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Relational, Ableist and Gendered Sites of Violence: Perspectives of Tanzanian Girls With Disabilities on Access to Sexual and Reproductive Health Services

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Abstract Adolescent girls' access to sexual and reproductive health services is a critical development issue in Tanzania where the intersection of disability and adolescence is compounded by barriers to sexual and reproductive health service access and socially normalised gender-based violence. Using the method of empathy-based stories, I explored the perceptions of 136 Tanzanian adolescent girls with disabilities of how gender-based violence and access to sexual and reproductive health services are intertwined. The findings demonstrate that the intersection of disability and adolescence within sexual and reproductive health services render invisible various forms of violence, which are not only gendered but also ableist. Recognising access to sexual and reproductive health services as a distinct site of violence and addressing the issue in relevant policies and programmes could strengthen the sexual and reproductive health of girls with disabilities. Through an Afrocentric perspective, the findings contribute to the current theoretical constructs used to study disability and development. They call for a reconsideration of relational dynamics in the context of accessible and protected sexual and reproductive health services.

Keywords: sexual and reproductive health and rights; access to sexual and reproductive health services; gender-based violence; adolescence; disability; Tanzania

1. Introduction

This article is situated at the nexus of scholarly literature on development and disability studies (Grech and Soldatic, 2016; Katsui and Chalklen, 2020; Shakespeare, 2014), and within the conceptual development of violence in the context of sexual and reproductive health services (Chadwick, 2021; Lappeman and Swartz, 2021; Laverty and de Vos, 2022; Wudneh et al., 2022). It draws on the understanding that ensuring access to safe, accessible, and good quality adolescent sexual and reproductive health services is critical for sustainable development (Starrs et al., 2018).

The Sustainable Development Goals' target 3.7 calls for universal access to sexual and reproductive health services, and the United Nations (UN) Convention on the

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Rights of Persons with Disabilities (CRPD) stipulates obligations to make sexual and reproductive health services available to persons with disabilities on an equal basis with others (UN, 2006, art. 25). Moreover, the UN Committee on the Elimination of Discrimination against Women (CEDAW) general recommendation No. 35 states that 'abuse and mistreatment of women and girls *seeking sexual and reproductive health information, goods and services*, are forms of gender-based violence' (CEDAW, 2017, emphasis added). In this vein, addressing violence against adolescents, and improving adolescent sexual and reproductive health services have been identified as key priorities in research on sexual and reproductive health and rights in Africa (Ali et al., 2018).

Despite ambitious international policy frameworks, the available evidence from African contexts demonstrates that although adolescents with disabilities have unique, and at times greater needs for sexual and reproductive health services, they often face challenges accessing them (Burke et al., 2017; Obasi et al., 2019; Rugoho and Maphosa, 2020). Furthermore, girls with disabilities are at an increased risk of gender-based violence (Bangura et al., 2021; Carew et al., 2017; Meer and Combrinck, 2015; Njelesani, 2018; Wudneh et al., 2022). Additionally, it has been established that in various contexts violence influences the access of persons with disabilities to sexual and reproductive health services (Mesiäislehto et al., 2021; Patel, 2017; Tilley et al., 2012; Wudneh et al., 2022).

Using empathy-based stories (EBS) as a method to study the perspectives of Tanzanian girls with disabilities, I explore gender-based violence in the context of access to sexual and reproductive health services. I ask, how is gender-based violence and access to sexual and reproductive health intertwined, and specifically, how could the intersectional perspectives of disability, adolescence and gender inform the contextualised conceptualisation of violence and provision of sexual and reproductive health services. The topic is especially significant in the context of Tanzania, a country with multiple international and national commitments to sexual and reproductive health and rights of adolescent girls with disabilities and an expanding adolescent population, which is expected to double by 2050 (United Republic of Tanzania, 2018). Thus, addressing adolescents´ sexual and reproductive health and rights in a way that reduces social inequalities will have an impact on the future of the nation (Neal et al., 2020).

Moreover, the intersection of disability, adolescence and gender remains largely unexplored in Tanzania, and is limited to only a few studies (Mbwilo et al., 2010; Ngilangwa et al., 2016; Quinones et al., 2021; Sanga et al., 2022). As the gender-based violence experienced by adolescents with disabilities in Tanzania remains largely unknown, recognition, prevention and addressing it is difficult. In Tanzania, adolescence is characterised by limited access to sexual and reproductive health services (Mchome et al., 2015; Nkata et al., 2019), and it has been suggested that negative adolescent sexual and reproductive health outcomes are exacerbated by disability (UNICEF, 2021). Furthermore, the standpoints of Tanzanian adolescent girls in the context of accessing sexual and reproductive health services remain underrepresented

in research as well as in a society. This excludes the perspectives of this population from contextualised understanding of the links between access to sexual and reproductive health services and gender-based violence.

This article is divided into six parts. First, I introduce the conceptualisations of disability and violence. Second, I present the structural factors specific to the Tanzanian context. Third, in the methods section I present practices of knowledge production, researcher positionality, ethical considerations and limitations of this study. Fourth, I provide the results of the analysis. Fifth comes the discussion of the conceptual advancement following on from the results, and finally I conclude with implications for development and disability research, policy and practice.

2. Definitions of concepts and theoretical inspirations

Disability is a multifaceted, complex phenomenon. It is a manifestation of human diversity that varies across different contexts (Katsui and Chalklen, 2020). Lack of welfare regimes and formal safety nets often characterise the experience of disability in global South contexts (Grech, 2011, p.91) where 80 per cent of the world's persons with disabilities live (WHO and The World Bank, 2011). Unique aspects related to disability in the global South and the human rights paradigm introduced by the CRPD have intertwined disability and development (Katsui and Chalklen, 2020). The CRPD continues to frame the efforts and scholarly work on advancing the well-being of persons with disabilities globally. Its narrow and largely global North-oriented perspectives to disability, however, are increasingly being criticised for lacking engagement with local knowledges and strength-based strategies (Abbay, 2015; Grech, 2011; Grech and Soldatic, 2016; Oyaro, 2015; Rao and Kalyanpur, 2020).

According to the CRPD, disability results from the interaction between an individual's impairment, and personal and environmental factors (UN, 2006), a definition which is employed here. Furthermore, the intersectional understanding of disability, in relation to gender and adolescence (Baird et al., 2021; Larson et al., 2016) is useful for expanding our understanding of the multifaceted experience of disability and related intersecting and unique forms of dis/advantage (McCrae, 2019). One such disadvantage is lack of recognition for adolescent girls with disabilities as knowers which perpetuates epistemic violence against them (Dotson, 2011; Ndlovu-Gatsheni, 2018; Ned, 2022). Disregarding the intersectional perspectives of violence in the context of accessing sexual and reproductive health services may risk this epistemic violence being translated into other forms of structural and systemic violence (Ned, 2022, p. 486).

Gender-based violence matters to girls and women, families and societies, and our common future. I approach gender-based violence primarily as an international development issue, an impediment to the progress towards equality for persons with disabilities (UN, 2015; Starrs et al., 2018). The UN General Assembly (1993) defines gender-based violence as 'any act of violence that results in, or is likely to result in, physical,

sexual or psychological harm or suffering to women'. The concept of violence within sexual and reproductive health services is developing rapidly (e.g. Chadwick, 2021; Lappeman and Swartz, 2021; Lévesque and Ferron-Parayre, 2021) and a definition of violence that embeds the individual, structural and policy levels has proven useful (Freedman et al., 2014; Lappeman and Swartz, 2021). Violence can be understood as structural and when woven into the fabric of society it perpetuates social and health inequalities (Farmer, 2013; Sadler et al., 2016, p. 50). Structural violence manifests at organisational and relational levels yet is also felt deeply by individuals (Lappeman and Swartz, 2021). Individuals may also become perpetrators within systems of oppression even when they do not wish to harm others (Farmer, 2013; Lévesque and Ferron-Parayre, 2021) and when their institutional roles are complicated by their personal feelings (Dubois, 2017). The relational sociology (Emirbayer, 1997) and the feminist ethics of care paradigm (Kittay, 2011) shift attention beyond the singular and normative understanding of violence, based on the international human rights standards, to the *relational and contextual nature* of the networks of care and violence (Held, 2010).

The contextualised view is also critical from the perspective of disability. In many African contexts the exclusion of persons with disabilities is embedded in the geopolitical and historical contexts and colonial histories (MacLachlan & Swartz, 2009). This has resulted in persons with disabilities being neglected in daily living (Ned, 2022) and lacking protection (Nyamnjoh et al., 2022). The experiences of violence of children with disabilities and their protection from violence are increasingly theorised from Afrocentric perspectives as opposed to the dominant Eurocentric or Western perspectives (Bannink Mbazzi et al., 2020; Nyamnjoh et al., 2022). These Afrocentric perspectives draw from African communitarian philosophy (Menkiti, 1984; Gyekye, 1987; 2004) that outlines the understanding of personhood – the basis of human worth and entitlement to protection – as thoroughly social and community-based (Etieyibo and Ikuenobe, 2020). The potential of these theoretical advances lies in their ability to affirm human worth and the community's obligations towards the protection of girls with disabilities from violence based on thoroughly African perspectives (Imafidon, 2021).

The scholarly developments described here have framed the exploration of the studied phenomenon through an Afrocentric and relational lens in a largely uncharted scholarly terrain. Next, I contextualise the structural violence in the Tanzanian context of accessing sexual and reproductive health services, after which I present the methodological approaches to addressing the epistemic injustice of the studied adolescents.

3. Setting the scene: Intersection of disability, adolescence, and gender in Tanzanian sexual and reproductive health landscape

The challenges that Tanzanian adolescent girls with disabilities face in terms of access to sexual and reproductive health services are set against a landscape of complex

political, discursive and social norms (Bylund et al., 2020; Sambaiga et al., 2019). Tanzania was among the first signatories of the CRPD and the Optional Protocol in the East African region (Mitra, 2018). The nation is committed to multiple international legal and policy instruments that reaffirm its obligations to respect, protect and fulfil the sexual and reproductive health and rights of girls with disabilities as well as to ensure their freedom from violence.[1] Nevertheless the intersection of adolescence and disability remains ambiguous in policies and legislation, which place disability under the broader 'vulnerable groups' category, ignore unique forms of disability-specific violence and disregard disability-specific actions.

For instance, the National Health Policy Health Sector Strategic Plan (HSSP IV) and the Adolescent Health and Development Strategy of 2018–2022 set the standard that adolescents, irrespective of their disability, have a right to access sexual and reproductive health services that are appropriate and relevant for their needs. These standards, however, lack a definition of the terms 'relevant' or 'appropriate', and contain no specific guidance for adolescents with disabilities as service users. The above shortfalls are also present in the Tanzania National Plan of Action to End Violence against Women and Children (NPA-VAWC 2017/2018-2021/2022) (United Republic of Tanzania, 2016) which is currently being updated.

The social and gender norms related to disability often have a greater influence than policy and legislation on how persons with disabilities, and their sexual and reproductive health, are perceived in their communities (Onazi, 2020; Peta, 2017). These norms often exclude Tanzanian adolescents with disabilities from community life, deny them access to education, and lead to various negative health outcomes (Aldersey, 2012; Quinones et al., 2021). Furthermore, extensive evidence indicates that the stigma towards adolescents in sexual and reproductive health services is prevalent in Tanzania and hinders the access of adolescents, including those with disabilities, to sexual and reproductive health services (Mbeba et al., 2012; Mesiäislehto et al., 2021; Nyblade et al., 2017). Gender-based violence against adolescents is socially normalised in Tanzania (Abeid et al., 2014; Mlyakado and Li, 2019). Furthermore, evidence that women and girls with disabilities are disproportionately affected by gender-based violence is gradually accumulating (ADD International, 2016; Greenwood et al., 2016). Like other forms of gender-based violence in Tanzania, violence in sexual and reproductive health care settings is widespread and systematic in nature and is rooted in patriarchal structures and gendered stereotypes (Kujawski et al., 2015; Sando et al., 2016).

1 UN Convention on the Elimination of Discrimination against Women (CEDAW) (1979), UN Convention on the Rights of the Child (CRC) (1989), Agenda 2030 for Sustainable Development (2015); International Conference on Population and Development (ICPD) Programme of Action (1994), Nairobi Statement ICPD+25 (2019), Maputo Protocol (2003), and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (2018).

The above contextual and structural factors tend to marginalise girls with disabilities in Tanzanian society. However, how these factors are manifested in relational terms and at the individual level remains largely unknown. This article examines the largely unexplored epistemic standpoints of Tanzanian girls with disabilities to gain a more comprehensive understanding of this topic and to counteract the coloniality of knowledge production.

4. Methods

This study is grounded in the constructivist paradigm (Denzin and Lincoln, 2018) and aims to understand the social world of its participants. In my quest for rich exploratory data, I used qualitative participatory disability research methodology. A research triad consisting of the researcher, a Tanzanian research advisory committee and a Tanzanian research assistant with disabilities was established in collaboration with the Tanzania Federation of Disabled People's Organisations. This cross-disability triad ensured that persons with disabilities maintained an active stance throughout the research, which was crucial for developing appropriate methods, interpreting data, and validating the results (Grischow et al., 2021; Kuper et al., 2021; Wickenden and Kembhavi-Tam, 2014). The expert members of the committee had knowledge of the status of girls with disabilities beyond their own experiences, making them insightful sources of information (Katsui and Mojtahedi, 2015; Sanderson et al., 2013).

My position as a European woman in her fourties, a development studies scholar, and a mid-career international development professional has influenced the research to some extent. However, the participatory research design, residing in Tanzania for over nine years and the experiences in engaging with adolescents with disabilities in community development programmes proved useful in making sense of the studied phenomena. As I do not share the experience of disability with those whom I have collaborated with in this research I practiced self-reflexivity to recognise and avoid assumptions based on my own experiences. Although my mind was already ideologically wired into the human rights ideology, my long-term presence and experiences in Tanzania allowed me to critically reflect on it.

A purposive sampling frame was established together with the research triad to identify and recruit the study participants. The data were collected in three regions across 13 locations. The participants were 136 girls with disabilities, aged 10–19. Some of these adolescents were deaf ($n = 42$), and one deaf participant also had physical disabilities. Some participants had physical disabilities ($n = 33$). Of those with albinism ($n = 32$) some also had partial vision ($n = 11$). Other participants had intellectual disabilities ($n = 13$), blindness ($n = 12$), and partial vision ($n = 4$).

The research employed the method of empathy-based stories, which is based on constructivist epistemologies, and sees reality as contextually and socially constructed (Eskola, 1997). Empathy-based stories (EBS) are fictional short stories narrated by study participants as a response to a frame story (Posti-Ahokas, 2013). Although

the primary focus of method of empathy-based stories is not to investigate the experiences of the participants, but rather their perceptions; it enables participants to disclose their lived experiences if they so wish. method of empathy-based stories is an ethically sensitive data collection method, as it allows participants to distance themselves from sensitive and stressful topics (Wallin et al., 2018).

The frame stories centred on two protagonists, Fatuma and Nuru, and two scenarios based on the common reasons that adolescent girls seek sexual and reproductive health services in Tanzania: pregnancy and sexually transmitted infections (STI) (Mbeba et al., 2012). To capture the perspectives of the participants, I used the following frame stories:

> Fatuma John is an 18-year-old girl with disabilities, and she is pregnant. She needs to attend the health clinic. After visiting the clinic, she feels happy and safe. Tell us what happened at the clinic that made her feel happy.
> Nuru Hassan is a 15-year-old girl with disabilities. Nuru has a disease in her private parts, and she is experiencing discomfort. She needs to see the doctor. In the meeting with the health professional something goes terribly wrong. Afterwards Nuru is really upset. Tell us what happened when she met the health professional. Tell us what disturbed her so much.

The frame stories were developed by the research triad and piloted prior to data collection. The stories were compounded with audio and visual aids. The participants took part in the storytelling verbally, by writing in Kiswahili or by using Tanzanian sign language. The verbally collected stories were transcribed verbatim and then translated from Kiswahili into English. The quality of the translations was monitored by the research triad. The data comprised 257 EBS narrated by the 136 girls with disabilities. The EBS were on average 902 characters long. In addition, two focus group discussions (FGD) (Breen, 2006) were held with the research advisory committee, during which preliminary results were discussed and final results were validated. This triangulation of the data from the EBS and the FDG strengthened the validity of the research and reduced researcher bias, as multiple streams of knowledge were utilised.

The design and methodology of the study were informed by various ethical considerations, such as ensuring the meaningful participation of persons with disabilities across different research phases and guaranteeing reasonable accommodation and accessibility (van der Heijden et al., 2019). To ensure informed consent, information sessions were held with the participants and their guardians on the research sites. An 'explain-back' protocol (Talevski et al., 2020) was used in the process of obtaining informed consent, followed by the written consent of the participants and their guardians. The National Research Ethics Committee at the National Institute of Medical Research in Tanzania granted ethical approval for this research.[2]

2 Ethical clearance reference NIMR/HQ/R.8a/Vol. IX/2970

The EBS were analysed as one entity beyond the division created by the story variations through an abductive data analysis approach (Timmermans and Tavory, 2022). This approach is exploratory and although guided by existing conceptual or theoretical frameworks, it does not attempt to fit findings into them; it leaves room for conceptual and theoretical contributions (Flick, 2017). This means that the current understanding of the forms of gender-based violence, as described above, was used as a basis. Then, the epistemic standpoints of the girls with disabilities were used to challenge these and gain a more comprehensive understanding (Kennedy and Thornberg, 2018). Thematic analysis (Vaismoradi et al., 2013) was employed to analyse the EBS. The appropriateness of the themes used for this paper was discussed with the research advisory committee until a consensus was reached on the following: forms of gender-based violence when accessing sexual and reproductive health services, inaccessible and inappropriate communication, and relational dynamics of accessibility and protection.

This study has various limitations. The study explored access to maternal and STI services as directed by the frame stories, thus a broad spectrum of other sexual and reproductive health services were excluded. Moreover, the limitation of the EBS was that they were mainly based on perspectives and not experiences. This, however, was also a strength of the method, as it enabled the studied adolescents to talk about a culturally contested topic related to an intimate sphere of human existence. If personal experiences had been investigated, this may have impeded participation in the research and excluded valuable perspectives. Moreover, although it has been evidenced that boys with disabilities are also subject to multiple forms of violence due to the gendered site of sexual and reproductive health services this study focused on the gender-based disadvantage of girls with disabilities. Increasing knowledge about violence against boys with disabilities and experiences of masculinity from an intersectional perspective should be included in future research to address gender binaries in disability research on gender-based violence (see Dolan, 2014; Ward, 2016).

5. Results

In this section, I present the results of the analysis as directed by the methodological choices related to the frame stories; adolescent pregnancy and STIs. First, the different forms of gender-based violence embedded in the EBS are discussed, then structural violence through the issues related to inaccessibility and inappropriateness of services are addressed, and finally, I reveal the findings related to the relational dynamics of accessibility and protection.

5.1. *Forms of gender-based violence when accessing sexual and reproductive health services*

Emotional violence as verbal abuse, threats of violence, and humiliation (Jewkes, 2010) was the most common account of violence linked to sexual and reproductive

health service access. The adolescents' EBS revealed that emotional violence could occur when seeking sexual and reproductive health services, at homes, *en route* to and at health facilities; by family and community members, friends, and health care providers. The participants' accounts entailed emotional violence based on social and gender norms. For instance, disability portrayed a person as a lesser human, and being an adolescent and unmarried was linked to not needing sexual and reproductive health services or being blamed for risky sexual behaviour.

> He [the doctor] may have abused her with words, he might have told her to get out and that the [laboratory] results were bad news. He might have told her to get out because she is a person with disabilities, so that another person can come in. This is because persons with disabilities are not loved.

Participant with physical disabilities, aged 16

> He [the doctor] may have said why did you go around so carelessly, and catch a sexually transmitted disease? Who do you think can treat you now?

Participant with albinism, aged 19

At times, the described emotional violence took the form of verbal abuse, neglect, and being ignored. This, compounded by the experience of physical pain, led to descriptions of despair.

> She feels bad because when she goes to pee, it hurts. Now the doctor laughed at her and used offensive words. Nuru was very irritated because of the pain and because the doctor laughed at her.

Participant with physical disabilities, aged 16

> I came home from the hospital as the doctor didn't listen to me. I had just been sitting there, very sick, my private parts were itching and in pain, but the doctor didn't listen to me, instead he ignored me.

Participant with blindness, aged 17

Emotional violence also took the form of refusal to provide services, withholding and delaying laboratory test results, or distorting the information related to the results. Emotional violence was intertwined with the fear of poor health outcomes or even complications leading to death.

> When I get in and explain to the doctor that I'm sick, that I'm feeling this way and that way, and he listens to me, but then he leaves me and goes out to attend to another person. But I was the first one here even before that person! Or after that he may tell me to wait as he is going to get his equipment. He leaves and when he gets back a lot of time has passed, and that's why a lot of patients lose their lives because the doctors don't really consider us patients.

Participant with blindness, aged 17

Economic violence is understood as denying access to and control over basic resources (Stylianou et al., 2013). This was also apparent in the EBS as the refusal of others to contribute financially to the transport or service costs depicted controlling resources needed to access sexual and reproductive health services. Economic violence also took the form of misinformation about the costs of the services, which caused stress due to uncertainty about whether the patient could afford the service. In several EBS, the studied adolescents described access being compromised due to cost-related issues.

> I may go to the hospital, and I'm told the treatment is five thousand shillings and when I go again, I'll be told it's fifteen thousand shillings. Now that will be bad.

A participant with blindness, aged 12

The EBS also included perceptions of sexual violence in sexual and reproductive health services. Sexual violence is defined as unwanted sexual comments, sexual acts and attempts of sexual acts (Valentine et al., 2019). Male sexual and reproductive health service providers in particular were described as having sexual intentions and suggestions. Their sexual temptations and propositions were carefully described by the studied adolescents in the context of interaction with the service provider.

> Instead of listening and treating her, the doctor was thinking of something else, or the doctor got tempted to have her. This lady only required treatment but the doctor needed something else.

Participant with physical disabilities, aged 15

> There are some doctors who are just crazy. You go to the hospital expecting to be treated but he starts doing other things instead of treating you. He starts telling you strange things. You get out of there angry and frustrated because you went there to seek medical treatment and not to be asked strange, silly questions or to be seduced.

Deaf participant, aged 14

The EBS also depicted interlinkages between financial dependence, economic violence and sexual exploitation. Some EBS indicated that the desire for privacy had led to the patient seeking services alone, without assistance, which in turn had resulted in exposure to sexual exploitation.

Overall, the studied adolescents' EBS shed light on why violence in sexual and reproductive health services often goes unnoticed, as power over them may be used to justify various forms of abuse and mistreatment. Evidence from other African settings aligns with my findings that this is a major concern in sexual and reproductive health services for persons with disabilities (McKenzie, 2016; Peta, 2017; Wudneh et al., 2022).

5.2. *Inaccessibility and inappropriateness of the services*

The EBS described inaccessibility of communication, information, transportation, and facilities hindering access to sexual and reproductive health services. Inaccessibility was perceived to complicate seeking, attaining, and engaging in one's sexual and reproductive health care. Health providers were portrayed in the EBS as unwilling to engage in alternative forms of communication; for instance, they would decline to use writing as a form of providing information or refused to speak directly to the deaf adolescent. This inaccessibility at times included accounts of violence; for instance, when measures that could have increased accessibility were intentionally withheld. Such actions may have long-term health implications and decrease individuals' use of services.

Accounts of violence were frequently compounded by inaccessible communication with the service provider and their lack of age-appropriate communication skills. When communication with the health care providers was insufficient, it could lead to having to just endure the health condition as demonstrated in what follows:

> My genitals are itching and hurting, and I haven't been given any medicine. As I've not been given medicine, my genitals will continue to burn and if I try to go to sleep, I can't […]. So, I continue to suffer. The condition is so bad because the doctor and I failed to understand one another. But if we could understand each other well, I'd be given medicine and it would heal.

Deaf participant, aged 17

Victim blaming is a concurrent theme across a range of sexual and reproductive health – related experiences of adolescent girls (Coast et al., 2019). It was also present in the EBS of the studied adolescents, compounded by the pervasive stigma towards adolescents as sexual and reproductive health service users (Nyblade et al., 2017), making the service they received inappropriate, as exemplified here:

> What disappointed her after the check-up and being told that she's sick, after hearing the results is when she felt bad and when she met a discriminating doctor who told her that you went around and look you caught sexually transmitted diseases, that's the reason why Nuru was not at peace and got angry.

Participant with albinism, aged 19

Victim blaming related to the experiences of disability, was also present in the EBS of the studied adolescents. For instance, Nuru, the protagonist, was blamed for not being able to express herself well enough, for not behaving politely enough, or not understanding the information provided by the sexual and reproductive health service providers.

> You can go to the hospital and get tested and then perhaps you're told that you have a certain kind of disease, of which you were not even aware. You leave the place feeling sad because you went there pregnant, and because you are a person with disabilities you were told that probably you have this and this condition. […] But because you can't express yourself, which is why you got the problem in the first place, and that happens mostly to people who fail to express themselves.

Participant with physical disabilities, aged 14

Such examples depict also internalised victim blaming, as a result of the services that due to inaccessibility and inappropriateness do not respond well to the characteristics of the studied adolescents. Such shortcomings of these services may result in further marginalisation of girls with disabilities.

5.3. *Relational dynamics of accessibility and protection*

The findings support the existing literature, which claims that despite many shortcomings, family and community remain the most reliable care and support system for marginalised children and persons with disabilities in many African and Tanzanian communities (Aldersey, 2012; Nyamnjoh et al., 2022; Onazi, 2020). Against this backdrop, the notion of accessibility in Article 9 of the CRPD, which conceptualises accessibility as an important aspect of *independent* living, appears peculiar, as in the EBS, accessibility was strongly linked to interdependence and relationality. It is also known that child protection approaches that emphasise individuals have not worked well in African settings because collective problem-solving is more socially accepted than individualised activities (Chilwalo, 2020; Mabeyo and Kiwelu, 2019). In line with previous research (Ringson and Chereni, 2020), the studied adolescents also described the pivotal role that informal support networks play in protection from gender-based violence in sexual and reproductive health services.

These findings presented unique relational modalities for accessibility and protection in situations where gender-based violence intersects with access to sexual and reproductive health services in the Tanzanian context. Rather than depicting formalised or institutionalised measures of accessibility, such as the provision of sign language interpretation, ramps, assistive technology, or facility-based assistive personnel, the EBS demonstrated reliance on their informal support networks. A deaf participant, aged 19, describes the informal relational aspects of accessibility in sexual and reproductive health services:

> There should be somebody there to interpret or write down this information. Because Fatuma is deaf and maybe she doesn't want to take the medication, but if she had somebody with her that understands that about her, and if she was given the right medication and was helped by that person, if she had somebody who knew sign language or somebody like a parent or a husband […] then they would assist her.

Although the studied adolescents' EBS depicted how inaccessibility involves others in the access to their care, making it a collective effort, they also highlighted that inaccessibility could disrupt the relationship with the service provider and lead to negative interpersonal experiences and disharmony. The EBS included accounts of solidarity and support of girls with disabilities that were situated in their communities, but in health care facilities, solidarity was scarce and not encouraged. This depicts a disconnect between the collective care available in families and communities, and the individualistic care at health facilities.

6. Discussion

In this section, I discuss how the perspectives of girls with disabilities challenge the current conceptualisations of gender-based violence, and suggest Afrocentric ways of rethinking violence through the lens of intersectionality, relationality and collective dynamics. This discussion is central, as it entails recognising the specific forms of gender-based violence against girls with disabilities in a specific site of violence and revaluing their perspectives.

6.1. *Perspectives based on disability, adolescence and gender as a generative force for reconceptualising gender-based violence*

Violence within sexual and reproductive health services often goes unnoticed and remains neglected in gender-based violence protection and response policies and standards, as is the case in the Tanzania NPA-VAWC. The specific gendered features of sexual and reproductive health care and its invisibility and intimacy, and the implications of such violence for further utilisation of sexual and reproductive health care services highlight the importance of further scrutiny of violence in such settings (Lévesque and Ferron-Parayre, 2021). Sexual and reproductive health care has been conceptualised as a sexist system as the gendered services are impacted by gender inequalities as supported by my findings (Lévesque and Ferron-Parayre, 2021).

This study found that, in addition to sexism, systemic ableism (Goodley, 2014) was a system of oppression in sexual and reproductive health services affecting adolescent girls with disabilities (Casebolt, 2020; Kabia et al., 2018). The views of the studied adolescents reflected services predominantly designed for ideal and 'able' service users – where 'able' is understood through a singular normative view. Such ableist assumptions embedded in sexual and reproductive health care result in inaccessibility, which inflicts 'physical and/or mental harm or suffering' (UN, 1993, definition of gender-based violence). Thus, I argue that in Tanzania, societal norms related to disability, adolescence and gender, embedded in the health system and policies, have established inaccessibility as a form of structural violence within sexual and reproductive health services for girls with disabilities. The various normalised modes of information and communication, and the inaccessible infrastructure discovered in this study in the particular context of sexual and reproductive health care support this claim. However, by rejecting the normalisation of inaccessibility, the perspectives of girls with disabilities and their knowledge related to gender-based violence in the context of sexual and reproductive health services can be revalued and the knowledge deficits will not lead to further structural and systemic injustices (Ned, 2022).

In addition to sexism and ableism, the present study raises the possibility that when Tanzanian girls with disabilities try to access sexual and reproductive health services, structural violence based on ageism marginalise them. In the current study, access was influenced by a lack of age-appropriate, adolescent-friendly communication in the sexual and reproductive health services, the roots of which lay in the taboo of

adolescent sexuality (Bylund et al., 2020; Nyblade et al., 2017) and human worth being based on seniority (Nyamnjoh et al., 2022). As these intersecting systems of oppression may produce negative sexual and reproductive health outcomes, life-threatening situations and further marginalisation, recognising sexism, ableism and ageism will help unveil violence in the context of accessing sexual and reproductive health services against girls with disabilities.

Based on the intersectional perspectives brought forth in this study, I concur with Lévesque and Ferron-Parayre (2021) that acknowledging the particular, intimate context of sexual and reproductive health services, centring the voices of those affected by violence within these contexts, and identifying the systems of oppression inherent to the specific nature of sexual and reproductive health services is central for rethinking violence in access to sexual and reproductive health services. Disability-specific and gendered violence, when extended to the particular, intimate contexts of sexual and reproductive health care, would then require increasingly specific conceptualisations such as reproductive violence (Altunjan, 2021; Chiweshe et al., 2021; Laverty and de Vos, 2022), obstetric violence (Chadwick, 2016) and gynaecological violence (Rozée and Schantz, 2021). Thus, I concur with Lappeman and Swartz (2021) that development of accurate terminology has implications for how research results are reflected in policy and practice.

The current study therefore suggests that the conceptualisations of violence in the context of accessing sexual and reproductive health services need to be more specific. They should not all be merely placed under the broader category of gender-based violence (Chadwick, 2021), instead they should be approached through intersectional perspectives, including those based on disability (Chadwick and Jace Mavuso, 2021). These perspectives could be further used to identify and address the specific mistreatment that occurs both in sexual and reproductive health services, and when accessing them. Furthermore, applying these more detailed conceptualisations in this critical area of research is of paramount importance for unveiling and addressing discrimination, non-consensual care and abuse that underpin the experiences of girls with disabilities worldwide.

6.2. *Reframing accessibility and protection through Afrocentric disability theories*

The Tanzanian context highlights other limitations of current conceptualisations when disability, access to sexual and reproductive health services and gender-based violence overlap. The findings of this study support Katsui's (2012) view that the human rights model of disability founded on the CRPD, offers very little or no immediate relief for persons with disabilities who require day-to-day assistance to overcome barriers in environments where no formalised support systems are available (see Heikkilä et al., 2020). This is particularly so when formal and institutionalised accessibility does not exist and in situations in which accessible structures may fail either momentarily or for longer (Katsui and Chalklen, 2020). As the findings of the study portrayed,

overcoming barriers to safely accessing sexual and reproductive health services takes more than an individual claiming their rights.

When designing services that respond to the characteristics of adolescent girls with disabilities, this study suggest considering the relationality and collective dynamics between individuals and the informal familial and communal networks of care (Levesque et al., 2013; Onazi, 2020) that are different to those that are non-African (e.g. Amit, 2002). The relational dynamics presented in this study reflect the African ethic of interdependence, through which individuals are viewed in relational rather than individualistic terms (Berghs, 2017; Onazi, 2020). The findings concur with novel disability theorisations emerging from the African continent, which have the potential to frame these relational dynamics in research on access to and protection in sexual and reproductive health services and address the decontextualisation of global North-oriented disability theorisations (Imafidon, 2021; Nyamnjoh et al., 2022).

Central to Afrocentric disability theorisations is the concept of personhood that is the basis on which a person with disabilities is considered a full member of society and can enjoy services and protection on an equal basis with others (Imafidon, 2021; Nyamnjoh et al., 2022). The perspectives of the studied adolescents depicted how navigating access to sexual and reproductive health services resembled what Onazi (2020) described as 'asymmetrical obligations'. According to Onazi (2020), asymmetrical obligations are not based on mutual reciprocity; they are obligations for those who, in a certain time and place, are in a position to support and assist others. This highlights the ambivalence of disability and denaturalises persons with disabilities as vulnerable by default. Such understanding weaves persons with disabilities tighter into the social fabric of the society – informal networks of support, care and protection – that have the potential to advance sexual and reproductive health and protect against gender-based violence when gaps in formalised supports exists (Nyamnjoh et al., 2022).

The concept of asymmetrical obligations may be beneficial for re-imagining an accessible and protected access to sexual and reproductive health services that is responsive to the characteristics of adolescent girls with disabilities where interdependence tends to be valued over independence. Relational dynamics should therefore be understood as an under-theorised resource for addressing violence against adolescent girls with disabilities and access to sexual and reproductive health services in social contexts like Tanzania.

7. Conclusions

This study is the first known study in Tanzania to explore how gender-based violence intertwines with access to sexual and reproductive health services and to focus on the intersectionality of disability and adolescence. It contributes to rethinking the conceptual apparatus of gender-based violence through intersectional and contextual lenses. It highlights the potential of intersectional frames to identify, resist and address the normalisation of the ableist, sexist and ageist systems of oppression that impede

access to sexual and reproductive health services, result in violence and contribute to further marginalisation. Rethinking gender-based violence through intersectionality could potentially lead to the following: first, by rejecting the normalisation of the inaccessibility of sexual and reproductive health services and by reframing it as structural violence, a more disability-inclusive intersectional policy and programmatic interventions on adolescents' access to sexual and reproductive health services could be designed and implemented. Second, departing from general definitions of gender-based violence through precision in conceptualising gender-based violence (e.g. reproductive, gynaecological and obstetric), and its linkages to realising access to sexual and reproductive health services have implications for legal and policy frameworks. Third, conceptualisations of sexual and reproductive health care and protection against gender-based violence that draw from Afrocentric disability theorisations could enrich the human rights model of disability and research paradigms at the nexus of disability and development studies in contexts like Tanzania.

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