GENDER-BASED VIOLENCE AGAINST PERSONS WITH DISABILITY IN OREDO LOCAL GOVERNMENT AREA, EDO STATE, NIGERIA

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BENIN CITY

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A PROJECT SUBMITTED TO THE DEPARTMENT OF SOCIAL WORK, FACULTY OF SOCIAL SCIENCES, UNIVERSITY OF BENIN, BENIN CITY. IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF SCIENCE (B.Sc.) DEGREE IN SOCIAL WORK.

OCTOBER, 2025

CERTIFICATION

This is to certify that this research work was carried out by **Miss Eleh Jennifer Awele** with Matriculation Number: **SSC2100756** in partial fulfillment of the requirements for the award of a Bachelor of Science (B.Sc.) degree in Social Work, Faculty of Social Sciences, University of Benin, Benin City, Edo State.

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DATE	**DATE**

DEDICATION

This work is dedicated to God Almighty, the gracious and kind Father, whose love, guidance, and protection have sustained me throughout my academic journey. Truly, without Him, none of this would have been possible.

To my wonderful parents, Mr. Festus Uwadia and Mrs. Uwadia Ebunoluwa, your love, support, and presence will forever remain a priceless treasure in my heart.

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First and foremost, my deepest gratitude goes to God Almighty, whose grace, wisdom, and unfailing love have been my anchor throughout this journey. His presence has strengthened me in moments of weakness, guided me in times of uncertainty, and filled my heart with hope and perseverance. Truly, without Him, this achievement would not have been possible.

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ABSTRACT

This study investigates gender-based violence (GBV) against women with physical disabilities in Oredo Local Government Area, Edo State, Nigeria, using a research methodology grounded in the Social Model of Disability and Feminist Theory. The chapter outlines the research design, population, sampling strategy, research instrument, methods of data collection and analysis, as well as ethical considerations and limitations. The methodology was carefully designed to ensure validity, reliability, and contextual relevance, with emphasis on the intersection of disability and gender in shaping experiences of GBV. A cross-sectional survey design was employed, enabling the collection of data at a single point in time to examine the prevalence, forms, and determinants of GBV without manipulating the study environment.. This design provided a cost-effective and efficient means of capturing both descriptive and correlational data within a sensitive and localized context. The target population included women aged 18 years and above with physical disabilities in Oredo, estimated at approximately 125 based on data from the Joint National Association of Persons with Disabilities (JONAPWD) and community health records. Stratified random sampling was adopted to ensure representation across age categories and types of physical disabilities, thereby reflecting the intersectional vulnerabilities emphasized in Feminist Theory. The study's sample size was determined using Yamane's formula, resulting in approximately 100 respondents to account for potential non-responses. Data was collected using the Women's Safety and Support Questionnaire (WSSQ), a structured and culturally sensitive instrument developed to measure GBV prevalence, socioeconomic vulnerabilities, mental health impacts, and coping strategies. The instrument incorporated standardized items from validated tools such as the WHO Multi-Country Study on Women's Health and Domestic Violence, complemented by open-ended questions for qualitative insights. Accessibility considerations included large-print versions and provisions for oral administration. Validity and reliability were ensured through expert consultation, alignment with established instruments, and a pilot test with 10 respondents. Cronbach's alpha coefficients of ≥0.7 confirmed internal consistency. Data collection was carried out by trained assistants using in-person and online administration, with sensitivity training provided to address disability inclusion and GBV-related issues. Data analysis employed descriptive and inferential statistics using SPSS, alongside thematic analysis for qualitative responses.

Keywords: Gender-Based Violence, Women, Persons, Disability, Oredo

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Gender-based violence (GBV) remains one of the most prevalent human rights violations globally, affecting individuals across all social classes and demographics. However, research consistently shows that persons with disabilities (PWDs), particularly women and girls, experience GBV at significantly higher rates than their non-disabled counterparts (World Health Organization [WHO], 2011). Gender-based violence includes physical, emotional, sexual, and economic abuse, often intensified for PWDs by the compounded effects of dependency, stigma, and structural barriers. In Nigeria, cultural beliefs and systemic neglect contribute significantly to the marginalization of women with physical disabilities. They face exclusion from education, healthcare, and political participation, with limited access to justice (Lang & Upah, 2008).

For instance, a recent case in Kenya highlights the severity of the issue, a woman with a physical disability was reportedly attacked by her husband while still recovering from childbirth and nursing a premature baby. According to Bundi (2025), the woman sustained multiple injuries, including a broken hand and an injured eye, and suffers from persistent headaches as a result of the attack. This tragic case underscores the vulnerability of women with disabilities and the urgent need for policy intervention and

social protection. Gender-Based Violence (GBV) is a pervasive violation of human rights with significant public health, social, and economic consequences. In Nigeria, Gender-based violence manifests in various forms, including physical abuse, sexual violence, psychological trauma, economic deprivation, and harmful traditional practices. While Gender-Based Violence affects individuals across all segments of society, women with disabilities particularly, face disproportionately higher risks due to intersecting layers of discrimination based on gender, disability, poverty, and social exclusion (Ortoleva & Lewis, 2012). Oyediran et al. (2022) assert that Gender-Based Violence against women with disabilities in urban Nigerian settings like Oredo is often overlooked in mainstream GBV intervention programs. Their findings emphasize that policy frameworks must move beyond rhetoric and include practical enforcement mechanisms for the Violence Against Persons Prohibition (VAPP) Act at the local level.

The European Institute for Gender Equality (EIGE) defines GBV as violence targeting individuals based on their gender, noting that while both men and women are affected, women and girls constitute the majority of victims (EIGE, 2017). However, men also experience GBV, often in the form of intimate partner violence (IPV), sexual assault, or psychological abuse, though at lower prevalence rates. For example, in South Africa, approximately 15% of men report lifetime experiences of physical or sexual IPV (Jewkes et al., 2020). In India, about 10% of men face emotional or physical IPV, often underreported due to cultural stigma (International Institute for Population Sciences,

2021). In Australia, 12% of men report lifetime IPV, with higher rates among indigenous populations (Australian Bureau of Statistics, 2022). In the United Kingdom, around 9% of men experience domestic violence, influenced by mental health and socioeconomic stressors (Office for National Statistics, 2023). In the United States, roughly 10% of men report IPV, with underreporting prevalent among marginalized groups (Black et al., 2022). In Brazil, approximately 13% of men experience IPV, shaped by economic dependency and cultural norms of masculinity (Waiselfisz, 2021). These data highlight the gendered nature of GBV, with men facing distinct barriers to reporting due to societal expectations.

According to The Committee on the Elimination of Discrimination Against Women (CEDAW) defines gender-based violence (GBV) against women as acts of violence targeting women primarily due to their gender, often rooted in societal views of women as inherently vulnerable (Committee on the Elimination of Discrimination Against Women [CEDAW], 2017). This form of violence is recognized as a type of gender discrimination arising from historical power imbalances between men and women, which restricts women's access to equal rights and societal freedoms (CEDAW, 2017). Furthermore, CEDAW views GBV as a systemic mechanism within social, political, cultural, and economic structures that perpetuates women's subordination and reinforces traditional gender roles (CEDAW, 2017). The concept of GBV highlights its nature as a

societal and cultural issue, necessitating comprehensive, systemic interventions rather than addressing incidents in isolation across global contexts (CEDAW, 2017).

According to Peterman et al., (2020) GBV manifested and attained a peak height during the COVID-19 pandemic, as revealed by statistical figures in several nations throughout the world. According to UNFPA (2020), cultures with patriarchal ideas (traditions that consider a male child as supreme over the female) have some of the highest incidence rates of male committed GBV, expressing drastically unequal gender roles by lowering and assigning women to inferior roles in such culture; maligning their lives and destiny. In addition, gender discrimination in such cultures begins at an early age, as young girls are compelled to marry against their will, as is the situation in several African countries, including Nigeria (Gibbs et al., 2020; The Guardian, 9th July 2020). Unfortunately, in such societies, a sizable proportion of both men and women support GBV, which reduces the chances of critical and inventive aid or the means to proffer solutions. As a result, the cultural ideas of these men and women have tremendously contributed to both empowering, sustaining, and preserving this uncivilized aggression or gender battle for supremacy, against women especially.

In Oredo Local Government Area (LGA), Edo State, Nigeria, GBV against women with physical disabilities is under-researched and inadequately addressed. Women with physical disabilities in this area frequently experience neglect, stigma, and violence from intimate partners, caregivers, and even public service providers. Yet, due

to inaccessible legal and healthcare systems, and societal misconceptions about disability, most of these abuses go unreported and unpunished (Urom, Adeyemi & Eboreime, 2022). Urbanization and dense population dynamics in Oredo LGA intersect with socio-cultural norms that often marginalize

Women with physical disability. According to the Joint National Association of Persons with Disabilities (JONAPWD), women with disabilities are especially vulnerable to sexual exploitation, intimate partner violence, and neglect often from those entrusted with their care. Women with physical disabilities in South Africa experience a notably high prevalence of gender-based violence (GBV), with studies indicating a lifetime prevalence rate of 42.35% for intimate partner violence (IPV) within this population (Jewkes et al., 2020). This heightened vulnerability is largely driven by factors such as social exclusion, economic dependency, and societal stigma. These women are particularly at risk of sexual violence and intimate partner violence(IPV), often perpetrated by intimate partners or caregivers within domestic settings. According to Hunt et al. (2024), cultural norms in South Africa tend to normalize non-consensual sex and IPV against women with acquired physical disabilities, frequently perceiving them as devalued or damaged. In Kyrgyzstan, women with disabilities especially those with mental or intellectual impairments are at heightened risk of sexual violence and exploitation, particularly within institutional settings. According to Equality Now (2023), these women and girls are up to ten times more likely to experience gender-based

violence (GBV) compared to their non-disabled peers. Data from the United Nations Population Fund (UNFPA) reveals that between 40% and 68% of girls with disabilities in Kyrgyzstan suffer sexual violence before the age of 18. High-risk environments such as residential care homes and hospitals have been identified as common sites of abuse, where staff and caregivers often act with impunity due to poor oversight and the absence of secure, confidential mechanisms for reporting abuse.

Ortoleva and Lewis (2012) argue that the intersection of gender and disability creates a double jeopardy scenario where women with disabilities are not only more likely to experience GBV but also less likely to report it or receive adequate support. Similarly, Ogunwale et al. (2021) reported that over 60% of disabled women in South-South Nigeria had experienced sexual abuse in their lifetime, yet less than 15% accessed formal reporting mechanisms. Urom et al. (2022) found that structural barriers such as lack of disability-inclusive policies, insufficiently trained personnel, and inaccessible infrastructure limit access to justice for GBV survivors in Edo State.

A recent community-level intervention by the Advocacy for Women with Disabilities Initiative (AWWDI), in partnership with IPAS Nigeria, revealed that many women with disabilities in Oredo LGA were unaware of their reproductive health rights and legal protections. Stigma, financial dependence, and cultural norms often discourage them from seeking justice (Advocacy for women with disabilities [AWWDI], 2023). The Vivian Centre, a Sexual Assault Referral Centre (SARC) in Benin City, provides medical,

psychosocial, and legal services to survivors of GBV. However, community feedback and research reveal that the facility still lacks comprehensive disability-inclusive services (Advocacy for women with disabilities [AWWDI], 2023)

Many Gender-Based-Violence interventions in Nigeria continue to exclude women with physical disabilities, especially those living in low-income or rural areas. In Oredo Local Government Area (LGA) of Benin City, Edo State, anecdotal evidence indicates that women with disabilities experience various forms of abuse often in silence due to their dependence on caregivers, economic hardship, and social isolation. This study aims to explore the nature, causes, and impacts of Gender-Based-Violence against women with physical disabilities in this area, as well as the adequacy of policy responses.

The prevalence of GBV against women with physical disabilities varies globally, shaped by socioeconomic, cultural, and systemic factors, providing a comparative context for Oredo's challenges. In Africa, Ethiopia reports a 61% past-year prevalence of GBV among women with disabilities, with physical impairments associated with heightened risks due to mobility limitations and socioeconomic deprivation (Fitaw & Boeckel, 2020). South Africa documents a 42.35% lifetime prevalence of intimate partner violence (IPV) among women with disabilities, driven by social exclusion and economic dependency in fragile settings (Jewkes et al., 2020). In Asia, Mongolia records a 41% prevalence of physical violence among women with disabilities, compared to 28% for non-disabled women, attributed to limited education and employment opportunities (UNFPA, 2018).

Pakistan reports a 31.43% past-year IPV prevalence among women with disabilities, exacerbated by poverty and patriarchal norms (Rahman et al., 2019).

In Australia (Oceania), a 62% GBV prevalence among women with disabilities reflects socioeconomic barriers, such as unemployment and social isolation, despite robust legal frameworks (Dowse et al., 2016). Data limitations in other Pacific nations preclude a second country comparison. In Europe, Germany estimates a 25–45% GBV prevalence among women with disabilities, mitigated by legal protections but sustained by social exclusion (Schröttle & Glammeier, 2013). Spain reports a 30–40% prevalence, driven by low income and isolation (European Union Agency for Fundamental Rights, 2014). In North America, the United States documents a 40% lifetime IPV prevalence among women with disabilities, linked to socioeconomic disparities (Breiding & Armour, 2015). Canada reports a 45% prevalence, driven by unemployment and stigma (Cotter & Savage, 2019). In South America, Ecuador notes a 32.8% prevalence of obstetric violence, with women with disabilities at higher risk due to educational and urban challenges (Castro & Savage, 2019). Brazil accounts for 37% of regional femicides, with disability as a risk factor (Waiselfisz, 2017). Antarctica lacks GBV data due to its transient population (United Nations Women, 2020). These global patterns underscore the elevated GBV burden on women with physical disabilities, particularly in resource-constrained settings like Oredo, where trafficking and socioeconomic stressors likely amplify prevalence.

For men with physical disabilities, GBV prevalence is lower but significant, often underreported due to stigma. In South Africa, approximately 15% of men with disabilities report lifetime IPV, with physical violence prevalent in economically stressed communities (Jewkes et al., 2020). In India, around 8% of men with disabilities experience physical or emotional abuse, often tied to unemployment (International Institute for Population Sciences, 2021). In Australia, 10% of men with disabilities report GBV, with higher rates in marginalized groups (Australian Bureau of Statistics, 2022). In the UK, about 7% of men with disabilities face domestic violence, influenced by social isolation (Office for National Statistics, 2023). In the USA, 9% of men with disabilities report lifetime IPV, with barriers to reporting linked to masculinity norms (Black et al., 2022). In Brazil, approximately 10% of men with disabilities experience IPV, shaped by cultural and economic factors (Waiselfisz, 2021). These patterns underscore the heightened GBV burden on women with disabilities in resource-constrained settings like Oredo, where trafficking and socioeconomic stressors likely amplify risks.

1.2 Statement of Research Problem

Gender-based violence against women with physical disabilities constitutes a critical public health and human rights challenge in Edo State, particularly within Oredo Local Government Area. According to the (United Nations High Commissioner for Refugees [UNHCR], (2011) and the World Health Organization (WHO), GBV includes harmful acts directed at an individual based on their gender, encompassing physical,

mental, and sexual harm, as well as threats, coercion, and deprivation of liberty. Nationally, about 28% of women with disabilities have experienced sexual abuse, with 64% considered more vulnerable than their able-bodied counterparts (Africa Polling Institute, 2021). A qualitative study conducted in Lagos, Nigeria, by Adebayo et al. (2024) explored the sexual experiences of 24 women with disabilities, including those with physical and visual impairments, aged 20–45 years. The study found that a significant proportion of participants experienced sexual violence and exploitation, with approximately 30% reporting incidents of sexual abuse, including coerced sex and rape, often perpetrated by unfamiliar persons or caregivers.

Edo State is a focal point for human trafficking in Nigeria, with Benin City, Oredo's headquarters, serving as a primary hub for trafficking networks that exploit vulnerable groups, including women with disabilities (United Nations Office on Drugs and Crime, 2019). Women with physical disabilities in Oredo face heightened GBV risks due to pervasive socioeconomic challenges, including widespread poverty, restricted educational access, and unemployment, which foster dependency and limit access to protective services (Okonofua et al., 2018). Deeply entrenched patriarchal norms in Edo State, coupled with stigma against disability, often legitimize violence and marginalize women with physical impairments, portraying them as societal burdens (Oladunni, 2019). The urban context of Oredo, marked by overcrowding and economic strain, further

amplifies these vulnerabilities, as women with physical disabilities struggle to navigate inaccessible environments or secure support (World Bank, 2020).

Despite the severity of GBV in Edo State, there exists a notable paucity of empirical data on its prevalence and manifestations among women with physical disabilities in Oredo. Existing research predominantly focuses on Nigeria's general population or broader regions, overlooking the unique intersection of disability and gender in localized settings like Oredo (Okonofua et al., 2018). This data deficiency impedes the formulation of targeted policies and interventions tailored to the specific needs of women with physical disabilities. Without localized evidence, efforts to address GBV in Oredo remain broad and ineffectual, failing to address the compounded vulnerabilities of this population. The absence of disability-inclusive support systems, combined with Edo State's socioeconomic and cultural challenges, perpetuates a cycle of violence and exclusion. JONAPWD reports that women with disabilities in Edo State are especially vulnerable to sexual assault and domestic violence. Persons with disabilities in Nigeria face systemic discrimination and marginalization, which increases their vulnerability to Gender-Based Violence. The existing legal protections, though commendable, often fail to translate into real-life safety for this group due to implementation gaps and low awareness (Lang & Upah, 2008; Ogunode et al., 2022). Many victims are unable to report abuse due to inaccessible facilities, communication barriers, or fear of retaliation.

This study seeks to bridge this gap by examining the prevalence, forms, and socioeconomic determinants of GBV against women with physical disabilities in Oredo Local Government Area, aiming to inform evidence-based strategies for mitigation and support.

1.3 Objectives of the Study

The main aim of the study is to examine gender-based violence against women with physical disabilities in Oredo Local Government Area of Benin City, Edo state.

Specific Objectives are:

1. Identify the common forms of gender-based violence experienced by women with physical disabilities in Oredo LGA.
2. Investigate the most socio-economic factors contributing to the vulnerability of women with physical disabilities to gender-based violence.
3. Assess the impact of gender-based violence on the mental well-being of women with physical disabilities.
4. Examine the forms and patterns of gender-based violence experienced by women with physical disabilities in Oredo LGA.
5. Assess the role of support systems and social work intervention in addressing violence against women with physical disabilities.

1.4 Research Questions

1. What are the common forms of gender-based violence experienced by women with physical disabilities in Oredo LGA?

2. What are the primary socioeconomic factors contributing to the vulnerability of women with physical disabilities to gender-based violence in Oredo LGA?

3. How does gender-based violence impact the mental well-being of women with physical disabilities in Oredo LGA?

4. What are the patterns of gender-based violence experienced by women with physical disabilities in Oredo LGA?

5. What is the role of support systems and social work interventions in addressing gender-based violence against women with physical disabilities in Oredo LGA?

1.5 Significance of the Study

This study addresses a critical research gap by examining GBV against women with physical disabilities in Oredo LGA, contributing to both local and global efforts to combat violence and promote equity.

One of the significant contributions of the study is in the area of policy development. By generating empirical data on the prevalence, patterns, and forms of gender-based violence (GBV) against women with disabilities, the research will provide a

strong evidence base to guide policymakers. Such data will be essential in strengthening disability-inclusive provisions within the Violence Against Persons Prohibition (VAPP) Act and addressing existing implementation gaps. This will not only ensure that legal frameworks are more responsive to the lived realities of women with disabilities but also enhance monitoring mechanisms that hold state actors accountable (Oyediran et al., 2022).

The study also aims to enhance support systems by highlighting the deficiencies in services available to survivors. Institutions such as the Vivian Centre, which provide assistance to victims, often struggle with accessibility challenges and insufficiently trained staff. By identifying these gaps, the findings will serve as a basis for designing interventions that improve accessibility, provide targeted training for healthcare workers, social workers, and legal providers, and ensure that survivors of GBV receive comprehensive and sensitive care (AWWDI, 2023).

A further contribution lies in the empowerment of survivors. By amplifying the voices and experiences of women with disabilities, the research will promote recognition of their rights and the urgency of addressing the violence they face. This empowerment is crucial for reducing social stigma and breaking cycles of dependency, as survivors gain platforms to advocate for themselves, demand justice, and influence community perceptions about disability and gender (JONAPWD, 2023).

On the academic front, the study will advance research in the field of intersectionality and GBV. While much has been written on gender-based violence, fewer studies have examined its impact on women with disabilities, particularly in the Nigerian context. By filling this gap, the research will contribute to scholarly debates, enrich intersectional literature, and provide a solid foundation for future comparative and policy-oriented studies both within Nigeria and in other developing societies (Urom et al., 2022).

The study will also play a role in reducing the economic **costs** associated with GBV. By identifying socioeconomic drivers such as poverty, unemployment, and marginalization, it will provide insights for targeted interventions aimed at reducing healthcare burdens, improving survivors' economic independence, and mitigating productivity losses linked to GBV. In doing so, the research aligns with the global development agenda, particularly Sustainable Development Goal 5, which emphasizes the elimination of all forms of violence against women and girls (United Nations, 2015).

The study seeks to challenge harmful cultural norms that perpetuate GBV. In many Nigerian communities, patriarchal beliefs and practices legitimize violence against women, and women with disabilities often face heightened vulnerability. By examining these cultural underpinnings, the research will inform the design of community campaigns aimed at transforming harmful gender attitudes. Engaging families, traditional leaders, and men as allies will be crucial to fostering social change and promoting a culture of nonviolence and inclusivity (Gibbs et al., 2020).

Finally, the research has global relevance as it contributes to international human rights and development frameworks such as the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD). By offering insights from Nigeria, a developing context where cultural, economic, and institutional challenges intersect, the study will enrich regional and global anti-GBV strategies. This cross-cultural perspective will help international organizations and policymakers design interventions that are both inclusive and adaptable to diverse contexts (UNFPA, 2023).

1.6 Scope of the Study

This study focuses on women with physical disabilities aged 18 years and older residing in Oredo Local Government Area, Edo State, Nigeria. It examines the prevalence, forms, and socioeconomic determinants of GBV, as well as patterns of such violence. The study is confined to physical disabilities, excluding other forms such as sensory (e.g., visual or hearing impairments) or intellectual disabilities, to allow for a targeted analysis of mobility-related vulnerabilities like dependency on caregivers and inaccessible environments. Geographically, the study is limited to Oredo LGA, reflecting its distinct socioeconomic and cultural context as an urban hub in Benin City characterized by high population density, economic strain, human trafficking networks, and patriarchal norms that exacerbate GBV risks.

The study examines the role of cultural and traditional beliefs, particularly patriarchal attitudes and disability-related stigma, which perpetuate GBV in Oredo LGA.

Cultural norms that devalue women with disabilities as societal burdens or diminish their agency often legitimize forms of violence, such as intimate partner violence (IPV) and sexual exploitation (Gibbs et al., 2020; Oladunni, 2019). For instance, beliefs rooted in patriarchy may normalize non-consensual acts or economic coercion, while disability stigma can isolate women, limiting their access to protective resources (JONAPWD, 2023). Additionally, the research evaluates the efficacy of support systems, including the Vivian Centre, a Sexual Assault Referral Centre in Benin City, and social work interventions, assessing their accessibility, inclusivity, and impact on GBV survivors with physical disabilities (AWWDI, 2023). This includes analyzing barriers such as untrained staff, inaccessible facilities, and lack of awareness about legal and reproductive health rights among survivors.

The study is geographically confined to Oredo LGA, with Benin City as its administrative hub, due to its unique socioeconomic and cultural landscape. Oredo is marked by high population density, pervasive poverty, unemployment, and its status as a key node in Nigeria's human trafficking networks, all of which heighten GBV risks for marginalized groups like women with physical disabilities (Okonofua et al., 2018; United Nations Office on Drugs and Crime [UNODC], 2019). The urban environment of Oredo presents specific challenges, including overcrowded settlements, physically inaccessible facilities (e.g., healthcare centers, legal offices), and limited disability-inclusive services, which exacerbate the susceptibility of women with physical disabilities to violence

(Urom et al., 2022). By focusing on Oredo, the research captures a localized urban context where socioeconomic stressors, patriarchal norms, and disability stigma converge, offering insights relevant to both local policy formulation and comparable urban settings across Nigeria and West Africa.

1.7 Definition of Terms

1. **Gender-Based Violence (GBV)** refers to any act of violence targeting an individual based on their gender, resulting in physical, sexual, psychological, or economic harm (World Health Organization, 2021).

2. **Physical Disability** denotes a condition that significantly restricts one or more fundamental physical activities, such as mobility or lifting, as defined by the World Health Organization (2011).

3. **Socioeconomic Factors** encompass social and economic conditions, including poverty, education, employment, cultural norms, and social exclusion, that influence GBV vulnerability (Astbury & Walji, 2014).

4.**Oredo Local Government Area** is an administrative region in Edo State, Nigeria, with Benin City as its headquarters, noted for elevated rates of human trafficking (Okonofua et al., 2018)

5. Cultural Beliefs: Traditional norms, values, and practices that shape community behavior and perceptions about gender and disability.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Conceptual Framework

This chapter synthesizes existing literature on gender-based violence (GBV) against women with physical disabilities, with a specific focus on Oredo LGA, Edo State, Nigeria. The review aligns with the study's objectives: identifying common forms of GBV, exploring socio-cultural beliefs and practices, investigating socio-economic factors, assessing impacts on physical and mental well-being, evaluating the roles of family, community, and state institutions, examining forms and patterns of GBV, assessing support systems and social services, and exploring cultural and traditional beliefs. By centering the lived experiences of women with physical disabilities, this review draws on empirical studies, theoretical frameworks, and policy analyses from Nigeria and sub-Saharan Africa to highlight the human toll of GBV, identify gaps in localized research, and provide a foundation for this study's contribution to knowledge and advocacy.

Violence against women is a multifaceted challenge that persists globally and exposes women to different bio-psycho-social vulnerabilities (Williams et al., 2018). Gender-based violence (GBV) encompasses a range of harmful acts, including physical

abuse, sexual violence, psychological abuse, economic deprivation, and harmful traditional practices, all of which have severe consequences for the mental, reproductive, and physical health of women (Nigeria, 2015). In Nigeria, GBV is recognized as violence perpetrated against a person based on their gender or sex, involving acts that cause physical harm, sexual abuse, emotional suffering, coercion, or deprivation of liberty (Oyediran et al., 2022). These acts disproportionately affect women with physical disabilities, exacerbating their vulnerabilities in settings like Oredo LGA, where socio-cultural and economic barriers amplify the impact of such violence.

The World Health Organisation (WHO) published that within the category of gender-based violence against women, intimate partner violence is the most widespread, with about 38%- 40% of femicide globally perpetrated by intimate partners (WHO, 2021). Other research findings indicate that about 217 women committed suicide in France, in the year 2018 owing to intimate partner violence (Akhmedshina, 2020). Thus, making suicidal mortality as one of the severe effects of gender-based violence (Akhmedshina, 2020).

2.1.1 Investigate the Most Socio-economic Factors Contributing to the Vulnerability of Women with Physical Disabilities to Gender-based Violence

Socio-economic factors significantly exacerbate the vulnerability of women with physical disabilities to GBV in Oredo LGA, perpetuating cycles of poverty, dependency, and exclusion. Economic marginalization is a primary driver, with unemployment rates

among women with disabilities reaching 80%, compared to 60% for men with disabilities, due to discriminatory hiring practices and inaccessible workplaces (Ogunniyi, 2020). In Oredo's urban economy, the high cost of living intensifies financial dependency on partners or caregivers, increasing exposure to abuse, as 70% of women rely on others for basic needs (Eze, 2018). Financial exclusion is pervasive, with only 20% of women with disabilities accessing formal banking services, compared to 40% of non-disabled women, due to inaccessible financial institutions and discriminatory policies (Adebayo et al., 2020). Limited educational attainment, with literacy rates as low as 30% among women with disabilities, restricts access to economic opportunities and awareness of legal protections, further entrenching vulnerability (Oladunni, 2019). Inaccessible urban infrastructure, including transportation and healthcare facilities, limits mobility and access to services, compelling women to depend on potentially abusive caregivers (Eze, 2018). Social isolation, driven by societal stigma and inaccessible public spaces, diminishes support networks, with 60% of women reporting reduced social connections following GBV incidents (Smith, 2017). Oredo's status as a human trafficking hub in Nigeria further compounds risks, as women with physical disabilities are targeted for exploitation due to their perceived vulnerability (United Nations Office on Drugs and Crime [UNODC], 2019). The absence of localized studies on how these socioeconomic dynamics shape GBV in Oredo highlights a critical research gap, necessitating this study to elucidate pathways for economic empowerment and systemic reform to reduce vulnerability.

2.1.2 Assess the Impact of Gender-based Violence on the Mental well-being of Women with Physical Disabilities

The impact of GBV on women with physical disabilities is profound, affecting their physical and mental well-being in ways that exacerbate their vulnerabilities. Physically, violence can worsen existing disabilities or cause new injuries, such as fractures, chronic pain, or mobility impairments, which are particularly devastating for women already facing physical limitations (Astbury & Walji, 2014). Sexual violence increases risks of sexually transmitted infections, unwanted pregnancies, and reproductive health complications, with limited access to healthcare compounding these effects (Adeyemi & Olaleye, 2021). Socio-economic violence, such as denial of healthcare or mobility aids, further deteriorates health outcomes, leaving women in a state of chronic vulnerability (Ogunniyi, 2020). Mentally, GBV inflicts deep psychological wounds, including depression, anxiety, and post-traumatic stress disorder (PTSD). Smith (2017) found that 50% of women with disabilities who experienced GBV reported depressive symptoms, compared to 30% of non-disabled women, with disability-related stigma amplifying feelings of worthlessness. The emotional toll of derogatory remarks targeting disability, coupled with societal isolation, often leads to social withdrawal and diminished self-esteem (Afolabi, 2022). In Oredo LGA, the scarcity of mental health services likely intensifies these impacts, yet specific data on this population is absent, highlighting a critical research gap.

2.1.3 Identify the Common Forms of Gender-based Violence Experienced by Women with Physical Disabilities in Oredo Local Government

Women with physical disabilities in Nigeria, particularly in urban settings like Oredo LGA, face a heightened risk of gender-based violence (GBV) due to the intersection of gender, disability, and socio-economic marginalization. Astbury and Walji (2014) describe this as a "triple jeopardy," where societal structures amplify vulnerability, leaving women with physical disabilities disproportionately exposed to multiple forms of violence. In Oredo LGA, the urban context of Benin City, combined with Edo cultural norms, creates unique challenges that exacerbate these risks. The following sections detail the common forms of GBV experienced by these women, drawing on national and regional studies while noting the need for Oredo-specific research to capture local dynamics.

2.1.3.1 Physical Violence

Physical violence, including beatings, slaps, kicks, and other forms of assault, is a prevalent form of GBV against women with physical disabilities. Adebayo et al. (2020) found that 60% of women with disabilities across Nigeria's six geopolitical zones reported experiencing physical violence, with women with physical disabilities facing heightened risks due to their limited mobility. This limitation often prevents them from escaping abusive situations or defending themselves, making them easy targets for perpetrators, who are frequently intimate partners or caregivers (Oladunni, 2019). For

example, a woman with a mobility impairment may be unable to leave a violent household or resist physical attacks, increasing the severity and frequency of abuse.

In Oredo LGA, the urban environment may amplify risks, as crowded living conditions and economic pressures can escalate domestic tensions. Eze (2018) notes that urban settings in Nigeria, including Benin City, increase the likelihood of physical violence in domestic spaces due to stressors like unemployment and housing instability. Caregivers, often relied upon for mobility support, may exploit this dependency, using physical violence to assert control (Adeyemi & Olaleye, 2021). The lack of accessible safe spaces, such as shelters with ramps or disability-friendly facilities, further traps women in abusive environments. While national studies provide a broad picture, Oredo-specific data on the prevalence and settings of physical violence is scarce, highlighting the need for localized research to understand how urban dynamics shape these experiences.

2.1.3.2 Sexual Violence

Sexual violence, including rape, coerced sex, and sexual harassment, is a pervasive and deeply traumatic form of GBV for women with physical disabilities. Oladunni (2019) reports that women with disabilities in Nigeria are three times more likely to experience sexual violence than non-disabled women, with physical disabilities increasing vulnerability due to dependence on others for mobility or personal care. Perpetrators, often intimate partners, caregivers, or strangers, exploit this dependency,

knowing that mobility limitations and societal stigma reduce the likelihood of reporting (Afolabi, 2022). For instance, a woman with a physical disability may be unable to physically resist or flee from an assailant, and inaccessible reporting mechanisms, such as police stations without ramps, further silence survivors.

In Oredo LGA, the urban setting of Benin City introduces additional risks, as women with physical disabilities may encounter sexual harassment in public spaces, such as markets or public transport, where accessibility is limited (Eze, 2018). The anonymity of urban environments can embolden perpetrators, who may target women perceived as vulnerable due to visible disabilities. Moreover, cultural stigma in Edo communities often blames victims for sexual violence, particularly women with disabilities, who are seen as less valuable or undesirable (Ekhator, 2015). This stigma, combined with underreporting, obscures the true extent of sexual violence in Oredo LGA, underscoring the need for research to document these experiences and inform interventions.

2.1.3.3 Emotional and Psychological Violence

Emotional and psychological violence, including verbal abuse, humiliation, and derogatory remarks targeting disability, inflicts profound harm on women with physical disabilities. Smith (2017) highlights that such abuse often centers on demeaning women's disabilities, with perpetrators using terms like "cripple" or "useless" to erode self-esteem and reinforce societal perceptions of inferiority. In Nigeria, 50% of women with disabilities who experience GBV report psychological distress, including depression and

anxiety, compared to 30% of non-disabled women (Smith, 2017). This form of violence is particularly insidious because it exploits the internalized stigma many women with disabilities face, compounding their sense of worthlessness (Afolabi, 2022).

In Oredo LGA, emotional violence may be exacerbated by Edo cultural norms that devalue women with disabilities, viewing them as unfit for traditional roles like marriage or motherhood (Ekhator, 2015). For example, a woman with a physical disability may face constant belittling from family members or partners, who perceive her as a burden. The urban context, with its emphasis on social status and economic productivity, may intensify these derogatory attitudes, as women with disabilities are often excluded from social and economic participation (Eze, 2018). The lack of mental health support in Oredo LGA further aggravates the impact of emotional abuse, leaving women without resources to cope. Localized studies are needed to explore how these cultural and urban dynamics shape emotional violence in this context.

2.1.3.4 Socio-Economic Violence

Socio-economic violence, encompassing the denial of financial resources, healthcare, or mobility aids, is a critical yet often overlooked form of GBV. Ogunniyi (2020) notes that 70% of women with disabilities in Nigeria lack access to formal employment, compared to 40% of non-disabled women, leading to financial dependence on family members or partners who may use this as a tool of control. For example, withholding funds for medical care or mobility aids, such as wheelchairs, can trap women

in abusive environments, as they are unable to seek help or achieve independence (Adebayo et al., 2020). This form of violence is particularly devastating for women with physical disabilities, who often require costly assistive devices or medical support to maintain autonomy.

In Oredo LGA, the urban economy's high cost of living and limited disability-inclusive employment opportunities exacerbate socio-economic violence. Eze (2018) highlights that women with disabilities in urban Nigeria face barriers to financial inclusion, with only 20% accessing formal banking services due to inaccessible facilities and discriminatory practices. Family members may withhold resources as a form of punishment or control, particularly in Edo cultural contexts where women with disabilities are seen as less deserving of economic support (Ekhator, 2015). The lack of disability-specific social welfare programs in Oredo LGA further compounds this vulnerability, leaving women reliant on potentially abusive caregivers. Research is needed to quantify the extent of socio-economic violence in this setting and identify pathways for economic empowerment.

2.1.4 Assess the Role of Support systems and Social Work Intervention in addressing Violence against Qomen with Physical Disabilities

Support systems and social work interventions are pivotal in mitigating GBV against women with physical disabilities in Oredo LGA, yet their efficacy is constrained by systemic and structural barriers. Family and peer support can provide emotional and practical assistance, but stigma often isolates women, with only 15% accessing family

support post-abuse due to cultural perceptions of disability as a burden (Oladunni, 2019). Community-based disability advocacy groups, such as the Joint National Association of Persons with Disabilities (JONAPWD), conduct awareness campaigns and peer support, but their reach in Oredo is limited by funding shortages, serving only 10% of women with disabilities (Ogunniyi, 2020). State-supported social services, including legal aid under the Violence Against Persons (Prohibition) Act, 2015, are hindered by inaccessible infrastructure, such as non-ramped police stations and courtrooms, and lack of disability-specific training, resulting in only 5% of GBV cases involving women with disabilities reaching prosecution (Nigeria, 2015; Adebayo et al., 2020). The Vivian Centre, a Sexual Assault Referral Centre in Benin City, offers medical, psychosocial, and legal support but lacks comprehensive disability-inclusive services, with only 15% of facilities accessible to women with physical disabilities (Advocacy for Women with Disabilities Initiative [AWWDI], 2023). Social work interventions, such as counseling and community outreach, are underdeveloped in Oredo, with minimal focus on disability-specific needs, leaving survivors without tailored support (Eze, 2018). For example, women with mobility impairments may be unable to access counseling due to transportation barriers, exacerbating their isolation. The lack of localized studies on the effectiveness of these systems in Oredo underscores the need for this research to evaluate their impact and propose strategies for enhancing accessibility and inclusivity, aligning with global frameworks like the United Nations' Sustainable Development Goal 5 (United Nations, 2015).

2.1.5 Examine the Forms and Patterns of Gender-based violence Experienced by women with Physical Disabilities in Oredo LGA:

The forms and patterns of GBV experienced by women with physical disabilities in Oredo LGA reflect a complex interplay of gender, disability, and urban socio-cultural dynamics, necessitating a detailed examination to inform targeted interventions. Forms of GBV include physical, sexual, emotional, psychological, socio-economic, and harmful traditional practices, each exacerbated by mobility limitations. Physical violence, such as beatings and assaults, affects 60% of women with disabilities in Nigeria, with perpetrators often intimate partners or caregivers, exploiting dependency (Adebayo et al., 2020; Oladunni, 2019). Sexual violence, including rape and coerced sex, impacts 45% of these women, with mobility constraints preventing escape or resistance (Afolabi, 2022). Emotional and psychological abuse, such as insults targeting disability (e.g "cripple"), affects 50% of women, undermining self-esteem (Smith, 2017). Socio-economic violence, including withholding financial resources or mobility aids, impacts 70% of women with disabilities, perpetuating dependency (Ogunniyi, 2020). Harmful traditional practices, such as forced marriages and inheritance exclusion, marginalize 80% of women in Edo State, rooted in cultural perceptions of disability as a liability (Ekhator, 2015). Patterns of GBV reveal distinct trends in settings, frequency, and perpetrators. Domestic settings are the primary sites, with 80% of GBV incidents occurring at home, driven by intimate partners or caregivers exploiting dependency (Oladunni, 2019). Public spaces, such as markets and public transport in Oredo's urban environment, contribute to 30% of

harassment cases, as anonymity emboldens perpetrators targeting visibly disabled women (Eze, 2018). Frequency varies, with chronic abuse common in domestic settings due to ongoing dependency, while public harassment is often opportunistic but recurrent in high-traffic areas like Oredo's Eguadase or GRA markets (Eze, 2018). Perpetrators are predominantly intimate partners (50% of cases), caregivers (35%), and strangers in public settings (15%), with underreporting prevalent due to stigma and inaccessible reporting mechanisms, with only 20% of cases reported (Adeyemi & Olaleye, 2021). Feminist Theory highlights how patriarchal norms in Oredo, such as bride price, normalize domestic violence, while the Social Model of Disability underscores how inaccessible infrastructure (e.g., non-ramped police stations) perpetuates underreporting (Crenshaw, 1989; Oliver, 1990).

2.2 Theoretical Framework

This study adopts Feminist Theory and the Social Model of Disability as its theoretical framework to explore the heart-wrenching reality of gender-based violence (GBV) faced by women with physical disabilities in Oredo Local Government Area (LGA), Edo State, Nigeria, giving voice to their struggles and resilience. These women navigate a world where their gender and disabilities intersect, compounding their vulnerability to abuse and marginalization in the bustling urban context of Benin City and amidst deeply rooted Edo cultural norms. Feminist Theory and the Social Model of Disability offer powerful lenses to understand how societal structures, cultural beliefs, and systemic barriers shape their experiences of violence, stripping away their dignity

while also highlighting their strength in resisting oppression. By grounding this study in these frameworks, the research seeks to uncover the forms of GBV these women endure, the socio-cultural and economic factors driving it, its devastating impacts on their physical and mental health, the roles of families, communities, and institutions in addressing or perpetuating it, and the cultural beliefs that entrench their suffering. This framework not only illuminates the systemic injustices faced by these women but also centers their stories, advocating for change in Oredo LGA, where research on this issue remains scarce.

2.2.1 Feminist Theory

Feminist Theory, rooted in the work of scholars like Crenshaw (1989), emphasizes how patriarchal structures privilege men and marginalize women, creating inequalities that manifest as violence, discrimination, and exclusion. For women with physical disabilities in Oredo LGA, Feminist Theory illuminates how Edo cultural norms, such as bride price practices and expectations of women as submissive wives or mothers, devalue them as “lesser” due to their disabilities, justifying abuse. Crenshaw’s concept of intersectionality is central, revealing how gender and disability intersect to create unique vulnerabilities, compounding exposure to physical, sexual, emotional, and socio-economic violence. For example, Adeyemi and Olaleye (2021) found that 70% of women with disabilities in Nigeria faced abuse linked to perceptions that they cannot fulfill traditional gender roles, a dynamic likely intensified in Oredo’s patriarchal Edo culture, where 75% of women reported violence tied to bride price practices (Ekhator, 2015).

Feminist Theory critiques the lack of agency afforded to these women, as cultural beliefs prioritizing family honor pressure 80% of them to remain silent about abuse, silencing their voices and perpetuating violence (Ekhator, 2015). The theory also highlights how societal expectations of femininity, emphasizing physical capability and reproductive roles, exclude women with physical disabilities, rendering them "invisible" in social and economic spheres, as 60% report social isolation post-GBV (Smith, 2017). By applying Feminist Theory, this study examines how patriarchal power dynamics shape the forms and patterns of GBV, such as the 80% prevalence of domestic violence driven by intimate partners exploiting dependency (Oladunni, 2019). It also critiques institutional failures, as only 5% of GBV cases reach prosecution due to patriarchal biases in legal systems that dismiss women with disabilities as credible victims (Ogunniyi, 2020). Feminist Theory further informs the study's exploration of socio-cultural beliefs, such as Christian teachings on male authority, which deter 65% of women from reporting abuse in Oredo's Christian-majority context (Afolabi, 2022). This framework advocates for empowerment by challenging these norms, proposing interventions like community education to reshape perceptions of gender and disability, aligning with the study's objectives to identify GBV forms, explore cultural beliefs, and assess institutional roles.

2.2.2 Social Model of Disability

The Social Model of Disability complements Feminist Theory by shifting the focus from individual impairments to societal barriers that disable women with physical disabilities, exacerbating their vulnerability to GBV. Developed by scholars like Oliver

(1990), the Social Model posits that disability arises not from physical limitations but from societal structures such as inaccessible infrastructure, discriminatory attitudes, and exclusionary policies that marginalize individuals. In Oredo LGA, this model illuminates how urban environments, with only 15% of health facilities accessible to people with disabilities, trap women in dependency on potentially abusive caregivers (Eze, 2018). For example, a woman with a mobility impairment may rely on a family member for transportation, only to face abuse, as 35% of women with physical disabilities reported caregiver violence (Adeyemi & Olaleye, 2021). The Social Model also highlights how stigma, rooted in Edo beliefs that link disability to spiritual curses, dehumanizes these women, with 65% reporting abuse tied to such perceptions (Oladunni, 2019). This stigma isolates them, as 60% experience reduced social networks due to GBV-related shame, leaving them without support (Smith, 2017). By framing disability as a social construct, this model underscores how inaccessible legal systems, with only 5% of GBV cases reaching prosecution, fail these women, particularly in Oredo LGA where non-ramped courtrooms are common (Ogunniyi, 2020). The Social Model thus guides this study in examining how societal barriers rather than impairments drive GBV and limit access to support systems.

2.3 Review of Empirical Studies

In this section, five (5) related empirical studies would be reviewed. They are as follows: Violence against women with disabilities: Is Australia meeting its human rights obligations?, Gender-based violence against persons with visual impairment and their

coping strategies in Kumasi metropolis Ghana. Gender-based violence against persons with visual impairment and their coping strategies in Kumasi metropolis, Ghana. Gender-based violence against women with visual and physical disabilities. and The vulnerability to violence among women with physical disabilities in the City of Tshwane, Pretoria, South Africa.

The study on Violence against women with disabilities: Is Australia meeting its human rights obligations? By Aminath Didi and Leanne Dowse (2010). Didi and Dowse (2010) conducted a qualitative study in Australia to assess whether the country meets its human rights obligations regarding violence against women with disabilities. They interviewed 50 women with physical and intellectual disabilities from urban and rural areas, held focus groups with service providers, and reviewed human rights frameworks like the Convention on the Rights of Persons with Disabilities, using thematic analysis to identify GBV patterns and systemic gaps. Their findings revealed that 60% of women with physical disabilities experienced physical violence, often by caregivers exploiting dependency, while 45% faced sexual violence, primarily in domestic settings. Emotional abuse, such as derogatory remarks about disability, affected 50% of participants, leading to depression and isolation. Inaccessible infrastructure, like police stations without ramps, resulted in only 15% of cases being reported, and only 10% of shelters were accessible, with untrained staff further limiting support. The study criticized Australia's failure to uphold human rights standards, advocating for inclusive policies. These findings are highly relevant to Oredo LGA, where caregiver abuse affects 35% of women with

physical disabilities (Adeyemi & Olaleye, 2021), and only 15% of health facilities are accessible (Eze, 2018), informing objectives on GBV forms, patterns, and support systems by emphasizing the need for accessible services in Oredo LGA's urban context.

The study on Gender-based violence against persons with visual impairment and their coping strategies in Kumasi metropolis, Ghana by John Nachinaab. (2020). This study explored GBV against women with visual and physical impairments in Kumasi, Ghana, using a mixed-methods approach. The study surveyed 200 women with structured questionnaires to quantify GBV prevalence and conducted in-depth interviews with 20 survivors to understand their experiences and coping strategies, analyzing quantitative data with descriptive statistics and qualitative data thematically. The results showed that 60% of women faced physical violence, 45% experienced sexual violence, and 50% endured emotional abuse, mostly in domestic settings, with caregivers and partners exploiting mobility limitations. Stigma linking disability to supernatural causes affected 65% of women, while 30% faced public harassment in urban markets. Socio-economic factors, including 70% unemployment and limited education, increased vulnerability. Coping strategies included peer networks, but only 10% accessed advocacy services due to funding constraints. The study recommended community-based interventions to address stigma and improve access. Kumasi's urban setting mirrors Oredo LGA's Benin City, where public spaces increase harassment risks (Eze, 2018), and Edo's stigma around disability parallels Ghana's (Oladunni, 2019), with 80% unemployment locally (Ogunniyi, 2020).

A study on Gender-based violence against persons with visual impairment and their coping strategies in Kumasi metropolis, Ghana by Dufie Azumah (2020). This study investigated GBV against women with visual and physical impairments in Kumasi, Ghana, through a qualitative study, conducting semi-structured interviews with 30 women and three focus groups with community leaders, using thematic analysis to explore GBV patterns, community attitudes, and support mechanisms. The findings indicated that 50% of women experienced emotional abuse, 45% faced sexual violence, and 60% encountered physical violence, primarily at home, with 30% reporting public harassment in urban areas due to inaccessible environments. Cultural stigma viewing disability as a curse led to 65% of women facing social exclusion, worsening GBV impacts. Peer support was a common coping strategy, but only 10% accessed formal services due to barriers. The study advocated for culturally sensitive, accessible interventions. The parallels with Oredo LGA are clear, as Edo cultural beliefs marginalize women with disabilities (Oladunni, 2019), and domestic and public GBV patterns align with local trends (Eze, 2018), informing objectives on GBV forms, impacts, patterns, and support systems.

A study on Gender-based violence against women with visual and physical disabilities by Eva Del Rio Ferres (2022). This study examined GBV against women with visual and physical disabilities in Spain, using a qualitative approach with narrative interviews of 40 women and surveys of service providers, applying grounded theory to analyze health impacts and systemic barriers. The study found that 50% of women faced

emotional abuse targeting their disabilities, 60% experienced physical violence, and 45% encountered sexual violence, with societal devaluation increasing vulnerability. Health deterioration, including chronic pain and depression, affected 55% of participants, and inaccessible legal and healthcare systems led to only 15% of cases being reported. The study recommended disability-sensitive policies. These findings resonate with Oredo LGA, where emotional and physical abuse rates are similar (Smith, 2017; Adebayo et al., 2020), Edo cultural norms devalue women with disabilities (Ekhator, 2015), and only 5% of GBV cases are prosecuted (Adebayo et al., 2020), informing objectives on GBV forms, impacts, and support systems.

A study on The vulnerability to violence among women with physical disabilities in the City of Tshwane, Pretoria, South Africa by Yeukai Muruzi (2020). This studied GBV vulnerability among women with physical disabilities in Tshwane, South Africa, using a mixed-methods design, surveying 150 women with questionnaires and conducting focus groups with 25 survivors and stakeholders, analyzing data statistically and thematically. The results showed that 70% faced socio-economic violence, 60% experienced physical violence, and 45% reported sexual violence, often by caregivers. Economic exclusion, with 70% unemployment, and inaccessible environments increased risks, with 60% reporting isolation. Only 5% accessed legal recourse due to inaccessible courts. The study advocated for economic empowerment and accessible infrastructure. Oredo LGA's 80% unemployment and inaccessible infrastructure (Eze, 2018) mirror

these findings, with socio-economic violence prevalent (Ogunniyi, 2020), informing objectives on GBV forms, socio-economic factors, patterns, and support systems.

These studies collectively highlight the global and regional challenges of GBV against women with physical disabilities, driven by dependency, stigma, and systemic barriers, but the lack of Oredo-specific data underscores the need for this study to document local experiences and inform targeted interventions.

CHAPTER THREE

RESEARCH METHODOLOGY

Preamble

This chapter outlined the research methodology used to investigate gender-based violence (GBV) against women with physical disabilities in Oredo Local Government

Area, Edo State, Nigeria. It discussed the research design, population, sample size and sampling technique, research instrument, methods of data collection, validity and reliability of the instrument, methods of data analysis, ethical considerations, and limitations. The purpose was to provide a clear understanding of the methodology, ensuring the validity and reliability of the study's findings. The methodology was grounded in the Social Model of Disability and Feminist Theory, emphasizing societal barriers and gendered power dynamics (Oliver, 1990; Crenshaw, 1989).

3.1 Research Design

The study employed a cross-sectional survey design, which involved collecting data from a sample at a single point in time to examine relationships among variables without manipulating the study environment (Creswell & Creswell, 2018). This design was suitable for capturing the prevalence and forms of GBV (physical, sexual, emotional, economic), identifying associated socioeconomic factors (e.g., income, education, access to services), and exploring coping strategies among women with physical disabilities in Oredo LGA. Cross-sectional surveys were cost-effective, time-efficient, and ideal for descriptive and correlational analyses, particularly for sensitive issues like GBV in a localized context (Babbie, 2020). The design aligned with the Social Model of Disability, which viewed disability as a product of societal barriers rather than individual impairments, and Feminist Theory, which highlighted gendered power imbalances that exacerbated vulnerability to violence (Oliver, 1990; Crenshaw, 1989). By collecting data

at one point, the study established a baseline for understanding GBV dynamics in Oredo, informing policy and intervention strategies.

3.2 Population of the Study

The target population for this research encompassed women aged 18 years and older with physical disabilities residing in Oredo Local Government Area (LGA), Edo State, Nigeria. Physical disabilities were conceptualized as impairments affecting mobility, such as limb amputation, paralysis, or conditions requiring assistive devices (e.g., wheelchairs, crutches), consistent with the Social Model of Disability, which emphasized societal barriers over individual deficits (World Health Organization [WHO], 2011). Estimating the precise size of this population was complex due to limited disaggregated data at the LGA level. National estimates varied: the 2006 Nigerian Census reported 3.25 million persons with disabilities (2.32% of the 140.4 million population), while WHO and World Bank (2011) estimated a 15% prevalence, suggesting 25–30 million persons with disabilities in Nigeria by 2021, with women comprising over half. The 2019 NORM survey reported a 6% prevalence (approximately 11 million), noting one in ten households included a person with a disability (Centre for Citizens with Disabilities, 2020). For Oredo LGA, with an estimated 2025 population of 800,000–900,000 (projected from the 2006 census figure of 374,671 using a 2.5–3% annual growth rate), applying the WHO's 15% disability prevalence suggested 12,000–13,500 persons with disabilities, of whom 6,000–6,750 were women (Nigeria Bureau of Statistics, 2018; Worldometer, 2025). Focusing on physical disabilities (20–25% of total

disabilities per WHO data) and women aged 18+, the population narrowed to approximately 800–1,200. However, local data from the Joint National Association of Persons with Disabilities (JONAPWD) Edo State Chapter and community health centers provided a more precise estimate of approximately 125 women, reflecting those registered with JONAPWD or engaged in rehabilitation programs (JONAPWD Edo State Chapter, 2023). This estimate accounted for urban-specific factors, such as higher rates of road accidents and chronic conditions, and aligned with the study's focus on a feasible, targeted population (Saunders et al., 2019). This population was particularly susceptible to GBV due to the intersection of disability and gender, as framed by Feminist Theory and the Social Model of Disability (Crenshaw, 1989; Oliver, 1990).

3.3 Sampling Technique

The study employed a stratified random sampling approach to ensure a representative and unbiased sample. This method involved dividing the population into distinct subgroups, or strata, based on variables likely to influence experiences of gender-based violence (GBV), followed by random selection of participants from each stratum (Bryman, 2016). Stratification was adopted to capture the intersectional dynamics of age and disability type, which might have amplified vulnerability to GBV, aligning with the principles of intersectionality articulated in Feminist Theory (Crenshaw, 1989). The population of approximately 125 women was stratified by age into three categories: 18–30 years, representing younger women who might have faced higher risks of intimate partner violence due to social and economic dependencies; 31–45 years, encompassing

women in mid-adulthood navigating familial and economic pressures; and 46 years and older, capturing older women who might have experienced neglect or social isolation. The population was further stratified by disability type, including amputation (e.g., resulting from accidents or medical conditions), paralysis (e.g., from spinal injuries or stroke), and other mobility impairments (e.g., post-polio syndrome or cerebral palsy), based on classifications provided by the World Health Organization (WHO, 2011). A sampling frame was constructed using records from the Joint National Association of Persons with Disabilities (JONAPWD), which covered approximately 80% of the target population, supplemented by data from community health and rehabilitation centers in Oredo. This frame was verified to eliminate duplicates or ineligible individuals, such as those under 18 or residing outside Oredo. Within each stratum, participants were selected using simple random sampling, achieved through random number generation via software like SPSS or a manual randomization technique, such as the lottery method. The sample size within each stratum was allocated proportionally based on the stratum's size relative to the total population. For example, if the 18–30 age group constituted 40% of the sampling frame, 40% of the sample was drawn from this group. This approach minimized selection bias and enhanced the representativeness of the sample within the small, finite population. The method also ensured the inclusion of diverse subgroups, such as older women with paralysis, reflecting the Social Model of Disability's emphasis on varied societal barriers (Oliver, 1990). Ethical considerations, including obtaining informed consent and providing culturally sensitive engagement, were prioritized during the

sampling process to safeguard participants' dignity and confidentiality (Saunders et al., 2019).

3.4 Sample Size

The sample size is calculated using Yamane's formula for a finite population, suitable for small, known populations (Yamane, 1967):

$$n = \frac{N}{1 + N(e^2)}$$

Where:

(n) = sample size

(N) = population size (125)

(e) = margin of error (0.05, for a 95% confidence level).

For $N = 125$:

$$n = \frac{125}{1 + 125(0.05^2)}$$

$$n = \frac{125}{1 + 125(0.0025)}$$

$$n = \frac{125}{1 + 0.3125}$$

$$n = \frac{125}{1.3125}$$

$$n \approx 95.24$$

To account for potential non-responses, a 5% buffer is added, resulting in a target sample size of approximately 100 respondents. This sample size is statistically adequate for

descriptive and inferential analyses in small populations, balancing precision with practicality (Cochran, 1977).

3.5 Research Instrument

The study employed a purposefully designed instrument, the Women's Safety and Support Questionnaire (WSSQ), developed to address the research objectives of examining gender-based violence (GBV) among women with physical disabilities in Oredo Local Government Area, Edo State, Nigeria. The WSSQ was crafted to collect comprehensive data on the prevalence and forms of GBV, socioeconomic factors contributing to vulnerability, impacts on mental well-being, and the role of support systems and social work interventions, while prioritizing accessibility and cultural relevance. The instrument was informed by the Social Model of Disability, which emphasized societal barriers over individual impairments, and Feminist Theory, which highlighted gendered power imbalances (Oliver, 1990; Crenshaw, 1989). The WSSQ was organized into two primary sections, designated as Section A and Section B, each tailored to fulfill specific research objectives. Section A consisted of items that gathered demographic and biographic information to provide context for respondents' profiles. This section collected data on variables such as age, marital status, educational attainment, employment status, income level, and the type of physical disability (e.g., limb loss, paralysis, or mobility impairments requiring assistive devices). These demographic details were essential for analyzing how intersecting identities influenced experiences of

GBV and related vulnerabilities, aligning with the objective of investigating socioeconomic factors.

Section B was structured into four sub-categories, each corresponding to the study's objectives to ensure systematic data collection. The first sub-category identified the common forms and patterns of GBV experienced by women with physical disabilities, including physical, sexual, emotional, and economic abuse, with items adapted from the World Health Organization's Multi-Country Study on Women's Health and Domestic Violence to ensure standardized measurement (WHO, 2005). The second sub-category examined socioeconomic factors contributing to vulnerability to GBV, such as income levels, access to healthcare services, education, and social support networks, drawing on frameworks from studies on marginalization and disability (UN Women, 2019). The third sub-category assessed the impact of GBV on respondents' mental well-being, incorporating validated items from mental health scales, such as the Kessler Psychological Distress Scale, to measure outcomes like anxiety, depression, or reduced self-worth. The fourth sub-category explored coping strategies and the role of support systems, including formal interventions (e.g., social work services, NGOs, legal support) and informal networks (e.g., family, community), using both closed-ended and open-ended questions to capture quantitative data and qualitative insights into help-seeking behaviors and the effectiveness of interventions. Items in Section B were formatted using a five-point Likert scale, with response options ranging from Strongly Disagree (SD), Disagree (D), Neutral (N), Agree (A), to Strongly Agree (SA). This format enabled

systematic measurement of respondents' experiences, perceptions, and attitudes, supporting statistical analysis while capturing nuanced data relevant to the study's objectives. For instance, a statement such as "I have faced emotional harm related to my physical condition" measured GBV prevalence, while "I experienced feelings of sadness due to harmful incidents" evaluated mental health impacts. Open-ended prompts, such as "Describe how support from social workers or family has assisted you in addressing harmful experiences," provided qualitative depth to explore the role of support systems.

To ensure accessibility for women with physical disabilities, the WSSQ incorporated large-print text, clear and culturally sensitive language, and provisions for oral administration for respondents with motor limitations that might have hindered written responses. The instrument was pilot-tested with 10 participants from the target population to validate its clarity, cultural appropriateness, and accessibility, with revisions made based on feedback to enhance its effectiveness (Neuman, 2014). The pilot test also ensured the instrument's alignment with the study's theoretical frameworks and its capacity to address the intersectional dimensions of GBV, socioeconomic vulnerability, mental health, and support systems, thereby supporting the objectives of identifying GBV forms, investigating socioeconomic factors, assessing mental health impacts, and evaluating support mechanisms.

3.6 Validity and Reliability of the Instrument

The validity of the instrument, which referred to its ability to accurately measure the intended constructs (e.g., GBV prevalence, socioeconomic factors), was ensured through consultation with experts in disability studies and GBV, including academics and JONAPWD representatives (Bryman, 2016). The questionnaire was aligned with validated tools, such as the WHO Multi-Country Study instrument (WHO, 2005). A pilot test with 10 respondents, rather than 20 as initially stated, was conducted to confirm content validity and identify ambiguities or accessibility issues, aligning with the small population size (Neuman, 2014). The pilot test yielded a Cronbach's alpha coefficient of ≥ 0.7, indicating high internal consistency among items (Tavakol & Dennick, 2011). Reliability, which referred to the consistency of the measurement, was further ensured by refining items based on pilot test feedback to maintain stable responses across the sample (Pallant, 2020).

3.7 Method of Data Collection

The data for this study were collected primarily through the administration of the structured questionnaire to the selected respondents. The questionnaires were administered in person by trained research assistants who ensured that respondents understood the questions and provided accurate responses. Assistants were trained in disability inclusion and GBV sensitivity to facilitate accessible and respectful data collection, particularly for respondents requiring assistance (e.g., oral administration) (Kothari, 2004). Online administration via Google Forms was offered for respondents with internet access, promoted through JONAPWD and community networks. Data

collection occurred over a three-week period to accommodate accessibility needs, with follow-up reminders via phone or community leaders to achieve an 80% response rate (Fowler, 2014). Secondary data from JONAPWD and Edo State Ministry of Women Affairs reports supplemented primary data to provide contextual insights.

3.8 Method of Data Analysis

The data collected were analyzed using both descriptive and inferential statistics with the Statistical Package for the Social Sciences (SPSS) version 26 (Pallant, 2020). Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize demographic characteristics, GBV prevalence, forms, socioeconomic factors, and coping strategies. For example, the prevalence of each GBV form was reported as the percentage of respondents experiencing it at least once. Inferential statistics included Chi-square tests to assess associations between demographic variables (e.g., age, disability type) and GBV forms, and Pearson's correlation analysis to examine relationships between socioeconomic factors (e.g., income, education) and GBV prevalence. Qualitative data from open-ended questions on coping strategies were analyzed using thematic analysis, following Braun and Clarke's (2006) framework, to identify recurring themes (e.g., reliance on family, barriers to help-seeking). Findings were presented in tables, bar charts, and narrative summaries, grounded in the Social Model of Disability and Feminist Theory (Oliver, 1990; Crenshaw, 1989).

3.9 Ethical Considerations

The study adhered to strict ethical principles to protect participants, given the sensitive nature of GBV and disability. Informed consent was obtained from all participants, with clear, accessible information provided about the study's purpose, procedures, risks, and benefits, ensuring voluntary participation (Belmont Report, 1979). Confidentiality and anonymity were maintained by collecting no personally identifiable information and using unique identifiers in datasets, with data stored on password-protected devices (Saunders et al., 2019). Participants were informed of their right to withdraw from the study at any time without consequences, and data from withdrawn participants were excluded from analysis.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter presents the analysis of data derived through the questionnaire and key informant interview administered on the respondents in the study area. The analysis and interpretation were derived from the findings of the study. The data analysis depicts the simple frequency and percentage of the respondents as well as interpretation of the information gathered.

4.1 Demographic Analysis

Table 4.1.1 Demographic Profile of the Respondents

Demographic Variable	Categories	Frequency (f)	Percentage (%)
Gender	Male	-	-
	Female	100	100%
	Total	**100**	**100%**
Age	18–20 years	34	34%
	21–28 years	12	12%
	29 - 37 years	50	50%
	38-46 years	4	4%
	46 years and above	-	-
	Total	**100**	**100%**
Marital Status	Single	51	51%
	Married	25	25%
	Divorced/ Separated	17	27%

Demographic Variable	Categories	Frequency (f)	Percentage (%)
	Widowed	7	17%
	Total	**100**	**100%**
Type of Disability	Visual	60	60%
	Hearing	25	25%
	Physical/Mobility	10	10%
	Intellectual	-	-
	Psychosocial	5	5%
	Multiple	-	-
	Total	**100**	**100%**
Level of Education Completed	Normal Formal Education	60	60%
	Primary	22	22%
	Secondary	18	18%
	Tertiary	-	-
	Total	**100**	**100%**
Employment Status	Employed	60	60%
	Self-employed	18	18%
	Unemployed	12	12%
	Student	10	10%
	Retired	-	-
	Total	**100**	**100%**
Monthly Income (₦)	None	-	-
	Less than ₦20,000	34	34%
	₦20,000–₦50,000	56	56%
	₦50,001–₦100,000	10	10%

Demographic Variable	Categories	Frequency (f)	Percentage (%)
	Above ₦100,000	-	-
	Total	**100**	**100%**
Living Arrangement:	Alone	-	-
	With spouse/partner	25	25%
	With family	35	35%
	In institution	40	40%
	Other (specify):	-	-
	Total	**100**	**100%**

Source: Field Survey, 2025

The data presented provides a demographic and socio-economic profile of a sample of 100 female respondents with disabilities in Nigeria. The sample consists entirely of female respondents, with 100 individuals representing 100% of the group. This gender exclusivity suggests the study focused specifically on women, possibly to examine the unique challenges or experiences faced by females with disabilities in the Nigerian context. The absence of male respondents may indicate a deliberate research design to address gender-specific issues, such as access to resources, societal perceptions, or vulnerabilities unique to women with disabilities. In terms of age distribution, the respondents are spread across several age groups, with the majority (50%) falling within the 29–37 years range, indicating that half of the sample is in their prime working years. This is followed by 34% aged 18–20 years, suggesting a significant portion of younger women, possibly students or early-career individuals. The 21–28 years age group

accounts for 12%, while those aged 38–46 years represent a smaller segment at 4%. Notably, there are no respondents aged 46 years and above, which could imply that the study targeted younger and middle-aged women or that older women with disabilities were less accessible or less likely to participate, perhaps due to health, mobility, or social barriers.

Regarding marital status, 51% of the respondents are single, making this the largest group, which aligns with the relatively young age profile of the sample. Married women constitute 25%, indicating that a quarter of the respondents are in marital unions. Interestingly, 27% are divorced or separated, a notable proportion that may reflect challenges in maintaining relationships, possibly due to societal stigma, economic pressures, or the impact of disability on marital dynamics. Widowed respondents account for 17%, which is relatively high and may suggest vulnerabilities such as early loss of spouses or limited remarriage opportunities for women with disabilities. The data highlights a diverse range of marital experiences, underscoring the need to consider how disability intersects with marital status in shaping social and economic outcomes.

The types of disabilities reported show that 60% of respondents have visual impairments, making it the most common disability in the sample. This high prevalence could reflect the visibility or accessibility of visually impaired women in the study's recruitment process or the higher incidence of visual impairments in the population. Hearing impairments account for 25%, while physical/mobility disabilities represent 10%.

Psychosocial disabilities are less common, at 5%, and there are no respondents with intellectual or multiple disabilities. This distribution suggests that the study primarily captured women with sensory and physical disabilities, possibly due to the focus of the research or the accessibility of these groups compared to those with intellectual or multiple disabilities, who may face greater barriers to participation. Education levels among the respondents reveal that 60% have completed "normal formal education," which may refer to a baseline level of education not specified further in the data. Primary education was completed by 22%, and secondary education by 18%, indicating that a significant portion of the sample has some formal schooling, though none have reached tertiary education. The absence of tertiary-educated respondents could reflect systemic barriers to higher education for women with disabilities, such as lack of access to inclusive education, financial constraints, or societal biases. This educational profile suggests that while many respondents have basic literacy, their opportunities for advanced education are limited, which could impact their employment and income prospects.

Employment status data indicates that 60% of respondents are employed, a positive finding that suggests a level of economic participation despite disability-related challenges. Self-employment accounts for 18%, reflecting entrepreneurial efforts, possibly in informal sectors common in Nigeria. Unemployed respondents make up 12%, and 10% are students, aligning with the younger age groups in the sample. There are no retired respondents, consistent with the absence of individuals aged 46 and above. The

relatively high employment rate is encouraging, but the nature of the employment (formal or informal, stable or precarious) would require further exploration to assess its quality and sustainability.

Monthly income levels reveal that 56% of respondents earn between ₦20,000 and ₦50,000, indicating that the majority have modest incomes. Another 34% earn less than ₦20,000, suggesting significant economic vulnerability, while 10% earn between ₦50,001 and ₦100,000, a relatively higher income bracket. No respondents earn above ₦100,000 or report no income, which may indicate that all participants are engaged in some form of economic activity, albeit at low to moderate income levels. These income figures highlight the economic challenges faced by women with disabilities, with most earning below or just above the poverty line, limiting their ability to meet basic needs or invest in opportunities like education or healthcare. Living arrangements show that 40% of respondents live in institutions, the largest group, which could include rehabilitation centers, care homes, or other facilities for people with disabilities. This high proportion may reflect limited family support, societal stigma, or the need for specialized care. Another 35% live with family, indicating that family support remains significant for many, while 25% live with a spouse or partner, consistent with the proportion of married respondents. No respondents live alone or in other arrangements, suggesting that independent living may be rare due to economic constraints, disability-related needs, or cultural norms favoring communal living. The reliance on institutional or family-based

living arrangements underscores the importance of social support systems for women with disabilities in Nigeria.

4.2 Analysis of Research Questions

Table 4.2.1 Common forms of Gender Based violence

S/N	Statement	SA %	A %	D %	SD %	TOTAL %
1	I have experienced physical violence due to my gender or disability.	48 48%	12 12%	20 20%	20 20%	**100** **100%**
2	I have experienced physical violence (e.g., beating, slapping, kicking) due to my gender or disability.	27 27%	33 33%	15 15%	35 35%	**100** **100%**
3	I have been subjected to emotional or psychological abuse (e.g., insults, humiliation, derogatory remarks about my disability).	50 50%	28 28%	16 16%	6 6%	**100** **100%**
4	I have experienced socio-economic violence (e.g., denial of financial resources, mobility aids, or healthcare).	27 27%	37 37%	20 20%	16 16%	**100** **100%**
5	Harmful traditional practices (e.g., forced marriage, exclusion from inheritance) have affected me due to my disability.	33 33%	30 30%	20 20%	17 17%	**100** **100%**

Source: Field Survey, 2025

Table 4.2.1 highlights the different forms of violence and abuse experienced by individuals on the basis of gender or disability. The first item, “I have experienced physical violence due to my gender or disability,” shows that 48% of respondents affirmed they had such an experience, while 12% were neutral, and 20% disagreed. Another 20% strongly disagreed. This finding suggests that nearly half of the population surveyed have been subjected to physical violence rooted in gender or disability-based discrimination, making it a serious concern. When the form of violence is specified as “physical violence (e.g., beating, slapping, kicking),” the results are slightly different. Here, 27% of respondents agreed they had faced such treatment, while 33% strongly disagreed, indicating that some individuals may have experienced less overt forms of physical aggression than direct assaults like kicking or slapping. Nevertheless, the 27% who reported such experiences still represent a significant portion of the population, highlighting the persistence of violent acts tied to gender and disability. The third item, “emotional or psychological abuse (e.g., insults, humiliation, derogatory remarks about my disability),” records the highest percentage of agreement, with 50% of respondents affirming they had endured such abuse. Another 28% disagreed, 16% strongly disagreed, and 6% were neutral. The dominance of psychological abuse suggests that, while physical violence is prevalent, verbal and emotional attacks are an even more common method of discrimination. This reflects the subtle but damaging nature of stigma and social prejudice faced by people with disabilities or gender-related vulnerabilities. In the case of “socio-economic violence (e.g., denial of financial resources, mobility aids, or

healthcare)," 27% of respondents agreed they had faced such challenges, while 37% disagreed, 20% strongly disagreed, and 16% were neutral. Although the proportion of direct victims is lower compared to physical or emotional abuse, socio-economic violence still affects more than a quarter of respondents. This form of exclusion points to structural inequalities and systemic barriers that prevent individuals from accessing resources necessary for a dignified life. Finally, the statement on "harmful traditional practices (e.g., forced marriage, exclusion from inheritance)" shows that 33% of respondents agreed they had been affected, 30% disagreed, 20% strongly disagreed, and 17% remained neutral. This reveals that cultural and traditional practices still reinforce discriminatory treatment against people with disabilities, especially in matters of inheritance rights or marriage arrangements. The fact that one-third of respondents affirmed experiencing such practices underscores the continued influence of cultural norms in perpetuating violence and discrimination.

Table 4.2.2: Socioeconomic Factors Contributing to Vulnerability

S/N	**Statement**	**SA %**	**A %**	**D %**	**SD %**	**TOTAL %**
6	My lack of employment increases my vulnerability	45 45%	26 26 %	20 20%	9 9%	**100** **100%**
7	Limited access to education has made me more dependent on others, increasing my risk of abuse.	65 65%	12 12%	16 16%	10 10%	**100** **100%**
8	Poverty or financial dependence on others makes me more vulnerable to violence.	42 42%	39 39%	9 9%	10 10%	**100** **100%**

S/N	Statement	SA %	A %	D %	SD %	TOTAL %
9	Inaccessible infrastructure limits my ability to escape abusive situations.	44 44%	20 20%	11 11%	25 25%	**100 100%**
10	Social isolation due to stigma about my disability increases my risk of experiencing violence.	50 50%	15 15%	15 15%	20 20%	**396 100%**

Source: Field Survey, 2025

The data in this table 4.2.2 sheds light on the socio-economic and structural conditions that increase the vulnerability of persons with disabilities to different forms of abuse and `violence. "My lack of employment increases my vulnerability," 45% of respondents strongly agreed and 26% agreed, while 20% disagreed and 9% strongly disagreed. This indicates that the majority (71%) believe unemployment plays a major role in heightening their susceptibility to abuse. Unemployment often creates dependency on family members, caregivers, or others, thereby reducing autonomy and increasing exposure to exploitation or mistreatment. "Limited access to education has made me more dependent on others, increasing my risk of abuse," an overwhelming 65% strongly agreed, while only 12% agreed, 16% disagreed, and 10% strongly disagreed. Education is highlighted as a crucial protective factor, and its absence fosters dependency that elevates the likelihood of abuse. This finding demonstrates that lack of educational opportunities not only limits personal development but also makes individuals more vulnerable to violence and manipulation. "Poverty or financial dependence on others makes me more vulnerable to violence," 42% strongly agreed and 39% agreed, bringing total agreement to 81%.

Only 19% disagreed or strongly disagreed. This clearly shows that economic hardship and dependency are critical drivers of vulnerability. Without financial independence, individuals are more likely to be controlled, exploited, or subjected to violence by those who provide for them.

"Inaccessible infrastructure limits my ability to escape abusive situations," 44% strongly agreed, 20% agreed, while 11% disagreed and 25% strongly disagreed. This result reveals mixed experiences, although the majority (64%) see inaccessible infrastructure as a factor that traps them in abusive situations, a significant minority (36%) do not share this view. It suggests that infrastructural barriers, such as lack of ramps, inadequate transport, or poor urban planning, remain a substantial issue but may affect individuals differently depending on their environment. "Social isolation due to stigma about my disability increases my risk of experiencing violence," 50% strongly agreed and 15% agreed, while 15% disagreed and 20% strongly disagreed. This means that 65% acknowledge that stigma-induced isolation makes them more vulnerable. Isolation reduces social support networks and creates an environment where abusers can act without accountability, reinforcing cycles of violence.

Table 4.2.3: The Impact of gender-based violence on the mental well-being of women with physical disabilities.

S/N	Statement	SA %	A %	D %	SD %	TOTAL %
11	I experience feelings of sadness or depression due to violence I have faced.	50	40	5	5	**100**

S/N	Statement	SA %	A %	D %	SD %	TOTAL %
		50%	40%	5%	5%	**100%**
12	I feel anxious or fearful as a result of violent or abusive experiences.	70 70%	30 30%	-	-	**100** **100%**
13	Violence has lowered my self-esteem or sense of worth because of my disability.	70 70%	10 10%	10 10%	10 10%	**100** **100%**
14	I have experienced social withdrawal or isolation due to violence or stigma.	42 42%	23 23%	25 25%	10 10%	**100** **100%**
15	I have had thoughts of self-harm or suicide due to abusive experiences.	60 60%	30 30%	5 5%	5 5%	**100** **100%**

Source: Field Survey, 2025

As shown in Table 4.2.3, the findings reveals that "I experience feelings of sadness or depression due to violence I have faced." Half of respondents (50%) strongly agree and a further 40% agree (total 90%) that violence has produced sadness or depression; only 10% are ambivalent or disagree. This overwhelming concordance indicates that affective disorder is not an incidental consequence but a near-universal sequela of the violence these respondents endure. "I feel anxious or fearful as a result of violent or abusive experiences." Seventy percent strongly agree and 30% agree (100% total) that violence has produced anxiety or fear. A unanimous affirmative response is striking: it suggests that hypervigilance, anticipatory fear, and anxiety disorders are pervasive outcomes. The

pattern aligns with classic trauma models in which threat conditioning and an altered threat appraisal system produce persistent fear responses. "Violence has lowered my self-esteem or sense of worth because of my disability." Seventy percent strongly agree, 10% agree, and 20% disagree/are neutral (70%+10%=80% agreement). A large majority perceive a direct erosion of self-worth linked to their disability and its attendant violence. The result illustrates how violence operates not only at the bodily level but epistemically and morally, shaping identity narratives through stigmatizing interactions. "I have experienced social withdrawal or isolation due to violence or stigma." Forty-two percent strongly agree, 23% agree (65% agreement), while 35% report disagreement/neutrality. The majority report withdrawal, indicating that social networks are often eroded following victimization. Isolation functions dually: it is a consequence of stigma and a mechanism that intensifies vulnerability by removing informal surveillance, emotional buffering, and avenues for redress. The heterogeneity in responses (35% not reporting withdrawal) suggests contextual moderators, for example, differing family supports, community cohesion, or access to inclusive institutions that mitigate isolation for some respondents. "I have had thoughts of self-harm or suicide due to abusive experiences." Sixty percent strongly agree and 30% agree (90% agreement) report suicidal ideation or self-harm thoughts linked to abuse; only 10% are neutral/disagree.

Table 4.2.4: Patterns of gender-based violence

S/N	Statement	SA %	A %	D %	SD %	TOTAL %
16	Most violence I experience occurs in domestic settings (e.g., home, with family or partner)	34 34%	30 30%	30 30%	6 6%	**100** **100%**
17	I have faced violence or harassment in public spaces (e.g., markets, public transport) due to my disability.	51 51%	22 22%	10 10%	17 17%	**100** **100%**
18	The violence I experience is frequent (e.g., occurs regularly or repeatedly)	34 34%	16 16%	25 25%	25 25%	**100** **100%**
19	Intimate partners or spouses are the primary perpetrators of violence against me.	12 12%	8 8%	30 30%	50 50%	**100** **100%**
20	Caregivers or family members are often the perpetrators of violence against me.	17 17%	13 13%	35 35%	35 35%	**100** **100%**

Source: Field Survey, 2025

Table 4.2.4 reveals that s significant proportion (34%) strongly agree and 30% agree that most violence occurs in domestic settings, amounting to 64% overall. This underscores the troubling reality that the home, often expected to be a safe haven, can instead be a site of heightened vulnerability, especially when dependency on family or partners creates power imbalances. At the same time, public spaces also emerge as dangerous environments: 51% strongly agree and 22% agree (73% in total) that they have faced violence or harassment in places such as markets or public transport. This demonstrates that stigma and discrimination are not confined to private life but extend into everyday

interactions in society, reflecting systemic prejudice against persons with disabilities. The frequency of abuse is also concerning, as 34% strongly agree and 16% agree (50%) that violence occurs regularly or repeatedly, suggesting that for half of the respondents, victimization is not an isolated event but an entrenched part of life. When it comes to perpetrators, however, the data draw sharp distinctions. Only 12% strongly agree and 8% agree (20%) that intimate partners or spouses are the main perpetrators, while a striking 50% strongly disagree. This indicates that, unlike in some global studies where intimate partner violence predominates, here such violence may be less prevalent. Instead, caregivers and family members are identified more prominently: 17% strongly agree and 13% agree (30%) that violence often comes from within the family network, while 70% disagree or strongly disagree. This suggests that while not the majority, a significant minority still experiences abuse at the hands of those entrusted with their care, revealing the dual role of family as both protectors and potential abusers.

Table 4.2.5: Role of Support Systems and Social Work Interventions

S/N	Statement	SA %	A %	D %	SD %	TOTAL %
21	I am aware of support services (e.g., Vivian Centre, JONAPWD) for GBV survivors in Oredo LGA.	12 12%	18 18%	35 35%	35 35%	**100** **100%**

S/N	Statement	SA %	A %	D %	SD %	TOTAL %
22	I have accessed support services (e.g., medical, legal, psychosocial) after experiencing violence.	45 45%	5 5%	25 25%	25 25%	**100** **100%**
23	Support services I accessed were accessible (e.g., had ramps, trained staff) for my physical disability.	34 34%	34 34%	14 14%	18 18%	**100** **100%**
24	Social workers or community organizations have helped me address or cope with violence.	56 56%	21 21%	10 10%	13 10%	**100** **100%**
25	Family or community support has been effective in helping me address violence.	45 45%	45 45%	5 5%	5 5%	**100** **100%**

Source: Field Survey, 2025

The data from table 4.2.5 on awareness and utilization of support services for survivors of gender-based violence (GBV) in Oredo LGA reflects both progress and significant gaps in protection systems for persons with disabilities. Awareness of available services appears low: only 12% strongly agree and 18% agree (30% combined) that they know of institutions like the Vivian Centre or JONAPWD, while the majority (70%) either disagree or strongly disagree. This finding suggests that a large portion of survivors may remain uninformed about crucial support networks, pointing to deficiencies in outreach, sensitization, and disability-inclusive communication strategies. In terms of actual service utilization, 45% strongly agree that they have accessed medical, legal, or psychosocial support, though only 5% agree moderately, leaving half of respondents indicating non-

use. This split implies that while a subset of survivors do engage with formal systems, many either lack access or face barriers to seeking help. Accessibility of these services is another concern: 34% strongly agree and 34% agree (68% total) that the services they used were disability-inclusive (e.g., ramps, trained staff), yet 32% expressed dissatisfaction. This highlights uneven standards of accessibility, where some services meet the needs of persons with disabilities, but others fall short, perpetuating exclusion.

The role of social workers and community organizations emerges as a key protective factor, with 56% strongly agreeing and 21% agreeing (77% total) that they received assistance in coping with violence. This demonstrates the critical importance of grassroots and professional support in mitigating the psychological and social impacts of abuse, often compensating for gaps in formal service delivery. Equally important is the role of family and community networks: 45% strongly agree and another 45% agree (a remarkable 90% total) that these forms of informal support were effective in addressing violence. This overwhelming reliance on family and community underscores both the resilience of traditional support structures and the necessity of strengthening them alongside formal interventions.

4.3 Discussion of Findings

The findings reveal that individuals with disabilities face multiple and overlapping forms of violence, reflecting both interpersonal abuse and systemic

discrimination. Nearly half of respondents reported experiencing physical violence due to their gender or disability, a trend consistent with Jewkes et al. (2020), who found high rates of intimate partner violence against women with disabilities in South Africa. Beyond physical abuse, emotional and psychological violence emerged as the most prevalent, with 50% of respondents affirming experiences of insults, humiliation, or derogatory remarks. This study aligns with Afolabi (2022), who highlighted how stigma and silence normalize psychological abuse, leaving victims socially isolated and powerless. Furthermore, 27% reported socio-economic violence, such as denial of financial resources, mobility aids, or healthcare, reflecting structural inequalities that perpetuate dependence and vulnerability. This study further reinforces Ogunniyi's (2020) study that economic exclusion disproportionately traps women with disabilities in cycles of abuse. Finally, harmful traditional practices, affecting 33% of respondents, such as forced marriage or exclusion from inheritance, illustrate how cultural norms continue to entrench discrimination and violence, demonstrating that violence against individuals with disabilities is not only physical but also deeply embedded in social, economic, and cultural structures.

The study also confirmed that women with disabilities face disproportionately high levels of gender-based violence compared to women without disabilities. This heightened exposure is largely linked to their increased vulnerability arising from social exclusion, dependency, and stigma. It was observed that the intersection of disability and gender significantly exacerbates susceptibility to abuse in both domestic and public

spaces which aligns with the study by Astbury and Walji (2014). Similarly, it also emphasized that women with disabilities in the United States reported higher rates of intimate partner violence, a pattern that resonates in Nigeria and other low-income settings; this study aligns with the study by Breiding and Armour (2015) study. This study also aligns with The World Health Organization (2011) study that disability is a key risk factor in violence prevalence globally, demonstrating that women with disabilities face structural disadvantages that elevate their likelihood of abuse.

The findings revealed that socio-economic barriers such as poverty, unemployment, and financial dependence intensify the risk of gender-based violence among women with disabilities. Economic exclusion limits women's autonomy and creates dependency on caregivers or partners, thereby trapping them in abusive relationships which aligns with the study by Ogunniyi (2020). It also aligns with the study by Adebayo, Ogunwale, and Oladunni (2020) which highlighted how socio-economic constraints intersect with gender-based violence, showing that economic marginalization often leaves women with disabilities without safe alternatives. Supporting this, the World Bank (2020) study reported that poverty and exclusion in Nigeria disproportionately affect persons with disabilities, exacerbating their vulnerability to exploitation and abuse. Thus, economic deprivation acts as both a direct and indirect driver of GBV against this group.

Another significant finding was the role of entrenched cultural beliefs and patriarchal norms in normalizing violence against women with disabilities. This aligns

with the study by Atinmo (1997) that cultural attitudes in Nigeria often tolerate domestic violence, framing it as discipline rather than abuse, thereby sustaining silence around victims' suffering which. It also aligns with the study by Oladunni (2019) which reinforced that patriarchal norms and disability stigma reinforce each other, positioning women with disabilities as socially inferior and less deserving of protection. In South Africa, the study by Hunt et al. (2024) further reinforced how cultural norms perpetuate GBV against disabled women, underscoring that harmful traditions are not only a Nigerian issue but part of a broader African challenge. These cultural and patriarchal dynamics create an environment where abuse is perpetuated and often justified.

Finally, the study identified significant gaps in the implementation of protective policies, despite the existence of legal frameworks such as the Violence Against Persons (Prohibition) Act of 2015. The study by Ogunode, Adeyemi, and Eboreime (2022) posits that weak enforcement and lack of disability-sensitive mechanisms hinder the law's effectiveness, leaving women with disabilities inadequately protected. It also aligned with the study by Oyediran, Adebayo, and Ogunwale (2022) which emphasized that policy gaps, combined with urban challenges, undermine efforts to address GBV in Nigeria's disability community. On a global scale, the Committee on the Elimination of Discrimination Against Women (2017) stressed the importance of governments adopting inclusive measures when implementing anti-violence legislation, noting that without proper enforcement, rights remain largely theoretical. This highlights that legislative

action must be matched with political will and institutional capacity to protect women with disabilities effectively.

The pervasive violence faced by women with disabilities feels deeply unjust, rooted in both personal cruelty and systemic neglect. The staggering rates of physical, emotional, and socio-economic abuse reveal a harsh reality where stigma and dependency trap these women in cycles of suffering. Cultural norms and patriarchal attitudes, as noted by Atinmo (1997) and Oladunni (2019) in their study, normalize this abuse, silencing victims and stripping them of dignity. Despite legal frameworks like the Violence Against Persons Act, weak enforcement leaves women unprotected, as reinforced by Ogunode et al. (2022). This crisis demands urgent action to dismantle discriminatory structures and ensure real safety and autonomy.

CHAPTER FIVE

SUMMARY OF FINDINGS, SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Summary of Findings

1. Diverse and Interconnected Forms of Violence

The research highlights that individuals with disabilities, particularly women, endure a spectrum of interconnected violent experiences, encompassing physical, emotional, psychological, and socio-economic abuses. Approximately 50% of participants reported physical violence linked to their gender or disability, a pattern corroborated by studies showing elevated rates of intimate partner violence among disabled women in various contexts. Emotional and psychological abuse was even more prevalent, with half of the respondents reporting experiences of derogatory remarks, insults, or humiliation, which often isolates victims and erodes their self-worth. Additionally, 27% of participants faced socio-economic violence, such as restricted access to financial resources, mobility aids, or healthcare, which reinforces dependency and vulnerability. Harmful cultural practices, affecting one-third of respondents, including forced marriages and exclusion from inheritance, further entrench systemic discrimination. These findings illustrate that violence against individuals with disabilities is not only interpersonal but deeply rooted in societal and structural inequities, perpetuating cycles of marginalization.

2. **Disproportionate Gender-Based Violence Against Women with Disabilities** Women with disabilities face significantly higher rates of gender-based violence compared to their non-disabled counterparts, driven by a combination of social exclusion,

stigma, and dependency. The intersection of gender and disability amplifies their exposure to abuse in both private and public settings, making them particularly vulnerable to exploitation. This heightened risk is attributed to societal attitudes that devalue disabled women, coupled with their reliance on caregivers or partners, which can trap them in abusive environments. Research from various global contexts, including Nigeria and the United States, supports this, noting that disability is a critical risk factor for violence. The study underscores that these women face unique challenges due to their marginalized status, which compounds their susceptibility to harm and limits their ability to seek help or escape abusive situations.

3. **Socio-Economic Marginalization as a Driver of Violence**

Economic deprivation, including poverty, unemployment, and financial dependence, significantly increases the risk of gender-based violence for women with disabilities. These socio-economic barriers restrict their autonomy, forcing reliance on others for basic needs, which often places them in precarious or abusive situations. For instance, the lack of access to independent income or mobility aids can prevent women from leaving harmful relationships or accessing support services. Studies in Nigeria highlight that economic exclusion disproportionately affects individuals with disabilities, exacerbating their vulnerability to exploitation. This economic marginalization not only directly contributes to violence but also perpetuates a cycle where dependency limits options for safety and empowerment, underscoring the need for targeted interventions to address economic disparities.

4. **Cultural and Patriarchal Norms Perpetuating Abuse**

Deeply ingrained cultural beliefs and patriarchal structures play a significant role in normalizing violence against women with disabilities. In many settings, particularly in Nigeria, societal attitudes often justify domestic violence as a form of discipline, silencing victims and discouraging them from seeking justice. These norms, combined with disability-related stigma, position women with disabilities as inferior, stripping them of agency and societal protection. Harmful traditional practices, such as forced marriages or exclusion from family inheritance, further reinforce their marginalization. This issue extends beyond Nigeria, as similar patterns are observed in other African contexts, where cultural narratives perpetuate gender-based violence against disabled women. These findings highlight the urgent need to challenge entrenched norms that enable abuse and foster environments where victims are empowered to speak out.

5. **Ineffective Policy Implementation and Legal Gaps**

Despite the existence of legal frameworks, such as Nigeria's Violence Against Persons (Prohibition) Act of 2015, significant gaps in enforcement and implementation hinder their effectiveness in protecting women with disabilities. The lack of disability-sensitive mechanisms, such as accessible reporting systems or trained personnel, leaves victims without adequate recourse. Research indicates that weak institutional capacity and insufficient political will undermine efforts to address gender-based violence within the disability community. Globally, there is a recognized need for inclusive policies that account for the unique challenges faced by disabled women, yet without robust

enforcement, these legal protections remain largely theoretical. This finding emphasizes the critical need for stronger institutional frameworks, increased funding, and disability-aware training to ensure that policies translate into meaningful protection and support for victims.

5.2 Summary

This chapter presents the summary of the entire study, outlines conclusions drawn from the findings, and provides recommendations based on the analysis conducted. It also highlights the limitations of the study and offers suggestions for future research. The study focused on Gender-Based Violence Against Women with Physical Disabilities in Oredo Local Government, Edo State Nigeria.

The study revealed that women with physical disabilities in Oredo Local Government Area (LGA), Edo State, Nigeria, commonly experience physical, sexual, emotional, and socio-economic forms of gender-based violence (GBV). Physical violence, including beatings and assaults, is widespread, often perpetrated by intimate partners or caregivers, exploiting the women's limited mobility. Sexual violence, such as rape and coerced sex, is prevalent, with dependency and societal stigma reducing reporting. Emotional abuse, characterized by derogatory remarks targeting disabilities, significantly undermines self-esteem. Socio-economic violence, including withholding financial resources or mobility aids, further restricts autonomy, trapping women in abusive environments within Oredo's urban and cultural context.

The findings indicate that socio-economic factors significantly heighten the vulnerability of women with physical disabilities to GBV in Oredo LGA. High unemployment rates and low educational attainment limit economic independence, compelling reliance on potentially abusive partners or caregivers. Inaccessible urban infrastructure, such as non-ramped public transport and healthcare facilities, restricts mobility and access to services, increasing isolation. Pervasive poverty in Oredo’s urban economy exacerbates financial dependency, while the region’s role as a human trafficking hub amplifies risks of exploitation. Social stigma surrounding disability further isolates these women, weakening support networks and hindering help-seeking behaviors.

GBV profoundly impacts the mental well-being of women with physical disabilities in Oredo LGA, leading to depression, anxiety, and post-traumatic stress disorder. Emotional abuse targeting disabilities intensifies feelings of worthlessness, contributing to social withdrawal and diminished self-esteem. The scarcity of accessible mental health services in Oredo aggravates these psychological effects, leaving survivors without adequate coping resources. Physical injuries from violence often exacerbate existing disabilities, further deteriorating mental health by limiting autonomy and social engagement, perpetuating a cycle of psychological distress and isolation. The study found that GBV against women with physical disabilities in Oredo LGA manifests in distinct forms and patterns influenced by the region’s socio-cultural and urban dynamics. Physical, sexual, emotional, and socio-economic violence are prevalent, with domestic

settings being the primary sites, where intimate partners and caregivers exploit dependency for chronic abuse. Public spaces, such as markets and transport hubs, are sites of opportunistic harassment due to anonymity and visible disabilities. Socio-economic violence, like denying resources, and harmful traditional practices, such as inheritance exclusion, are widespread, rooted in cultural devaluation. Underreporting is common due to inaccessible reporting mechanisms and stigma, masking the true extent of violence.

Support systems and social work interventions in Oredo LGA are insufficient in addressing GBV against women with physical disabilities. Family and peer support are limited by cultural stigma that views disability as a burden, isolating survivors. Community-based advocacy groups provide awareness campaigns but are constrained by funding shortages, reaching few women. State services, including legal aid and the Vivian Centre, lack disability-inclusive infrastructure, such as ramps, and trained personnel, resulting in minimal prosecution of GBV cases. Social work interventions, such as counseling, are underdeveloped and often inaccessible due to transportation barriers, highlighting the need for enhanced accessibility and resources to support survivors effectively.

5.3 Contribution to Knowledge

This study significantly enriches the academic discourse on gender-based violence (GBV) by providing novel insights into the experiences of women with physical disabilities in Oredo LGA, a context characterized by unique socio-cultural, economic,

and urban dynamics. Grounded in Feminist Theory and the Social Model of Disability, the research advances theoretical and empirical understanding of GBV through a localized lens, addressing critical gaps in the literature. The following highlights the study's key contributions to knowledge:

1. Localized Empirical Data in an Under-Researched Context

The study generates original, context-specific data on the prevalence, forms, and patterns of GBV against women with physical disabilities in Oredo LGA, a region previously underexplored in GBV scholarship. By documenting that 48% of respondents experienced physical violence, 50% faced emotional and psychological abuse, and 27% encountered socio-economic violence, the research provides a quantitative foundation for understanding GBV in an urban Nigerian setting marked by high population density and human trafficking networks. This localized evidence extends global findings, such as those by Jewkes et al. (2020) and Breiding and Armour (2015), by situating them within Oredo's socio-cultural and economic milieu, thereby contributing to a nuanced understanding of how urban stressors amplify GBV risks for women with disabilities.

2. Advancing Intersectional Scholarship

By employing Feminist Theory's intersectionality framework (Crenshaw, 1989) and the Social Model of Disability (Oliver, 1990), the study elucidates how the confluence of gender, disability, and socio-economic marginalization exacerbates vulnerability to GBV. It reveals how Edo cultural practices, such as bride price and perceptions of disability as a spiritual affliction, intensify the marginalization of women with physical disabilities,

aligning with but extending prior work by Oladunni (2019). This contribution enhances intersectional scholarship by demonstrating how localized cultural norms interact with systemic barriers to perpetuate violence, offering a model for analyzing GBV among other marginalized groups in similar contexts.

3. Illuminating Socio-Economic Determinants of GBV

The research underscores the pivotal role of socio-economic factors, such as 80% unemployment rates, 30% literacy levels, and inaccessible urban infrastructure in driving GBV vulnerability among women with physical disabilities. By linking economic exclusion to increased dependency and risk of abuse, the study builds on Ogunniyi's (2020) findings while providing Oredo-specific insights into how financial dependence and limited access to services trap women in abusive environments. This contribution strengthens the evidence base for integrating economic empowerment into GBV prevention strategies, highlighting the need for structural interventions to address systemic inequities.

4. Exposing Cultural and Patriarchal Influences

The study contributes to the literature by detailing how entrenched cultural beliefs and patriarchal norms in Oredo LGA normalize GBV against women with physical disabilities. It reveals that 33% of respondents experienced harmful traditional practices, such as forced marriages and exclusion from inheritance, rooted in cultural devaluations of disability. This finding resonates with Atinmo (1997) and extends regional analyses, such as Hunt et al. (2024), by situating these dynamics within Edo's unique socio-cultural

framework. By highlighting the role of cultural narratives in perpetuating violence, the study informs culturally sensitive interventions aimed at challenging discriminatory norms.

5. Critiquing Support System Inefficiencies

The research provides a critical analysis of the limitations of support systems in Oredo LGA, such as the Vivian Centre and JONAPWD, which are constrained by inaccessible infrastructure (only 15% of facilities are accessible) and inadequate disability-specific training. By documenting that only 30% of respondents were aware of support services and that a mere 5% of GBV cases reached prosecution, the study exposes systemic gaps in policy implementation, aligning with Ogunode et al. (2022). This contribution bolsters the case for disability-inclusive reforms in legal, healthcare, and social work frameworks, particularly in resource-constrained urban settings.

6. Highlighting Mental Health Consequences

The study advances understanding of the psychological toll of GBV, with 90% of respondents reporting depression and anxiety and an equal proportion experiencing thoughts of self-harm or suicide. These findings highlight the compounded impact of GBV on women with physical disabilities, exacerbated by social isolation and the absence of accessible mental health services in Oredo LGA. By identifying limited coping mechanisms, such as reliance on underdeveloped informal support networks, the research contributes to the literature on mental health outcomes in GBV survivors, emphasizing the need for targeted psychosocial interventions.

5.4 Conclusion

The study has revealed that gender-based violence (GBV) remains a pervasive and deeply entrenched issue affecting women with physical disabilities in Oredo Local Government, Edo State. Findings demonstrated that many respondents were aware of the existence of support services such as Vivian Centre and JONAPWD, yet significant gaps remained in access and utilization. Survivors who managed to access medical, legal, or psychosocial support services highlighted barriers of accessibility, ranging from inadequate facilities to lack of disability-sensitive staff. Furthermore, while social workers and community organizations offered some assistance, and family or community support proved helpful to certain individuals, the overall effectiveness of these interventions was inconsistent and often inadequate. These findings emphasize the intersectional vulnerability of women with physical disabilities, who experience violence not only as women but also as persons with disabilities, thereby compounding their marginalization.

The broader implications of the findings suggest that the issue of GBV against women with disabilities in Oredo LGA is not merely a private or isolated matter but a structural and systemic problem rooted in gender inequality, disability discrimination, and weak social support frameworks. The lack of accessible and inclusive services reinforces a cycle of silence, stigma, and helplessness among survivors, leaving many without justice or adequate coping strategies. Moreover, the limited effectiveness of family and community support indicates the need for greater awareness, sensitization,

and community engagement to challenge discriminatory norms and provide holistic care for survivors. In addressing these challenges, the study calls for multi-level interventions. At the policy level, there is a need for stronger government enforcement of disability rights laws and gender-based violence legislation to ensure equal protection and justice for women with physical disabilities. At the institutional level, support centers, hospitals, and legal aid providers must adopt disability-inclusive measures such as ramps, trained staff, and confidential reporting channels. Social workers and NGOs should intensify awareness campaigns while providing psychosocial rehabilitation programs that empower survivors to rebuild their lives. At the community level, families, religious institutions, and grassroots organizations must actively combat stigma and provide sustainable support systems for survivors.

Gender-based violence against women with physical disabilities in Oredo Local Government is a pressing human rights issue that demands urgent and sustained attention. Combating this menace requires a holistic approach that combines structural reforms, institutional inclusivity, community engagement, and survivor-centered interventions. Only through coordinated efforts can society begin to dismantle the cultural, social, and institutional barriers that perpetuate violence against this vulnerable group. Ensuring justice and protection for women with disabilities is not merely an act of charity but a moral, social, and legal obligation that speaks to the dignity and equality of all human beings.

5.5 Recommendations

Based on the findings of the study, the following recommendations were made:

Stakeholders should intensify public awareness campaigns to ensure that women with disabilities, particularly those facing gender-based violence (GBV), are informed about the existence of support services such as the Vivian Centre and the Joint National Association of Persons with Disabilities (JONAPWD). Many women in vulnerable situations often remain unaware of these resources, which limits their ability to access timely help, protection, and rehabilitation. By increasing outreach through community forums, media platforms, and disability networks, more survivors would be empowered to seek assistance without fear of stigma or ignorance of available services.

For effective intervention, health, legal, and psychosocial support centers must be redesigned to ensure full accessibility for women with physical disabilities. This includes installing ramps, disability-friendly toilets, clear signage, and accessible transportation. In addition, staff at these centers should undergo specialized training to better understand the unique needs of women with disabilities, thereby reducing physical, attitudinal, and institutional barriers. Such structural and human resource reforms would guarantee that survivors can obtain essential medical care, legal redress, and psychological support without encountering exclusionary obstacles.

Social workers and community-based organizations occupy a critical position in addressing GBV against women with disabilities. To strengthen their role, they should be equipped with adequate resources, funding, and specialized training to provide consistent and survivor-centered interventions. This involves building skills in counselling,

advocacy, case management, and legal referral systems. By empowering social workers, the quality of care and protection offered to survivors will improve significantly, ensuring that women with disabilities receive continuous and comprehensive support tailored to their specific circumstances.

Families and local communities remain the closest safety nets for survivors of GBV. Programs should therefore be designed to encourage family members and community leaders to actively support survivors instead of reinforcing stigma and silence. Through education and sensitization campaigns, families can learn to respond compassionately, while communities can foster inclusive and protective environments where survivors feel valued and respected. This collective approach would not only reduce the stigma associated with GBV but also help in breaking the cycle of abuse by addressing the issue at its roots.

Addressing GBV requires more than immediate protection; survivors should be supported through long-term rehabilitation and empowerment programs. These initiatives should include economic empowerment schemes, vocational training, scholarships, and livelihood opportunities that enhance survivors' financial independence. Continuous counselling and psychosocial support should also be integrated to promote emotional healing, build resilience, and foster reintegration into society. By combining economic empowerment with psychological recovery, survivors are better positioned to rebuild their lives with dignity, confidence, and self-reliance.

5.6 Further Studies

The findings and limitations of this study provide a foundation for future research to deepen understanding and address unresolved questions about GBV against women with physical disabilities. The following recommendations outline avenues for extending this work, grounded in the study's theoretical and empirical contributions:

Further research should employ longitudinal methodologies to examine the trajectories of GBV, mental health outcomes, and coping strategies over time among women with physical disabilities in Oredo LGA. Such studies could elucidate how interventions impact GBV prevalence and survivor resilience, providing dynamic insights into the persistence of socio-cultural and economic drivers. Given the study's focus on Oredo's urban context, future research should investigate GBV against women with disabilities in rural areas of Edo State or other Nigerian regions. Comparative studies could highlight differences in GBV prevalence, forms, and support system accessibility between urban and rural settings, where factors like limited infrastructure or stronger adherence to traditional norms may amplify risks.

The current study centered on survivors' experiences, with limited exploration of perpetrators' motivations. Future research should investigate how these factors further shape GBV experiences among women with disabilities in Oredo LGA. For instance, women from minority ethnic groups may face compounded discrimination, warranting a deeper intersectional approach to inform inclusive policies.

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APPENDIX

DEPARTMENT OF SOCIAL WORK

FACULTY OF SOCIAL SCIENCES
UNIVERSITY OF BENIN
BENIN CITY

Dear Respondents,

I am a student of the above-named department and institution, currently conducting research on **Gender-Based Violence Against Women with Physical Disabilities in Oredo Local Government, Edo State Nigeria**. As part of the requirement for the award of Bachelors of Science (Sc) Degree in Social Work, this research is purely academic, and your anonymity is guaranteed. I would appreciate it if you could carefully read and answer the questions as honest as possible.

Thank you for your anticipated cooperation.

____

Eleh Jennifer Awele
Researcher

INSTRUCTION

Please () or (tick) the correct response (s) for the given close-ended items, and where applicable, fill the blank spaces.

SECTION A: DEMOGRAPHIC DATA

Instructions: Please provide the following information by ticking the appropriate box or filling in the blank. This section helps us understand your background and context.

1. Age of the Respondents 18 -20 ( ) 21-28 ( ) 29-37 ( ) 38-46 ( )46 and above ( )
2. Respondents Marital status:
   Single ( ) Married ( ) Divorced/Separated ( ) Widowed ( )
3. Type of disability:
   Visual ( ) Hearing ( ) Physical/Mobility ( ) Intellectual ( ) Psychosocial ( ) Multiple
4. Level of education completed:
   No formal education ( ) Primary ( ) Secondary ( ) Tertiary ( )
5. Employment status:
   Employed ( ) Self-employed ( ) Unemployed ( ) Student ( ) Retired ( )
6. Monthly income (₦):
   None ( ) Less than ₦20,000 ( ) ₦20,000–₦50,000 ( ) ₦50,001–₦100,000 ( ) ( ) Above ₦100,000
7. Living arrangement:
   Alone ( ) With spouse/partner ( ) With family ( ) In institution ( ) Other (specify): ___________

   Rating Scale: (SA) = Strongly Agree; (A) = Agree; (D) = Disagree; (SD) = Strongly Disagree.

Please read carefully and give your opinion on the Level of Gender based Violence Against women with physical disabilities

SECTION B:

S/N	**Common forms of Gender Based violence**	**SA**	**A**	**D**	**SD**
1	I have experienced physical violence due to my gender or disability.				
2	I have experienced physical violence (e.g., beating, slapping, kicking) due to my gender or disability.				
3	I have been subjected to emotional or psychological abuse (e.g., insults, humiliation, derogatory remarks about my disability).				
4	I have experienced socio-economic violence (e.g., denial of financial resources, mobility aids, or healthcare).				
5	Harmful traditional practices (e.g., forced marriage, exclusion from inheritance) have affected me due to my disability.				

SECTION C:

S/N	**Socioeconomic Factors Contributing to Vulnerability**	**SA**	**S**	**D**	**SD**
6	My lack of employment increases my vulnerability				
7	Limited access to education has made me more dependent on others, increasing my risk of abuse.				
8	Poverty or financial dependence on others makes me more vulnerable to violence.				
9	Inaccessible infrastructure limits my ability to escape abusive situations.				
10	Social isolation due to stigma about my disability increases my risk of experiencing violence.				

SECTION D:

S/N	**The Impact of gender-based violence on the mental well-being of women with physical disabilities.**	**SA**	**A**	**D**	**SD**

11	I experience feelings of sadness or depression due to violence I have faced.				
12	I feel anxious or fearful as a result of violent or abusive experiences.				
13	Violence has lowered my self-esteem or sense of worth because of my disability.				
14	I have experienced social withdrawal or isolation due to violence or stigma.				
15	I have had thoughts of self-harm or suicide due to abusive experiences.				

SECTION E:

S/N	Patterns of gender-based violence	SA	A	D	SD
16	Most violence I experience occurs in domestic settings (e.g., home, with family or partner).				
17	I have faced violence or harassment in public spaces (e.g., markets, public transport) due to my disability.				
18	The violence I experience is frequent (e.g., occurs regularly or repeatedly).				
19	Intimate partners or spouses are the primary perpetrators of violence against me.				
20	Caregivers or family members are often the perpetrators of violence against me.				

SECTION F:

S/N	Role of Support Systems and Social Work Interventions	SA	A	D	SD
21	I am aware of support services (e.g., Vivian Centre, JONAPWD) for GBV survivors in Oredo LGA.				
22	I have accessed support services (e.g., medical, legal,				

	psychosocial) after experiencing violence.				
23	Support services I accessed were accessible (e.g., had ramps, trained staff) for my physical disability.				
24	Social workers or community organizations have helped me address or cope with violence.				
25	Family or community support has been effective in helping me address violence.				