and comprehensive sexuality education.

Box 3 Definitions Sexual and Reproductive Health and Rights (source UNFPA policy analysis tool 2017 unpublished)

Attachment 2 Overview of Empirical Evidence for Southern Africa

Author and Title	Country	Target Population	Research Methods and Design	Identified Causes of Violence against Women and/or girls with disabilities
Burgers (2014) Contextualizing women's mental distress and coping strategies in the time of AIDS: a rural South African case study.	South Africa	19 HIV-affected women who experience depression or anxiety	Qualitative study with IDIs, purposely sampling	• Individual: poverty and relationship difficulties were driving distress • Structural: under-resourcing to address mental health
Charowa. G, (2005) The Body Blows: In the thick of Zimbabwe's current turmoil, women with disabilities face hellish prejudice, hunger and rape. *New Internationalist online*	Zimbabwe	3 women with disabilities	Informal journalistic interviews, no sampling method	• Individual: people with disabilities (and mothers) are blamed for impairment • Cultural: misconception about people with disabilities being virgins expose them to virgin cleansing • Structural: inaccessibility of houses and services and exposure to poverty increases risk
Choruma. T Progression (2006) The Forgotten tribe: People with disabilities in Zimbabwe	Zimbabwe	(number not clear) People with disabilities	Survey without identified methods and sampling approach	• Individual: misconceptions about the sexuality of people with disabilities and negligence of information about rights • Cultural: exclusion of people with disabilities from communities, boys with disabilities are valued more than girls with disabilities • Structural: failure to address the needs of people with disabilities • Legal: outdated disability policies
Dickman. B, et al (2005) Complainants with learning disabilities in sexual abuse cases: a 10-year review of a psycho-legal project in Cape Town, South Africa	South Africa	100 cases of sexual assault involving complainants with learning difficulties	Case review and document review, retrospective sampling	• Structural: Inadequate support staff and services for police and prosecutors, Poor monitoring
Elpick Jean (year not specified)	South Africa	(number not clear) caregivers of children with disabilities	Case reports and interviews, no sampling method	• Individual: Notion of children with learning disabilities not being able to stand as a witness • Cultural: Negligence child's rights on lack of follow up in rape as sexual assault

		belonging to Afrika Tikkun		• Structural: lack of access to education, health, child protection and legal systems, including abuse reporting mechanisms • Legal: Lack of proactivity and urgency in protecting children in potential danger by the authorities
Hanass-Hancock. J, (2008) Interweaving Conceptualizations of Gender and Disability in the Context of Vulnerability to HIV/AIDS in KwaZulu-Natal, South Africa	South Africa	25 people with disabilities and their caregivers	Qualitative study with IDIs applying theoretical and snowball sampling, ranking exercise and grounded theory	• Individual: misconceptions about disability and the intersection of notions about sexuality, gender and HIV/AIDS • Cultural: practice of sexual purification rituals, sexual exploitation and lack of prosecution through the judicial system. • Structural: exclusion from sexual education and prevention and treatment of HIV/AIDS.
Handicap International and Save the Children (2011) Out from the shadows	Burundi, Madagascar, Mozambique and Tanzania (Zanzibar)	241 adults with disabilities who had experienced violence or abuse as children as well as carers and professionals (lawyers, judges, police, social workers, teachers, DPO members)	Survey with semi structured questionnaires (no validated scales), snowball and purposeful sampling	• Individual: notion that the results of sexual violence such as pregnancy are a fortune for women with disabilities • Cultural: social stigma and negative cultural attitudes towards disability (disability as divine punishment) • Structural: lack of access to education, few of the survivors had completed primary school or attended secondary school
Kvam. M, et al (2008) "I thought . . . maybe this is my chance": Sexual Abuse Against Girls and Women With Disabilities in Malawi	Malawi	23 women with physical, hearing, visual, or intellectual disability and women with albinism.	Qualitative study with IDIs, sampling not provided, (potentially snowballing through FEDOMA)	• Individual: misconceptions about women with disabilities having to be grateful despite abuse • Cultural: socio-cultural misconceptions such as “cleansing of HIV” • Structural: lack of access to services, lack of free services that prevent and respond to violence
Kvam. M, et al (2006) Violence and abuse against women with disabilities in Malawi	Malawi	23 women with disabilities	Qualitative study with IDIs & FGD, (potentially snowball sampling)	• Individual: misconceptions about disability being associated to witchcraft or bad luck • Cultural: the notion of sexual intercourse with women with disabilities being able to "cleanse of HIV"

				• Structural: Lack of resources that cater for the needs of women who have a disability
Neille, J et.al (2015) Beyond physical access: a qualitative analysis into the barriers to policy implementation and service provision experienced by persons with disabilities living in a rural context	South Africa	30 adults with a variety of congenital and acquired disabilities (15 men and 15 women)	Qualitative study with narrative inquiry, snowball sampling, participant observation	• Individual: disability stigma and discrimination, social isolation • Structural: physical barriers to accessing support services • Legal: corruption and lack of transparency in the implementation of government policies and practices.
Pillay. A, et al (2000) Psycho-legal issues affecting rape survivors with mental retardation	South Africa	Cases of 10 rape survivors' with intellectual disabilities	Non-standardized psychometric tests to establish functioning an interview with the survivor and family members	• Individual: notion that survivors with intellectual disability cannot be considered a competent witness • Cultural: misconception that sexual intercourse with a virgin child offers a cure for AIDS
SINTEF. Living conditions among people with disability in Botswana. Trodheim: SINTEF; 2016	Botswana	9894 household (989 case and 8905 control) and individual survey (1931 individuals)	Case and control individual and household survey with socio-economic items, stratified sampling approach	• Individual: negative attitudes by public servants and family members • Prevalence; 13.7% of respondents were scolded or beaten because of their disability
Sicking, L et.al (2013) The challenges of reporting, investigating, and prosecuting of sexual violence among people with disabilities in South Africa	South Africa	13 stakeholders (DPO, NGO representatives), investigating and prosecuting authorities	Qualitative study with IDIs, purpose maximum variation and snowball sampling,	• Individual: lack of knowledge and motivation on how to deal with sexual abuse cases of people with disabilities, inability to recall events under the strict rules of court procedures • Cultural: cultural misconceptions ‘ virgin cleansing’ • Structural: high caseloads, lack of disability accommodation • Little to no access to sexuality education including positive sexual concepts

Smith, E et al (2004) Barriers to accessing safe motherhood and reproductive health services: the situation of women with disabilities in Lusaka, Zambia	Lusaka, Zambia	24 purposively selected women with disabilities and 25 public sector health service providers.	Qualitative study with IDIs, purposive sampling	• Individual: a generalized assumption among reproductive health service providers that women with disabilities will not be sexually active, and not require RH services
Southern Litigation, Africa Centre (2017) Prosecuting Sexual Violence against Women and Girls with Disabilities in Malawi. A preliminary analysis of the attrition of sexual offence cases in the criminal justice system	Malawi	KII (11) policy makers, duty bearers and other important stakeholders (8) and women with disabilities (1)	key informant interviews, In-person interviews, convenient sampling	• Cultural: misconception of virgin cleansing, practice of witchcraft rituals based on the belief that a person would get rich if they rape a woman or girl with disability. • Structural: lack of access to justice and SRHR services • Legal: The Gender Equality Act specifically provides that every person has the right to SRHR but does not provide for people with disability.
Van Der Heijden. I, (2016)	South Africa	30 women with physical disabilities	in-depth interviews, convenient sampling	• Individual: exploitation, dehumanization and stigmatization of women with disabilities • Cultural: notion that having sex with a virgin with disabilities can cure a person with HIV • Structural: lack of services and responses for survivors with disabilities who have experienced violence.
Van der Heijden, I. (2018)	South Africa	30 women with physical disabilities	in-depth interviews, convenient sampling	• Individual: embodiment of perceived inadequacy, undesirability and pity that shape pursuit of intimacy and its link to low self-esteem, assertiveness and risk of violence, women with disabilities feeling obliged to express gratitude for attention • Cultural: disability stigma in combination with patriarchal context reinforcing rejection and isolation which reduces likelihood of stable partnership and protection • Structural: limited opportunities to meet potential partners, engage or report violence

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