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Triple Jeopardy: Gender-based violence and human rights violations experienced by women with disabilities in Cambodia

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The research team consisted of five project partners: *Banteay Srei*, the Cambodian Disabled People's Organisation (CDPO), CBM Australia, the International Women's Development Agency (IWDA) and Monash University. This report was coordinated on behalf of the research team by Fareen Walji, CBM Australia Nossal partnership.

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ABSTRACT

Cambodian women with disabilities experience multiple disadvantages resulting from the interplay between gender, disability and poverty. This participatory research project, developed collaboratively between Australian and Cambodian partners, investigated prevalence and experiences of gender-based violence of women with disabilities in comparison to women without disabilities; assessed the extent to which existing policies and programs include or address women with disabilities; and explored how women with disabilities are supported or denied access to existing programs.

The study found that women with disabilities and women without disabilities faced similar levels of sexual, physical and emotional violence by partners. However, the picture that emerged in terms of family violence (excluding partners) was starkly different. Women with disabilities experienced much higher levels of all forms of this violence. They were much more likely to be insulted, made to feel bad about themselves, belittled, intimidated, and subjected to physical and sexual violence than their non-disabled peers.

These results, building on scarce developing country evidence, speak to the unique vulnerabilities of women with disabilities to violence. There is an urgent need for mainstream services to ensure that women with disabilities can access their services, and for services for people with disabilities that address gender concerns. Similarly, it is critical that discriminatory attitudes which condone and perpetuate violence against women with disabilities are challenged and transformed.

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About this research project

This working paper complements a number of practical tools on gender-based violence and women with disabilities developed through the project. Other material, including peer-reviewed articles, policy brief, awareness-raising posters, pamphlets, and a community training tool will be publically available by early 2013. Most of these publications will be available in English, Khmer and accessible formats. Please contact the research partners for further information.

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ACRONYMS

AusAID	Australian Agency for International Development
CSES	Cambodian Socio-Economic Survey
DfID	Department for International Development
DPO	Disabled People's Organisation
ERW	Explosive remnants of war
GBV	Gender-based violence
NAPVW	National Action Plan to Prevent Violence on Women
NGOs	Non-government organisations
SRQ	Self-report Questionnaire
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
VAW	Violence against women
WHO	World Health Organisation

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The interplay between gender, disability and poverty

Overview

Women with disabilities in Cambodia face multiple disadvantages as a result of the interplay between gender, disability and developing world status (UNESCAP 1995; Rao 2005). Whilst little precise disability and sex-disaggregated data exists for the Asia-Pacific region, we know that women with disabilities are disadvantaged compared to their peers without disabilities. Challenges such as poverty, violence against women, and barriers to adequate sexual and reproductive education, experienced in conjunction with disability, magnify the challenges women with disabilities face in accessing appropriate services and support. Currently no policies in Cambodia exist which address the types of violence and barriers to services faced specifically by women with disabilities. There are no women with disability-specific legal, advocacy, shelter or other support services, and the few mainstream services lack the appropriate knowledge and tools to include women with disabilities sufficiently.

This mixed method study, undertaken by Monash University, CBM Australia and the International Women's Development Agency with Cambodian partners *Banteay Srei* and the Cambodian Disabled People's Organisation, provides quantitative data on the prevalence of gender-based violence (GBV) experienced by women with disabilities compared to their peers without disabilities. It also provides qualitative data on their unique experiences of violence, and the barriers and facilitators to accessing appropriate support and services. These results have informed the development of practical tools to improve access and service response.

The questionnaire used in the survey component of the study incorporated measures of socio-demographic position, financial autonomy, reproductive health, intimate partner violence, violence by other members of the household (excluding partners) and patterns of disclosure and help-seeking following experiences of violence. Mental health was assessed using the World Health Organisation (WHO) Self-Report Questionnaire (SRQ), a well-validated measure of common mental disorders. Disability was identified using the Washington City Group Questions on Disability. Participatory techniques such as a life narrative approach and focus group activities (for example, storytelling, voting, and visioning) were utilised to collect qualitative data.

Survey results showed no significant difference between women with disabilities and women without disabilities in the prevalence of physical or sexual violence perpetrated by a partner, meaning that women with disabilities are just as likely to experience violence from a partner as women without disabilities. However, women with disabilities were up to 4.2 times more likely to experience controlling behaviour from partners.

The most statistically significant differences between women with and without disabilities emerged in the area of family (non-partner) violence. More than half (or 52.5

per cent) of the women with disabilities who participated in the survey (n = 177) reported emotional abuse, 25.4 per cent reported physical violence, and 5.7 per cent reported sexual violence from family members. This was in addition to an array of controlling and coercive behaviour including having to seek permission from others in the family before accessing health care. These prevalence rates were all statistically significantly higher than those experienced by non-disabled women. Women with disabilities also experienced higher levels of psychological distress than other women, irrespective of their exposure to violence. Few women who participated in this study disclosed violence to others — whether or not they lived with a disability — and even fewer still were able to seek formal or informal support.

Barriers to disclosure and access to services are particularly acute when the violence is perpetrated by family members rather than intimate partners. The study results suggest that immediate, targeted policy and programming action is required to address high-levels of both partner and family violence faced by women with disabilities, and to ensure they are receiving the urgent psychological, material and other support they require.

Violence against people with disabilities

A number of studies now indicate a clear link between disability and vulnerability to violence (Barrett et al. 2009). A recent World Health Organization (WHO) meta-analysis of 21 557 individuals with disabilities, across 21 studies around the world, found that people with disabilities were 1.5 times more likely to experience physical, sexual or intimate partner violence compared to their peers without disabilities. The analysis further demonstrated substantial diversity among people with disabilities in terms of vulnerability to interpersonal violence, concluding that those with mental illnesses or intellectual disability could be particularly vulnerable. However, the authors also acknowledged that robust studies for most regions of the world, and particularly for low- and middle-income countries, were absent (Hughes et al. 2012).

Violence against women with disabilities

While there are limited studies on prevalence and experiences of violence for women with disabilities in developing country settings, small-scale studies such as one conducted with women with disabilities in Orissa, India, have indicated that experiences of violence are ubiquitous: 100 per cent of women with disabilities interviewed had experienced violence in their homes (Mohapatra and Mohanty 2004). A 2009 Pacific Island report demonstrated that compared to women without disabilities, women with disabilities are at greater risk of all forms of violence: at home, in their community and in institutions. Women with intellectual and psychiatric disabilities were particularly vulnerable to physical and sexual violence. The research also revealed that women with disabilities were less likely to access support, refuge or legal redress than their peers without disabilities (UNDP 2009).

Available evidence suggests that women with disabilities experience adverse physical, mental, sexual and reproductive health outcomes as a result of violence at a higher rate than women without disabilities (Walji 2009). Women with disabilities who have experienced gender based violence (GBV) are also at increased risk of experiencing high levels of stigma, discrimination and other rights violations including in relation to reproductive rights and sexual health (Astbury 2003; Astbury 2009).

Disability, as it is traditionally conceived and understood in burden of disease research, can also result as a consequence of intimate partner violence (Vos et al. 2006). Evidence from the recent *Violence against women: 2009 follow-up survey* (Ministry of Women's Affairs 2010: 38) in Cambodia clearly indicates the likely contributory role of GBV to the burden of disability. In this study, a quarter of women reported physical illness or weight loss as a result of domestic conflicts, 66 per cent reported becoming anxious, fearful or depressed, 68 per cent reported being unable to sleep, and 12 per cent admitted to feeling suicidal. Earlier research by Nelson and Zimmerman (1996) reported that 50 per cent of all women reporting abuse had sustained injuries as a result of that violence.

Barriers to representation and services

Women with disabilities are particularly marginalised from international development activities, programs and services. One of the few existing studies in Cambodia suggests that a fundamental issue regarding lack of access is the absence of the 'voices' of women with disabilities, within both the disability and women's services sectors. Women with disabilities are also less likely than men to be leaders or decision-makers of disabled people's organisations (UNESCAP 1995). This absence of voice impacts on organisational priorities. Male leaders of disabled people's organisations (DPOs) setting advocacy agendas raise issues of common interest to both sexes, such as access to infrastructure and education, but cannot adequately capture the gendered experience of disability, or the unique barriers faced by women with disabilities. Gender-based violence, sexual and reproductive health –traditional 'women's program' areas– are often unaddressed in disability-specific programming. Equally, the particular needs of women with disabilities are not always well-reflected in the priorities of women's organisations, which often focus on priorities shared by all women, rather than the unique barriers experienced by women with disabilities.

Many women with disabilities are not aware of programs, and therefore do not access services and resources, resulting in a high level of unmet need and increased risk of violence and ill-health. Physical barriers to services, attitudinal barriers in community level awareness-raising programs and communication barriers with service providers are all examples of ways women with disabilities experience difference and exclusion, leaving their voices unheard (Fiduccia and Wolfe 1999; Walji 2009). Moreover, as our research found, women with disabilities are often unaware of, or unable to, exercise their right to control their own bodies and sexuality (CBM 2007: 13, 18).

Gender-based violence in Cambodia

Gender-based violence is widespread in Cambodia. The Ministry of Women's Affairs large-scale study found that 22.5 per cent of women reported experiencing physical violence from their partners (MOWA 2005: 30). The 2005 Social and Demographic Survey found that over 20 per cent of women had experienced the same (National Institute of Public Health 2005: 286). MOWA's follow-up study in 2009 does not give an overall prevalence rate for domestic violence but found that generally rates of physical violence had dropped. One-third, or 33 per cent of women reported their partner cursing them, six per cent reported being thrown, and four per cent reported being knocked on the head or experiencing other forms of violence. The 2009 study did find great disparities between the number of respondents who reported experiencing violence themselves and

those reporting that they knew others who experienced such violence and suggest that this could mean that women respondents have significantly under-reported violence (MOWA 2010: 25, 27).

A number of other studies on GBV, with widely varying estimates on the prevalence of such violence, have been conducted in Cambodia. Nelson and Zimmerman (1996) found that 36.4 per cent of women between 15-49 years of age reported having been threatened with a knife or gun and 5.5 per cent reported being stabbed or shot at by their abusive spouse. Half of all women who reported violence had injuries as a result of that violence. In 2004, Kishor and Johnson conducted a multi-country study of domestic violence, finding that the lifetime prevalence of spousal physical violence (defined as 'ever beaten by a spouse/partner') was 17.5 per cent among married Cambodian women.

Yount and Carrera (2006) undertook a study of domestic violence amongst 2074 married women in Cambodia, finding the overall prevalence rate for certain forms of psychological, physical or sexual violence since marriage was 25 per cent. Twenty-three per cent of women reported that such violence had occurred in the prior year. The most common form of marital violence was psychological (17 per cent ever experienced), followed by physical violence (16 per cent ever experienced). Less than four per cent of women reported sexual violence since marriage but more than three per cent reported such violence in the prior year. More than half of all women surveyed (56 per cent) agreed that a husband is justified in beating his wife for certain reasons. Participants in Yount and Carrera's study (2006) agreed such action was justified if, for example, she goes out without telling him (30 per cent) or neglects the children (32 per cent).

The lack of current data, under-reporting of violence, and methodological variability raise concerns about the comparability and adequacy of studies on violence against women. These were some of the factors informing the WHO's efforts to establish a benchmark for measuring violence against women through its 2005 multi-country study.

Disability in Cambodia

The *World Report on Disability* (WHO, World Bank, 2011) documents the transition from the 'sick-individual', cure-focused 'medical model' of disability to a human-rights-based 'social model' whereby individuals are viewed as being disabled by the infrastructural, institutional, and communication barriers constructed by society rather than by their own bodies and minds. This perspective, now widely adopted in both developed and developing countries, provides people with disabilities with equal rights as citizens, and simultaneously places responsibility upon the state and other parties to realise these rights.

As in other developing country contexts, accurate statistics on the number of people with disabilities are not available in Cambodia (DfID 2005). National census data returns a range of prevalence rates from a low of one per cent in the 2009 census to a high of almost five per cent in the Cambodian Socio-Economic Survey (CSES 2004). However, according to the *World Report on Disability*, around 15 per cent of the world's population lives with some form of disability (equating to over 2 million people with disabilities in Cambodia) which suggests that Cambodian census data may not accurately reflect the true prevalence. Moreover, the United Nations Economic, and Social Commission for Asia and the Pacific (UNESCAP) estimates Cambodia to have one of the highest rates of disability in the developing world (World Bank 2007, UNESCAP 2002), consistent with

Cambodia's recent history, the continuing presence of unexploded ordnance and rate of road accidents. Many government institutions and non-government organisations working closely with people with disabilities also consider the official figures significantly underestimate disability prevalence and that rates are closer to, if not in excess of, the most recent global WHO estimate (15 per cent). These UN prevalence estimates are also much higher than official rates reported by Cambodian government statistical collection agencies. Cambodia-based disability stakeholders also agree that the majority of people with disabilities are amongst the poorest and most vulnerable in society.

According to official data from 1999, two per cent of the total population had disabilities of which 11.4 per cent were caused by landmines, 10.8 per cent by war, 32.5 per cent by diseases, 5.5 per cent by traffic accidents, 7.2 per cent by other accidents, 20.5 per cent by birth, and 12 per cent the result of other causes (CSES 2004). The CSES (2004) also reports that women (4.9 per cent) were more likely to have a disability than men (4.5 per cent). Higher numbers of people with disabilities lived in rural areas of Cambodia (5 per cent) than in Phnom Penh and other urban areas (3.3 per cent and 4.1 per cent respectively). Women predominated in several types of impairment including vision, hearing, speaking and mental impairment, while more men had mobility, feeling, learning, fits and other sources of impairment such as those resulting from mine injuries and traffic accidents.

Legislative framework for gender and disability

The Cambodian Government ratified the Convention to Eliminate all forms of Discrimination Against Women in 1992. The Cambodian Constitution (1993) enshrines equality between men and women before the law (Article 31) and freedom from discrimination on the basis of sex (Article 45). The Law on Prevention of Domestic Violence and Protection of the Victim was passed in 2005 and there are associated provisions in the Penal Code to criminalise conduct constituting domestic violence.

The General Assembly of the United Nations adopted the Convention on the Rights of Persons with Disabilities (UNCRPD) and optional protocol on 13 December 2006. Australia signed the UNCRPD on 30 March 2007. Cambodia signed the Convention on 1 October 2007 and ratified it in 2012. It entered into force on 3 May 2009.

The Cambodian Law on the Protection and Promotion of the Rights of Persons with Disabilities, first drafted in 2001, was approved by Cambodia's National Assembly in 2009. The purpose of the law is to protect the freedom and rights of people with disabilities, prevent and eliminate discrimination against people with disabilities, and provide for their full participation in society. The law mentions various causes of disability including landmine/explosive remnants of war (ERW), traffic accidents, work accidents, malnutrition, diseases, and other causes that lead to high numbers of people with disabilities. It does not however mention violence against women as a possible cause of disability despite the extensive global research on the severe physical and psychological disorders associated with such violence.

Current policy and programming on gender and disability in Cambodia

The Government has set itself the target of significantly reducing all forms of violence against women and children through working towards the Cambodian Millennium Development Goals. The Ministry of Women's Affairs is implementing its third strategic plan, Neary Rattanak III, which promotes women's empowerment and gender equality and the mainstreaming of gender concerns across all government agencies. The Government has developed a four-year National Action Plan to Prevent Violence on Women (NAPVW), 2009-12. This aims to raise public awareness about laws protecting women's rights; improve services; improve policies and laws; strengthen capacity of relevant officials; and improve data collection. There has been significant progress made in some areas, such as increased awareness of the criminalisation of various forms of violence against women. However, while people recognise certain forms of violence against women as illegal, there remain high levels of acceptance of violence (Ministry of Planning 2010: 21).

The Disability Action Council was established by Government decree in 1997 as the national coordination and advisory mechanism on disability issues. The Government adopted the National Plan of Action for Persons with Disabilities including Landmine/ERW survivors 2009-11 (extended until 2013). The National Strategic Development Plan 2006-10 mentions the need for improved social services for people with disabilities, though is not addressed the issue in the 2009-13 Plan.

Many foreign governments, through their overseas development agencies, aim to support activities which promote gender equality in Cambodia. AusAID supports activities to promote gender mainstreaming in government policy and the public services; activities which aim to improve policy, planning and services to women and children who are victims of violence; legal frameworks and regional cooperation to combat crimes which particularly affect women; and gender analysis of all Australian aid activities (AusAID 2012: 13). Similarly, the Governments of the USA, European Union countries, Japan, Canada, and multilateral institutions such as the World Bank, Asian Development Bank, European Commission and UN agencies, provide funding for major gender-focused projects. There is a very large number of NGOs in Cambodia, many of which have projects on gender.

While there is a considerable amount of work on gender and a growing amount of work on disability, there is a glaring omission in the absence of specialist services or programs for women with disabilities who have experienced violence.

Research aims

The results of this study aim to fill a gap in knowledge by:

- providing quantitative and qualitative evidence on the prevalence and experiences of emotional, physical and sexual violence faced by women with disabilities in Cambodia, compared to their non-disabled peers
- demonstrating the unique barriers to and facilitators of accessing violence-related services and support for women with disabilities
- providing an evidence base and rationale for implementing low-cost methodologies and tools that are effective in ensuring women with disabilities

have access to anti-violence and related support services in the Cambodian context

- providing tools and training materials to support inclusion of women with disabilities in Cambodian violence prevention and support programs
- enhancing research capacity of local partners to develop and conduct qualitative and quantitative participatory research related to disability and violence
- provide AusAID, the Royal Government of Cambodia and other stakeholders with research reports, policy briefs and clear direction on inclusion of women with disabilities in GBV programming
- giving voice and profile to experiences of violence in the lives of women with disabilities in Cambodia.

Methodology and participants

The research project employed a mixed methods investigation that relied on a number of different sources of data to ensure that multiple perspectives on GBV and disability were canvassed. The project built in a strong capacity development component to enable the organisations and staff members involved to learn from each other and transform their work to be more disability and gender-inclusive. Substantial time was invested in training women with and without disabilities as field researchers and sensitising researchers to gender and disability issues.

Table 1: Research data sources

Methodology	Participants	Sites
Survey	354 women from urban and rural Cambodia (177 women with disabilities and 177 women without disabilities)	5 sites: 3 rural sites (Siem Reap, Battambang, Kampong Speu) 2 urban sites (Phnom Penh and Siem Reap)
In-depth Interviews	30 women with disabilities who had reported violence in the survey	5 sites as above
Focus Group Discussions	8 focus groups each involving approximately 10 women with disabilities, who were members of self-help groups	Mix of urban and rural sites across Cambodia based on existing projects and networks of research partners.
Key Informant Interviews	15 key informants from DPOs, NGOS, INGOs, UN organisations, donors, local and national Cambodian Government.	Mix of urban and rural sites as above.

In total 480 participants were included. Slight oversampling occurred as a power analysis indicated a total sample size of 330 would be sufficient to detect a difference in the rates of violence between women with disabilities and those without disabilities if one existed.¹

Inclusion criteria for the survey

The inclusion criteria for the survey were:

- women with disabilities and those without disabilities aged between 18 to 45 years

¹ The power analysis was performed to determine the size of the sample so that if there was a difference in rates of violence between women with disabilities and those without, the sample was large enough (had sufficient power) to detect this difference.

- the ability to comprehend and communicate sufficiently well to be able to respond to questions in the study tools and to give informed consent to participate in the research.

Researchers were unable to recruit participants who were completely deaf. This is a limitation of the study and reflects the lack of appropriately trained workers available to communicate with profoundly deaf women who do not speak sign language.

Recruitment strategy

The recruitment of research participants involved a two-step process. First, women with disabilities were identified with the assistance of local disability organisations. Following this, women without disabilities who lived in the same neighbourhood were selected. This was to enable broad socio-economic matching based on geographical area. Equal numbers of women with disabilities (n=177) and without disabilities (n=177) were recruited for the study. Recruitment was also designed to be broadly representative of the urban/rural distribution of the Cambodian population. Just over a quarter of participants (26.3 per cent) were recruited from urban settings (Phnom Penh and urban Siem Reap) and nearly three quarters (73.8 per cent) were recruited from rural areas (Siem Reap, Battambang and Kampong Speu).

Quantitative method

The survey component was undertaken to ascertain the prevalence of gender-based violence and whether—and in what ways—experiences of violence differed for women with disabilities compared to women without disabilities. Other important topics in the survey included the socio-demographic characteristics of participants, patterns of disability, gender norms and beliefs, measures of psychiatric disturbance, patterns of help-seeking for women who reported violence, and financial autonomy.

The survey used questions from the WHO Multi-country Study on Women's Health and Domestic Violence Against Women; the Self-Reporting Questionnaire (SRQ), 20 questions developed by the WHO to assist with identifying psychiatric disturbance, particularly in developing countries; and the Washington City Group Questions on Disability (Washington Group, 2006). The WHO Multi-country Study questionnaire was modified and shortened in length to reduce the burden on participants, especially those with disabilities. The Washington Group questions are designed to provide comparable data cross-nationally for a great variety of cultures with varying economic resources. They have been tested globally and provide a more accurate means of ascertaining if people have disabilities than self-identification (for instance asking, 'Do you have a disability?').

Qualitative methods

Thirty women with disabilities who had disclosed experiences of violence in the initial survey were recruited to participate in in-depth interviews. The research team selected women with disabilities for interviews based on geographical location, disability status, and forms of violence experienced in order to capture diversity in experiences. Participants were asked to tell their 'life stories.' Interviewers provided prompts, or asked follow-up questions when necessary.

Approximately 80 women with disabilities who were members of self-help groups participated in focus group discussions across eight field sites. Women with disabilities were asked to share their views on disability rights, violence, and barriers and facilitators to accessing services through a set of participatory activities including story-telling, village mapping and voting.

Finally, key informant interviews were conducted with 15 respondents representing a range of stakeholders from local government, community-based service providers, national and international NGOs, UN organisations, bilateral donors and national government. Interviewees were asked a series of open-ended questions regarding violence and disability-related policies and programs, and barriers and facilitators to service access.

All qualitative data was analysed using a thematic analysis approach, and was designed to enhance understanding of quantitative data, give voice to the statistics – so that real women’s experiences and voices could be heard in writing up the research results around the prevalence and health, including mental health, consequences of violence and patterns of disclosure, and access to services and other formal and informal support mechanisms.

Results

Socio demographic profile of survey sample

Participants' ages ranged from 18 to 45 years with a mean of 31.76 years. Over three-quarters (76.5 per cent), of participants had attended school. More than two-thirds (68.8 per cent) had completed some or all primary schooling, followed by 20.8 per cent who had some secondary education (years seven to nine), and 7.4 per cent who had attended high school in years 10-12. Only three per cent of participants reported they had completed tertiary education, and three quarters of these were women without disabilities. Table 2 below presents some basic demographic data, broken down to show differences between women with disabilities and those without.

Of the total participants in the study, 38.4 per cent said they had never been married or lived with a male partner while 61.6 per cent reported that they had. Forty-eight per cent reported that they were currently married or had a male partner. Women with disabilities were overrepresented among those who had never married or lived with a male partner. This is consistent with the findings of other studies on women with disabilities reported recently in the *World Report on Disability* (WHO, World Bank, 2011).

Table 2: Socio-demographic profile of survey sample

	Women with disabilities	Women without disabilities	P
Total number of survey respondents (354)	177 (n)	177 (n)	
Age Years	32.1	31.4	Ns ²
No school	28.2%	19.2%	0.046
Never married	57.6%	19.2%	0.000
Unmarried now	75.1%	28.8%	0.000
Lives with birth family	75.1%	44.6%	0.000
Earns money	70.6%	81.4%	0.018
Mean financial autonomy ³	3.2 (2.5)	5.2(2.4)	0.000

² Ns= Not Significant. Nil value indicated that the differences between the two groups are highly statistically significant, i.e. there is less than one chance in a 1000 that the difference between them occurred by chance.

³ Mean financial autonomy score was based on adding the responses participants gave to the 11 questions on financial autonomy. Each question asked about ownership of something including both large items such as a house or land and small items such as a mobile phone or jewellery. Theoretically scores could range from a minimum of zero (owned nothing) to a maximum of 11 (owned all items asked about). In practice, women with disabilities owned three things and those without disabilities owned five.

Findings on Disability

A total of 159 participants (44.9 per cent) reported difficulty seeing, with just over a third (34.8 per cent) reporting some difficulty, 8.3 per cent a lot of difficulty and 2.3 per cent not being able to see at all. Only 3.4 per cent of participants had hearing difficulties. Of survey participants, 17.6 per cent reported having some mobility difficulties, and 5.7 per cent of the sample could not walk or climb steps at all. A total of 15.1 per cent reported having a lot of difficulty remembering or concentrating and another seven per cent has a lot of difficulty, or could not complete self-care activities such as washing or dressing (this measure is used as an indicator for intellectual or psychiatric disabilities). A further 7.1 per cent of the sample reported a lot of difficulty with communication.

Table 3: Disability Status using Washington City Group Questions

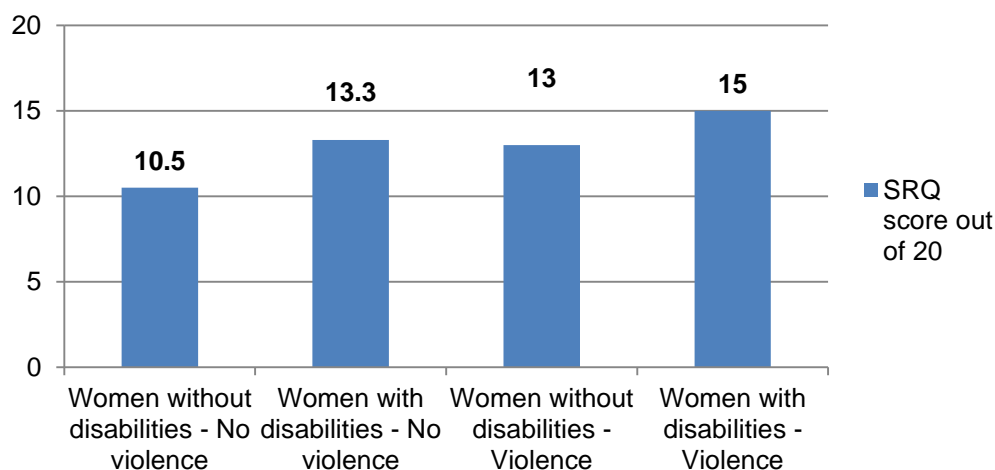
Washington Questions	A lot of difficulty %	Cannot do at all %	Total %
Difficulty seeing	8.3	2.3	10.6
Difficulty hearing	3.4	0	3.4
Difficulty walking	17.6	5.7	23.3
Difficulty remembering/ concentrating	15.1	0.3	15.4
Difficulty with self- care/washing	6.0	1.1	7.1
Difficulty communicating	7.1	0.3	7.4

Results for Self-Report Questionnaire on Mental Health (SRQ 20)

The mean score on the SRQ 20 for the total sample was 12.8 (sd=4.6) out of a total possible score of 20. This indicates that on average, women in the study answered yes to 13 out of the 20 possible questions on psychiatric disturbance (for example, do you have trouble sleeping, loss of appetite, thoughts about killing yourself?).

The below graph presents mean SRQ scores for different sub-groups of women who participated in the survey. The first group, with the lowest levels of psychological distress as measured by the SRQ, are women who did not have a disability and had never experienced partner violence. The second group consists of women with disabilities who had never experienced partner violence. The third group are women without disabilities who had experienced violence. The fourth group with the highest mean SRQ score are women with a disability who had also experienced violence.

Graph 1: SRQ scores on mental health by disability and partner violence status



The graph above reveals a clear gradient illustrating the link between violence and disability and rising levels of psychological distress. In this sample, women with disabilities are more likely than those without disabilities to sleep badly, feel frightened, have trouble thinking clearly, cry more than usual, feel their work was suffering, feel like a worthless person, feel tired all the time, to think about ending their life and to have tried to do so. Taken together, these feelings and behaviours underline the heavy burden of psychological distress experienced by women with disabilities in Cambodia.

Analysis revealed a highly significant difference in the mean scores of women with disabilities (13.7, $sd=4.5$) and those without (11.9, $sd=4.6$). The mean score for women who reported any violence was 13.57 ($sd=4.23$) compared with 11.06 ($sd=5.39$) for women who did not report violence. This difference was highly statistically significant.

It should be noted that the mean SRQ scores in this study show that even women who did *not* have a disability and had never experienced partner violence, had a higher SRQ score (10.5, $sd=5.2$) than the highest mean scores documented in every country in WHO Study. The lowest mean SRQ score for women who reported any type of partner violence in the WHO study was 2.7 (Ethiopia, provincial). The highest mean score was 9.8 (Peru, provincial). In other words, the levels of psychological distress for Cambodian women are high and especially so for women suffering the double burden of disability and violence. These women reported that they experienced an exceptionally high level of distress, responding to 15 out of a possible 20 symptoms of psychological distress on the SRQ. This exceptionally high level of psychological distress is cause for concern and response.

“I feel pain when I hear his voice. I don’t want to hear his voice anymore. I face a lot of suffering and difficulties in my life. During the past few months I have tried to kill myself a few times.” (IDIPP4).

Differences between women in rural and urban areas

An interesting finding of the research was that a significantly lower proportion of women (14.6 per cent, 38/260) living in a rural area *reported* ever experiencing physical violence by a household member than those living in an urban setting (29.0 per cent, 27/93). This was the only statistically significant difference found between women living in urban versus rural areas.

Intimate partner violence

Comparing women with disabilities and those without disabilities

Women with disabilities were less likely than women without disabilities to have ever been married or had a partner (42.4 per cent compared with 80.8 per cent). This needs to be taken into account when interpreting the lack of significant differences between women with disabilities and those without on a number of measures of interpersonal violence. For example, no statistically significant differences were found between the two groups in the lifetime prevalence of emotional, physical or sexual violence perpetrated by partners.

Prevalence of controlling and violent behaviours by partners

Significant differences were found between women with and without disabilities for two of the seven possible controlling behaviours exerted by partners. It is important to point out that while the total number of ever married/partnered women in the study was 218, the number of women who answered questions on partner violence and controlling behaviours was 177. This is because a number of questions asked about violence in the last 12 months and thus excluded women who were not married/partnered during this time period. Compared to partnered women without disabilities, those with disabilities were 4.2 times more likely to have their activities and whereabouts monitored by partners. They were also 2.5 times more likely to need the permission of partners before seeking health care for themselves.

Table 4: Prevalence of controlling behaviours

	Women with disabilities %	Women without disabilities %	Both %
Insists on knowing where you are at all times	62.2	28.0	36.7
Expects you to ask his permission before seeking health care for yourself	71.1	49.2	54.8

“I have never gone to the hospital even when I’ve been sick. When my wheelchair broke, I could have used my cart to help me travel to the central hospital when I was pregnant. I asked my husband to take me to the hospital but he refused and tied up my cart so that I couldn’t go.” (IDI 3)

Emotional violence

‘Emotional violence’ was defined as any positive response to questions on whether partners had insulted, humiliated, scared, intimidated or in other ways belittled the respondent. Participants were asked to specify whether these behaviours had occurred in the last 12 months or before the last 12 months. Lifetime prevalence was based on a positive response to one or more of these questions.

Of the 177 married/partnered women who answered ‘yes’ to these questions, 36.7 per cent reported that they had experienced some type of emotional violence from a partner in the last 12 months. The lifetime prevalence of emotional violence was 43.5 per cent (77/177) in this sample of women.

Physical and Sexual Violence

The 12 month prevalence rate for any type of partner physical violence was 19.2 per cent (34/177) and the lifetime prevalence was 24.3 per cent (43/177) with the majority of women reporting more than one type of physical violence.

The lifetime prevalence rate for any type of sexual violence perpetrated by a partner was 18.6 per cent (33/177). Once again, the majority of women had experienced multiple forms of sexual violence. Only 7.3 per cent reported just one type of sexual violence (13/177), nine per cent reported two types of sexual violence and 2.3 per cent reported all three types of sexual violence. A total of 13.6 per cent of the sample (24/177) reported they had ever been physically forced to have sex by their partner, 14.7 per cent of participants (26/177) reported they had had sex because they were fearful of what their partners might do if they did not. Four per cent of women (7/177) reported ever being forced to do something sexual that they felt was degrading or humiliating.

“My husband hits me mostly when he drinks alcohol, when he doesn’t feel good about the children, or when he doesn’t have enough money to buy wine. Sometimes if I don’t stay away from him he hits me. Nobody can help me, if they try he will just hit them....So I do not talk aggressively to him, just plead with him ‘do not hit me’.” (IDIPP3)

Table 5: Partner ever used emotional, physical and sexual violence

	Women with disabilities %	Women without disabilities %	Both %*
Emotional violence	48.9	41.8	43.5 (ns) ⁴
Physical violence	26.6	23.4	24.3 (ns)
Sexual violence	24.4	16.8	18.6 (ns)
Any partner violence	60	46.2	53.1 (ns)

Injuries from partner violence

A total of 10.9 per cent (24/220) of the sample reported being injured as a result of violence by a current partner. Of these, 14.6 per cent (12/82) of women with disabilities, and 8.7 per cent (12/ 138) of women without disabilities reported injuries. The difference in injury rates between women with and without disabilities is not statistically significant.

⁴ NS indicates that the difference is not significant.

Women who reported a violence-related injury were asked if they had ever received health care in this circumstance. Close to one third (10/32 or 31.3 per cent) of women said they had received health care while more than two-thirds (22/32 or 68.8 per cent) had not. No significant difference in rates was associated with disability status.

Violence perpetrated by household members (excluding partners)

Although few significant differences were found between women with disabilities and women without disabilities for partner violence (emotional, physical or sexual), a very different picture emerged for violence perpetrated by other members of the household. Analysis revealed a number of highly statistically significant differences between the two groups on both controlling behaviours and different types of violence.

Controlling behaviours by household members

Participants were asked a number of questions about controlling behaviours. Results showed that women with disabilities were subjected to much higher levels of control by household members than their counterparts without disabilities. Of the seven items related to controlling behaviours by household members, significant differences between the two groups were found on four items.

Significantly more women with disabilities (48 per cent of women with disabilities or 85/177) than those without (37.5 per cent of women without disabilities, or 66/176) reported family members needing to know where they were at all times. The odds of women with disabilities reporting this were one and a half times higher than those of women without disabilities (OR= 1.54, 85 per cent CI 1.01-2.35). A total of 27.1 per cent of women with disabilities, compared to 17 per cent of non-disabled women, reported that they were ignored or treated differently by family members, and this difference was also statistically significant (OR=1.81, 95 per cent CI 1.08-3.03). Nearly half of the women with disabilities surveyed (48.6 per cent), compared with 34.7 per cent of women without disabilities, reported that family members expected them to seek permission before accessing health care. This difference was highly statistically significant (OR= 1.78, 95 per cent CI 1.16-2.73) and indicates that household or family members of women with disabilities can present a formidable barrier to their access to health care.

Household emotional violence

Statistically significant differences between women with disabilities and those without were found in relation to three-quarters of the questions on emotional violence.

Almost half of the women with disabilities (48.0 per cent, 85/177) reported that family members insulted them or made them feel bad about themselves, compared with 30.7 per cent (54/176) of non-disabled women. Nearly a quarter of women with disabilities (24.9 per cent, 44/177), compared to 13.1 per cent (23/176) of non-disabled women, said that family members belittled or humiliated them in front of other people. In relation to both types of emotional violence, differences between women with and without disabilities were statistically significant. Finally, significantly more women with disabilities, 23.2 per cent, (41/177), compared to 14.2 per cent (25/176) of non-disabled women, reported that family members scared and intimidated them on purpose.

*Table 6: Family violence - coercive control
Controlling behaviour in household (excluding partner)*

	Women with disabilities	Women without disabilities	Odds Ratio	95CI
Insists on knowing where you are at all times	48%	37.5%	1.5	1.0-2.3*
Ignores or treats you differently	27.1%	17%	1.8	1.1-3.0**
Expects you to ask permission before seeking health care for yourself	58.5%	34.7%	1.8	1.1-2.7***

*p=0.05, **p=0.02, ***p=0.008

“My mother doesn’t care about me the way she does about my brother. I have to do everything myself including cooking, cleaning, washing and ironing while my mother does everything for my brother. One day I said to her in tears, “Mum, I am angry that I have to do everything by myself and you do everything for my brother.” She thought about that and started to take care of me for a while, but then it went back to the same thing. I think she does that because she thinks she can depend on him when she gets old, but not on me because I have a disability.” (IDIPP5)

Household physical violence

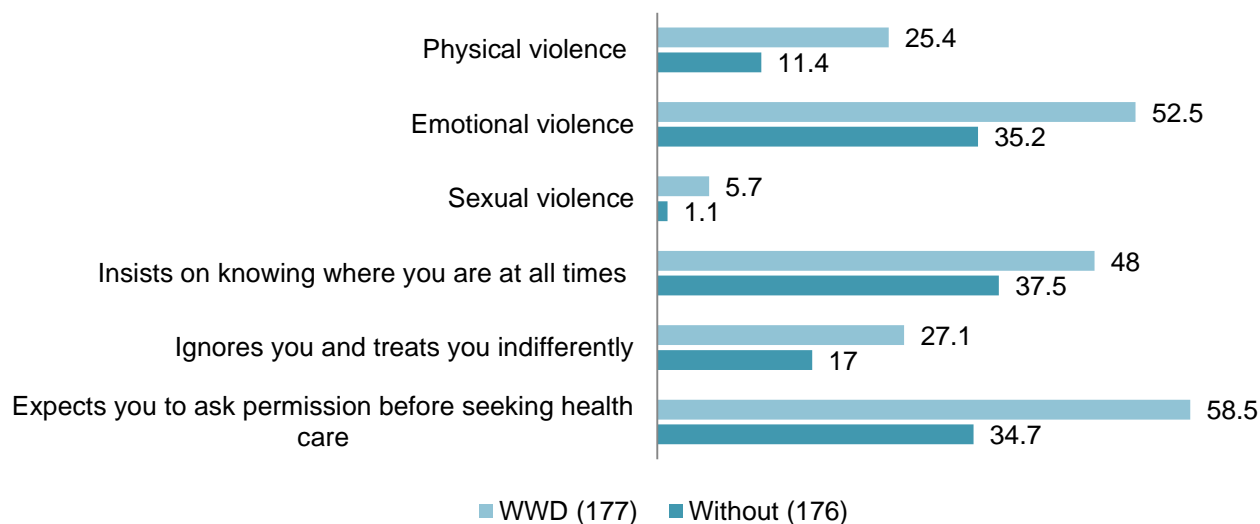
Significantly more women with disabilities reported being slapped or having something thrown at them by a family member than did non-disabled women (9.6 per cent or 17/177 compared with four per cent or 7/176). They were also more likely than non-disabled women to be pushed, shoved, hit with a fist, or otherwise hurt. For example, for women reporting being hit or otherwise hurt, 15 per cent were women with disabilities, compared to 5.7 per cent of non-disabled women (p=0.003; OR= 8.61, 95 per cent, CI 1.40-6.37). These differences were all highly statistically significant. However, no significant differences between the two groups were found on questions asking about more severe forms of violence such as being kicked, dragged or beaten; choked; burnt on purpose; or being threatened with or actually assaulted by someone using a gun, knife or other weapon.

“My mother hit me many times. I don’t know the reason at all. But I do remember that she wasn’t happy that I couldn’t do things like other people. She didn’t understand I couldn’t see like other people, but I really tried my best. I was really suffering and couldn’t stay with my parents any longer. I ran away to an NGO in Phnom Penh where my eyes were operated on. My aunt found out about this and sent me back home even though I didn’t want to go.” (IDIPP4)

Non-partner sexual violence

More women with disabilities (5.1 per cent, 9/177) than those without (1.1 per cent, 2/176) also reported being physically forced to have unwanted sex by someone other than a partner. This difference was statistically significant ($X^2= 4.55$ with 1 df, p=0.033; OR=4.66, 95 per cent CI .99-21.88).

Graph 2: Disability by household violence or coercive control (%)



Graph 2 above summarises the data on household emotional, physical and sexual violence, highlighting the differences in the extent of violence experienced by women with disabilities and their peers without a disability.

Injuries as a result of violence by household/family members

Women with disabilities were more likely to report injuries resulting from household violence than non-disabled women (18.8 per cent, 33/176 compared with 8.5 per cent, 15/176). This difference was highly statistically significant. Most injured women (82.9 per cent, or 34/41) received no health care for their injuries. This amounted to 85.2 per cent or 23/27 of women with disabilities and 78.6 per cent or 11/14 of women without disabilities. This difference is not statistically significant. No one in either group who reported injury had ever been hospitalised.

Only 21.7 per cent (5/23) women had told a health worker the real cause of their injury (i.e., it was inflicted by a household member). The vast majority, 78.3 per cent (18/23), had not disclosed how they acquired their injury (81.3 per cent, or 13/16, of women with disabilities and 71.4 per cent, or 5/7 of women without disabilities). The difference is not statistically significant.

The vast majority of women, 80.5 per cent (91/113), reported that the violence against them by a family member had had an impact on their physical or mental health. This response was more common for women with disabilities (92.1 per cent (58/63) compared to 66 per cent or 33/50 of women without disabilities). The difference was highly statistically significant and the odds ratio (OR=5.97, 95 per cent CI 2.02-17.68) shows that women with disabilities had an almost six-fold increase in their odds of reporting an adverse impact on their health as a result of violence by a family member than women without disabilities.

“One time [after being beaten by my father] I became unconscious. I have had serious physical injuries from my waist down. He used to beat me very seriously. Sometimes he would slam me against the wall. He has beaten me countless times. It is the most painful when he threatens me, that “I will certainly beat you tomorrow”. I become frightened, in pain and also afraid of him.” (IDI SRU4)

Most common perpetrators of household or non-partner violence

No significant differences were found between women with disabilities and those without, as far as perpetrators of household violence were concerned, so results for the most common perpetrators for the total sample are presented here in rank order.

Of all those affected by household violence, 49 per cent (24/49) nominated a father or mother as the perpetrator, 31.3 per cent (15/48) reported another male family member, 27.1 per cent (13/48) nominated another female family member, 6.3 per cent (3/48) nominated a stepfather or stepmother. No participants nominated a teacher, police/soldier, male friend of family, female friend of family, boyfriend, stranger, someone at work, or priest or religious leader.

Patterns of disclosure and seeking help

Patterns of disclosure for partner violence

Of the women who responded to questions on disclosure of violence, 54.4 per cent (31/57) had told no one about their partner's violence. This was more prevalent among women with disabilities (68 per cent, 17/25) than women without disabilities (43.8 per cent, 14/32).

For those who did disclose, brothers and sisters were the most common confidante, with 33.3 per cent (19/57) of the sample nominating them (44 per cent or 11/25 of women with disabilities and 25.0 per cent or 8/32 of those without disabilities). Nearly a quarter of the total sample (24.6 per cent or 14/57) had told their parents about violence (28 per cent or 7/25, of women with disabilities, and 21.9 per cent or 7/32 of non-disabled women, the difference is not statistically significant). Some 21.1 per cent (12/57) of the total sample had told neighbours (32.0 per cent or 8/25 of women with disabilities compared with 12.5 per cent or 4/32 of those without, revealing a clear trend).

The next most common confidantes were local leaders (12.3 per cent, 7/57), police (5.3 per cent, 3/57), a doctor or health worker (7 per cent, 4/57), priest/religious leader (zero per cent), counsellor (3.5 per cent 2/57), NGO or women's organisation (1.8 per cent, 1/57), disability organisation (1.8 per cent, 1/57). Only one of the 25 women with disabilities had contacted a disability organisation.

"I just told my relatives. I never told the local authorities about my husband's violence. I didn't want to break the relationship, so I just tried to be patient and live with him. His father is the vice-chief of the village, but he never educated his son not to do such bad things. I have never told other people because they will not think it is true, and since my father-in-law is the vice-chief, most people in the community respect him. They are afraid that they will not be invited to participate in the community or receive gifts." (IDIBB5)

Patterns of disclosure of violence for family violence

Of all the women who answered the questions regarding disclosure of family violence, 57.1 per cent (52/91) had told no one at all (55 per cent or 33/60 of women with disabilities and 61.3 per cent, or 19/31, of women without disabilities, not statistically significant). Parents were identified as the people confided in by 23.1 per cent (21/91) of the sample (23.3 per cent or 14/60 of women with disabilities and 22.6 per cent, or 7/31, of women without disabilities). Friends were nominated by 20.9 per cent (19/51) of all women (20 per cent of women with disabilities, or 16/60, and 22.6 per cent of those

without, or 7/31). Neighbours were identified by 20.9 per cent of the sample with no significant differences between women with disabilities (20 per cent, 12/60) and those without (22.6 per cent, 7/31).

A brother or sister was nominated by 18.7 per cent (17/91) of the sample. Some 15.4 per cent told an uncle or aunt.⁵ A doctor or health worker was nominated by 4.4 per cent (4/91) of the sample, but none of these were women with disabilities (0/60 compared with 12.9 per cent, or 4/31, of those without disabilities). This represents a highly statistically significant difference ($X^2=8.09$ with 1 df, $p=0.004$). Of the sample, 3.3 per cent (3/91) had told a local leader, one of these was a woman with a disability (ns). Similarly, 3.3 per cent of women had disclosed to a disability organisation. All three were women with disabilities (ns). Only one woman with a disability from the total group who responded to this question had disclosed to police (1/90). No women in the sample of those subjected to violence from a family member had disclosed to a priest, a counsellor, an NGO or women's organisation.

Of the sample, 11.1 per cent (10/90) had disclosed to some other person: 5 per cent (3/60) being women with disabilities and 23.3 per cent (7/30) being women without disabilities, representing a highly significant difference between the groups ($X^2=6.80$ with 1 df, $p=0.009$).

Table 7: Disclosure of violence

	Partner Violence %		Family Violence %	
	Women with disabilities	Women without disabilities	Women with disabilities	Women without disabilities
Nobody	68	43.8	55	61.3 (ns)
Parents	28	22 (ns)	23.3	22.6 (ns)
Siblings	44	25 (ns)	20	16 (ns)
Neighbours	32	12.5 (trend)	20	22.6 (ns)
NGO / women's group	1.8	1.8	0	0

Sources of help seeking for partner violence

Participants were asked whether they had ever sought help from a range of people when faced by violence by a current or former partner. The small numbers of women who responded in the affirmative to these questions indicates the need for caution when interpreting the results. None of the differences between the groups of women were statistically significant. Thirty per cent of women with disabilities (6/20) had contacted a local leader for help and 23.3 per cent of women without disabilities (7/30) had done so. Fifteen per cent of women with disabilities (3/20) sought help from police and 6.7 per cent of women without disabilities (2/30) did so. No women with disabilities had contacted a women's organisation; 6.7 per cent (2/30) of those without disabilities had done so. Only one woman with a disability and one without had contacted a hospital or health centre. Only one woman with a disability had contacted social services and no

⁵ Note that these figures are not broken down for disability/number distribution.

women without disabilities had done so. No women from either group had contacted a legal advice centre, court or shelter. Only one of the 50 women who responded to the question had sought help from a disability support organisation and not surprisingly, she was a woman with a disability (ns). No other sources of help seeking were cited by either group.

Sources of help-seeking for family violence

Participants were asked whether they had ever sought help when they faced violence from a member of their household. Differences in help-seeking between women with disabilities and those without were negligible, indicating that household-related violence is even less likely to result in any help-seeking by victims than partner-related violence. Only two women sought help from the police and both were women with disabilities. No women from either group sought help from a hospital or health centre, social services, a legal advice centre, a court or a priest or religious leader. Two women sought help from a shelter and neither were women with disabilities (ns). Local leaders were contacted for help by almost the same proportion of women with disabilities (5.6 per cent or 3/54), and those without (5.7 per cent, or 2/35) (ns). Only one woman sought help from a women’s organisation and she was a woman with a disability. Two women, both of whom were women with disabilities, sought help from a disability support organisation (ns). No one from either group identified any other source of help they had used.

Table 8: Sources of help-seeking for partner and family violence

	Partner Violence %		Family Violence %	
	Women with disabilities	Women without disabilities	Women with disabilities	Women without disabilities
Police	15	6.7	2.3	0 (ns)
Local Leaders	30	23.3 (ns)	5.6	5.7 (ns)
Shelter	0	0	0	2.2 (ns)
NGO/ Women’s org	0	6.7 (ns)	2.3	0 (ns)

These findings show very low levels of disclosure overall and help-seeking, with family members or neighbours being the most common confidantes. Those providing services in the community such as police, doctors or health workers, counsellors, NGOs, women’s organisations or disability organisations were much less common recipients of a disclosure of partner and family violence or a source of help. There were no significant differences in disclosure patterns regarding partner violence between women with disabilities and women without disabilities.

Childhood sexual abuse

Participants were given a card with two pictures at the end of the interview, the first of which was a sad face and the second, a happy face. They were then asked to put a mark next to the sad face if anyone had ever touched them sexually or made them do

something sexual before the age of 15 years. According to their responses, 13.1 per cent (46/350) had experienced some form of sexual abuse in childhood. As the responses on the cards did not contain identifying information it was not possible to use these to compare the prevalence of such abuse between women with disabilities and those without. However qualitative data demonstrates that in at least some of the cases of childhood sexual abuse, family members took advantage of the girl specifically because she had a disability.

“One day when I was 13 my parents went out and my grandfather was responsible for looking after me. He turned on the TV very loud so that the neighbours could not hear. He took the opportunity to rape me. I told my parents about it. My grandfather rejected it and said I was stupid. I showed them the evidence of blood on my skirt, and then he admitted that it was true. He promised not to do it again. So the problem was solved by compromising. At this time I suffered a lot, and my father also suffered. In contrast my mother didn’t understand my suffering and said, “It is a good time for you to take some pills.” I really suffered at that suggestion. The second time my grandfather tried to do this I was 18 so I could help myself by kicking him. He ran away. Then I told my parents about what had happened but my grandfather did not admit it. I repeatedly said what had happened. Finally my grandfather said, “You are blind and so you won’t have a chance at having a husband.” This was the point that he admitted that he did it. He said sorry and asked me to accept his apology, but I couldn’t. It was the second time. Then he ran away to another province because he was afraid that I would file a complaint. I’ve been told that he now has another young wife and a few children.” (IDIPP4)

Discussion: higher levels of violence against women with disabilities needs to be addressed

Approximately one-quarter of all women surveyed had experienced physical violence perpetrated by a partner. This aligns with the study by Yount and Carrera (2006) but is higher than the figure of 17.5 per cent from the 2004 Kishor and Johnson multi-country study. It also aligns with the finding from the 2005 violence against women survey from the Ministry of Women's Affairs of 22.5 per cent women who have experienced domestic violence. Nevertheless, it remains possible that the actual experience of family or partner violence remains even higher, given the likelihood of under-reporting and the significant cultural acceptance of violence against women.

The results of both quantitative and qualitative analysis on gender-based violence amongst Cambodian women with disabilities demonstrate that, compared with women without disabilities in the sample, women with disabilities experience significantly higher levels of emotional, physical and sexual violence by household members other than partners. It is clear that women with disabilities are considered less valuable and more burdensome than family members without disabilities and that the home is an extremely risky environment, possibly more so for women with disabilities in urban areas than those in rural areas. The finding that women in rural areas reported less violence perpetrated by a family member than that reported by women in urban areas is interesting and worth further investigation. While the WHO Multi-country Study also found that women in rural areas experience lower levels of non-partner violence than women in cities (WHO 2005: 85), it is not accurate to say these studies entirely support each other as our study included half women with disabilities, and women with disabilities were not specifically targeted in their study.

Our study found that women with and without disabilities experience similar levels of partner violence, in contrast to a WHO meta-analysis which found that people with disabilities were 1.5 times more likely to experience partner violence compared to their peers without disabilities. A possible explanation for this is that comparing the two studies is not comparing like with like: the WHO study was a global meta-analysis, did not focus on the developing world, and did not focus solely on women. Though women with and without disabilities experience similar levels of partner violence, women with disabilities are more likely to experience higher levels of psychological distress compared to their peers without disabilities and are less able to disclose family violence or seek appropriate support. Formal support-seeking for all women who participated in this research project is low, indicating that services are both scarce and difficult to access. Barriers to access include the belief that violence against women with disabilities is normal and intervention to stop violence is not worth the time. Community members often exclude women with disabilities and fail to provide them with support. NGOs lack

understanding of how to identify and reach women with disabilities, lack capacity to communicate with women with disabilities, and may be physically located in inaccessible buildings. Considering the levels of violence and discrimination experienced by women with disabilities, profound improvements to services and attitudes are urgently needed.

Examples from a number of developing countries demonstrate that low-cost, easy-to-implement solutions exist for effective inclusion of women with disabilities in women-specific programs. In Uganda and India, activities which have made a great impact on access to sexual and reproductive health care services for all women with disabilities in the service provision area, at a marginal cost, include:

- sensitisation of service providers
- supporting women with disabilities to share their concerns with community workers
- training women with disabilities to act as liaison points and advocates for, and counsellors of, other women with disabilities (Maxwell et al. 2006).

Limitations of this study

The results of this study, while coming a long way in providing a quantitative picture of violence experienced by women with disabilities in Cambodia, is, due to its design, not a random sample of Cambodian women with disabilities. Participants were chosen based on their existing affiliations with the Cambodian Disabled People's Organisation and therefore may already reflect a more 'empowered' group of women with disabilities than those not currently linked in to a disabled people's organisation.

The research team found it challenging to gather information from deaf women and women with intellectual disabilities. As few deaf women, particularly in rural areas, speak sign language, communicating a large amount of quantitative data was a barrier. This was also the case for women with intellectual disabilities. The research team attempted to compensate for these shortcomings by gathering information from deaf women and women with intellectual disabilities through qualitative methods such as the life narrative approach. However, the prevalence of information on violence should be interpreted with caution for this group.

Finally, due to the small percentage of women who reported confiding about either partner or family violence, or seeking support for violence (in some cases only one or two women), the data on reporting of violence and support should also be interpreted with these considerations in mind.

Implications for donor agency policy

It was clear during our research that AusAID's championing of the rights of people with disabilities was having a significant impact in terms of drawing attention to the issue and catalysing change in policy and programming. We recommend that donors provide funding specifically for activities which address the intersection of gender and disability, support organisations to develop policies and programs to identify and reach women with disabilities, and also consider other factors such as minority ethnic group membership and children.

Implications for GBV and disability policy

The results of this research demonstrate that women with disabilities are equally vulnerable to partner violence, and much more vulnerable to family violence than their peers without disabilities. National policies on gender-based violence should consciously include strategies for preventing all forms of violence against women with disabilities. Depending on the national strategy, this could mean including women with disabilities in existing VAW strategies, ensuring data collection mechanisms are sensitive to disability (and ensuring that disaggregation of such data is possible), and providing dedicated programs to change attitudes of family members towards women with disabilities. Considering that a national study on violence against women is currently being planned and the next *National Plan of Action on Violence against Women* is being developed, it is critical that stakeholders specifically address the intersection of gender and disability in these activities.

This research project employed an innovative survey tool (a composite of WHO VAW survey, SRQ 20, and Washington City Group Questions on Disability). With further piloting this could be used to collect national statistics on violence against all women, including women with disabilities.

Disability policies do not yet take into account the physical and mental health consequences of violence which can lead to disability. Disability policy-makers could work with gender policy makers to ensure these intersections are adequately addressed in both policies.

Implications for GBV and disability programming

GBV programmers should also consider developing activities that address the specific challenges that women with disabilities face with regard to violence including those associated with high levels of violence-related psychological distress so evident in the current study (Astbury, 2012). It is clear from the results of this research project and from existing data that women with disabilities, though more vulnerable to violence, are not adequately included in prevention of violence campaigns or support services. There is currently a strong focus on violence perpetrated by partners, though our results indicate that women with disabilities not only face much higher levels of family violence but are also extremely unlikely to seek help for family violence. Public education and community awareness programs around violence should expand their focus from partner violence to also address family violence. This will empower both victims of violence and other community members to be able to correctly identify situations where violence (including coercive or controlling behaviours) is perpetrated by family members.

As much of the disclosure of violence is to family members, neighbours, and others in close proximity to the women experiencing violence, it is recommended that awareness-raising on violence against women, and especially women with disabilities, begins within communities. Targeted education programs on providing support and referrals would also boost the capacity of existing informal support networks to address violence more effectively. Another strategy is to develop public campaigns. For example, national days on eliminating violence against women with disabilities should be considered.

Village leaders, as one of the few groups of people to whom women disclose violence outside of their family and neighbours, are also an important target group. There is an

urgent need to change complacent and discriminatory attitudes which accept violence against women as normal. The community training tool developed by the Triple Jeopardy project is available for all organisations to use to bring about transformative change in attitudes and behaviours in both bystanders who can help women suffering violence and perpetrators of the violence.

Trauma-related counselling to respond to the psychological distress associated with partner and family violence needs to be made more readily available and accessible to women with disabilities. Special attention must be given to the difficulty women with disabilities may face in being able to access health care or counselling for themselves without having to ask permission from others, especially when the family member they need to seek permission from is the perpetrator of the violence and has a vested interest in preventing them from seeking health care.

Education on sexual and reproductive rights, as well as access to appropriate anti-violence and support services are key areas where empowering women with disabilities would make a huge impact on their ability to control life choices and increase well-being (CBM 2007).

GBV programs should also consider the specific infrastructural, communication or other barriers that women with disabilities may face in accessing their services and take appropriate steps to increase access. Finally, local authorities, police and courts need training on the rights of people with disabilities to improve implementation of existing laws. Other initiatives to improve general access to justice will need to be complemented by a specific focus on access of people with disabilities to ensure that they do not remain forgotten.

Recommendations for future research

Research on violence against women, children and people with disabilities in developing countries is severely limited. Small-scale studies and qualitative information exists, however large studies on violence have yet to successfully include people with disabilities. This study contributes to evidence on violence against women with disabilities, but also demonstrates the importance and ease of designing national or large-scale prevalence studies that are disability sensitive. The researchers strongly recommend that future studies on violence include identifiers of disability.

As the results of this research show, it is clear that much of the violence against women with disabilities is perpetrated by family members. The women we spoke to shared stories of severe abuse dating back to their childhood and it is clear that girls with disabilities are extremely vulnerable to violence including childhood sexual abuse. It is also highly likely that men with disabilities are also vulnerable to family violence. Further research is urgently needed in this area in Cambodia, and in other developing country settings.

Specific studies with methodologies that are able to capture quantitative information from deaf women and women with intellectual disabilities need to be developed and piloted in developing country settings. As noted previously, this was a limitation of the Triple Jeopardy research project.

Finally, the project partners represented academic institutions, disability specific organisations, and gender specific organisations. This unique partnership ensured that

expertise was available in the areas of research, disability and gender, and that each partner learned new skills from the other, strengthening the research itself, and developing mutual capacity. This approach is recommended in future research that investigates intersections of violence.

References

- Astbury, J, 2003, 'Whose honour, whose shame? Gender based violence, rights and health', in L Bennett & L Manderson (eds) *Violence against Women in Asia: Gender Inequality and Technologies of Violence* Routledge, London, pp159-170.
- Astbury, J, 2009, 'Overview of the key issues', in J. Fisher, J. Astbury, M. Cabral & S. Saxena (eds). *Mental health aspects of women's reproductive health: A global review of the literature*, Geneva, WHO Press, World Health Organization and United Nations Population Fund, pp 170.
- Astbury, J, 2012, 'Violating the right to health: how partner violence and disability undermine women's mental health in Cambodia', Special issue on disability and mental health. *Journal of Disability and International Development*.
- AusAID, 2012, *Australia-Cambodia Joint Aid Program Strategy 2010-15*.
- Barett, KA, O'Day, B, Roche, A, and Carlson, BL, 2009, 'Intimate partner violence, health status, and health care access among women with disabilities', *Women's Health Issues*, 19, pp 94-100.
- CBM, 2007, *CBM Disability and Development Policy*, CBM, Bensheim.
- Fiduccia, BW, & Wolfe, LR, 1999, *Women and girls with disabilities: defining the issues*, Center for Women Policy Studies and Women & Philanthropy, Washington.
- Hughes, K et al, 2012, 'Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies', *Lancet*, 379 (9826), pp 621 – 1629.
- Kishor, S, and Johnson, K, 2004, *Profiling Domestic Violence – A Multi-Country Study*, Maryland: ORC Macro.
- Maxwell, J, et al, 2006, *A Health Handbook for Women with Disabilities*, Hesperian, Berkeley.
- Ministry of Women's Affairs, 2005, *Violence against women: A baseline survey*, Cambodian Ministry of Women's Affairs, Phnom Penh.
- Ministry of Women's Affairs, 2010, *Violence against women 2009 Follow up survey: Final study report*, Cambodian Ministry of Women's Affairs, Phnom Penh.
- Ministry of Planning, 2010, *Achieving Cambodia's Millennium Development Goals*, Cambodian Ministry of Planning, Phnom Penh.
- Mohapatra, S, and Mohanty, M, 2004, *Abuse and activity limitation: A study on domestic violence against disabled women in Orissa, India*, Swabhimana, Orissa.
- National Institute of Public Health, National Institute of Statistics (Cambodia), and ORC Macro, 2006, *Cambodia Demographic and Health Survey 2005*, Phnom Penh, Cambodia and Calverton, Maryland, USA: National Institute of Public Health, National Institute of Statistics and ORC Macro.
- Nelson E, and Zimmerman C, 1996, *Household survey on domestic violence in Cambodia*. Ministry of Women's Affairs, Project Against Domestic Violence, Phnom Penh.
- Rao, I, 2005, *Equity to women with disabilities in India*, CBR Network, Bangalore.
- Thomas, P, 2005, *Poverty reduction and development in Cambodia: Enabling disabled people to play a role*, DfID, London.
- UNDP, 2009, *Pacific sisters with disabilities: at the intersection of discrimination*, UNDP Pacific Centre, Fiji.
- UNESCAP, 1995, *Hidden Sisters: Women with Disabilities in the Asia Pacific Region*, Social Devt Division, Bangkok.
- UNESCAP, 2002, in Thomas, P, 2005, *Poverty reduction and development in Cambodia: Enabling disabled people to play a role*, DfID, London.
- Vos, T, et al, 2006, 'Measuring the health impact of intimate partner violence on the health of women in Victoria, Australia', *Bulletin of the World Health Organization*, 84, pp 739-744.
- Walji, F, 2009, 'Including women with disabilities in gender and disability policy: reflection on experiences in the Asia-Pacific Region', *Journal for Disability and International Development*, Bensheim.
- World Bank, 2007, *Measuring Disability Prevalence*, World Bank, Washington.
- WHO and World Bank, 2011, *World Report on Disability 2011*, WHO, Geneva.
- Yount, KM, and Carrera JS, 2006, 'Domestic Violence Against Married Women in Cambodia', *Social Forces*, 85 (1) pp 356-387.