HERE THE WALLS HAVE EARS TOO
TESTIMONIES OF WOMEN WITH MENTAL DISABILITIES ABOUT GENDER-BASED VIOLENCE IN RESIDENTIAL INSTITUTIONS
HERE THE WALLS HAVE EARS TOO

TESTIMONIES OF WOMEN WITH MENTAL DISABILITIES ABOUT GENDER-BASED VIOLENCE IN RESIDENTIAL INSTITUTIONS

This publication is produced with funding from the UN Trust Fund, however the views expressed and content included does not imply official endorsement or acceptance by the United Nations.
AUTHORS:
Biljana Janjić, Dragana Ćirić Milovanović

RESEARCH TEAM:
Maja Popović, Marijana Jović

PUBLISHER:
Disability Rights Initiative MDRI-S

DESIGN:
Mlađan Petrović

PRINTED BY:
Manuarta, Belgrade

CIRCULATION:
200 copies
Belgrade, December 2017

Realized within the project “Deinstitutionalize and End Violence against Women with Disabilities in Custodial Institution” funded by United Nations Trust Fund to End Violence against Women and supported by Disability Rights International.

CONTENTS

INTRODUCTION ......................................................................................................................... 7
LIFE IN RESIDENTIAL INSTITUTION ...................................................................................... 11
Violation of the Right to Privacy and Disrespecting Person’s Identity ................................. 12
Deprivation and Restriction of Movement ............................................................................. 16
Partner and sexual relationships in residential institutions: practice and consequences for women’s life ........................................................................................................................................ 19
Forced Interventions and Increased Risk of Violence against Women .................................. 24
FORMS AND MANIFESTATIONS OF VIOLENCE AGAINST WOMEN
WITH DISABILITIES IN RESIDENTIAL INSTITUTIONS ...................................................... 27
Vertical Violence: Violence that Women Survive from Employees ........................................ 28
Horizontal Violence: Power and Control ................................................................................... 31
GENDER-BASED VIOLENCE ..................................................................................................... 35
Sexual Harassment and Abuse ................................................................................................. 36
Partner Violence ....................................................................................................................... 39
Reproductive Health: Problematic Practices ........................................................................... 42
Administration of Contraceptives without Informed Consent ................................................ 44
Forced Abortions ...................................................................................................................... 46
Forced Sterilization .................................................................................................................. 48
PREVENTION AND PROTECTION FROM VIOLENCE ......................................................... 51
Accessibility of Protection Mechanisms .................................................................................. 55
Physical and Architectural Accessibility .................................................................................. 55
Informational Accessibility ..................................................................................................... 56
Financial Accessibility ............................................................................................................ 58
A WAY FORWARD .................................................................................................................... 65
METHODOLOGY ON COLLECTING TESTIMONIES .............................................................. 67
Our work on collecting testimonies of women with mental disabilities on gender-based violence in residential institutions would not be possible without the support of the United Nations Fund for the Elimination of Violence against Women and Disability Rights International. MDRI-S team thanks the Protector of Citizens and the National Mechanism for the Prevention of Torture on the possibility of using testimonies collected during joint visits which could not be part of the visit report due to the specific format of the report. Therefore, we are publishing the testimonies in this publication so that the voice of women with mental disabilities are heard outside of the institution’s walls.

Authors thank the researchers Maja Popović and Marijana Jovčic who talked to women, and analysts Kosana Beker and Tijana Milošević on a comprehensive study of laws and public policies in Serbia, as well as the entire MDRI-S team and external associates who supported us in different ways and demonstrated commitment during this process, including Maša Pavlović, Snežana Lazarević, Mira Petrović, Milan M. Marković and Milan Marković. We also thank some of the employees in social welfare institutions that have openly talked with us about the position and treatment of women with disabilities in residential institutions.

We owe special gratitude to all women who shared their life stories with us. Until the conditions are created for the position of women with disabilities and the voices of self-advocates to be recognized in our society, we hope that this publication will contribute to raising awareness about their life stories.
INTRODUCTION

There are 18,250 people living in some form of collective accommodation[^1] in Serbia and over 11,000 of them report to have some type of disability[^2]. Half of them are girls and women. According to the 2015 data of the Republic Institute for Social Welfare, 48% of clients in residential institutions for adults with disabilities were women[^3], while there were about 40% of girls and women in institutions for children and youth[^4].

Life in a residential institution is characterized by lack of privacy, inability to make decisions about one’s own life, social exclusion, and violation of fundamental human rights and dignity of a person, but it also represents a high risk of violence, abuse, and neglect. Although precise data are not available, most women with intellectual and psychosocial disabilities in institutions are deprived of their legal capacity and put under guardianship, which means that they cannot decide on their own place of residence, their own treatment, medical interventions, pregnancy, parenting, partnership. Denial of the right to informed decision-making on important life issues degrades

[^1]: Collective placement here refers to social welfare institutions for placement of children and youth, institutions for children with disabilities, institutions for placement of adults and elderly, institutions for adults with disabilities, adults with intellectual and psychosocial disabilities;


[^4]: It should be considered that two thirds of clients in these institutions are adults; Report on residential institutions for children and youth, Republic Institute for Social Welfare, Belgrade, 2016
these women and additionally puts them at risk of various coercive interventions, such as isolation, overmedication, administration of contraception without consent, sterilization, forced abortions, and separation from the child.

The patriarchal and stereotyped roles of men and women in Serbia negatively affect already difficult position of women with disabilities\(^5\). They are discriminated in all areas of public and private life. They are invisible in public life, encounter obstacles to education, health and social protection; they are poorer and more often unemployed than men with disabilities, they are victims of psychological, physical, sexual, economic, and institutional violence, and there are stereotypes and prejudices related to their gender roles, especially regarding marital and family relationships and parenting\(^6\). Women with intellectual, cognitive or psychosocial disabilities are in additionally vulnerable situation and at higher risk of violence, especially if they are in closed institutions. Their statements about the experiences of violence are questioned, they are not believed, and are often assumed to be unaware of the violence they suffer, or that they cannot recognize it.

Since 2008, Mental Disability Rights Initiative of Serbia MDRI-S has been working on advocacy for the realization of the rights of persons with mental disabilities and their full social inclusion on an equal basis with others. We put special focus on the rights of persons who are completely excluded from society, such as persons in residential institutions or those under guardianship, because they do not have access to basic human rights due to discriminatory and outdated policies and practices.

---

\(^5\) Mitanovski, L., et al. *Women with Disabilities in Serbia – first analysis of the position and legislation related to women with disabilities in the Republic of Serbia,* ... Iz kruga – organization for protection and support to women with disabilities in Serbia and Center for Monitoring and evaluation, Belgrade, 2009;

\(^6\) Special report on discrimination against women, Commissioner for Protection of Equality, Belgrade, May 2015

---

In 2012, MDRI-S conducted independent monitoring of residential institutions for children and youth with disabilities and we recognized that staff lacks understanding of relationships and sexual needs of women and men with disabilities. In one facility, staff told us that “sexuality of this client is turned off,” which shows a very low level of awareness and understanding of the needs of clients in the institution. Employees believe that clients are not aware of their sexuality and that they have no sense of shame. Accordingly, boys and girls sleep in the same rooms, and video surveillance is set up even in bathrooms, while staff does not understand why separate rooms and privacy are important “when they [clients] are unaware of it.”\(^7\) We recognized the increased risk of abuse of girls and women in institutions that led us to further research and pay attention to their position and risks of violence in residential institutions.

In Serbia, there is no comprehensive analysis of the situation of women with disabilities who are placed in residential institutions, and this publication is also an initiative for further research, studies, and discussions on this topic. At the same time, we want to contribute to existing international research that shows that women with disabilities in institutions are victims of intersectional discrimination and that they are at greater risk of surviving physical, emotional, and sexual violence from employees and other users\(^8\). Their situation and exposure to violence is not visible or recognized in public policies in Serbia. This publication is an effort to emphasize the need to urgently work on deinstitutionalization in Serbia, ensure adequate and sustainable services in the local community, and create conditions for women and girls with disabilities to have the choice and right to decide on their life.

---


\(^8\) Comprehensive overview of international and analysis is given in the publication “Violence against women with disabilities in residential institutions” by authors Kosana Beker and Tijana Milosevic, 2017, publisher Mental Disabilities Rights Initiative of Serbia
Our goal is to create conditions for women and girls who survived or survive violence in residential institutions to have a higher level of support in exercising the right to life without violence and have access to community services.

**LIFE IN RESIDENTIAL INSTITUTION**

“Our rights were violated. We could not set our goals and make our decisions, fight for us and others. It was not possible. Caregivers loudly bang with keys to wake us up, as if they cannot say it nicely. They bang as if we were some animals. That was the procedure in the institution. We couldn’t do anything about it.” (E)

One of the basic characteristics of life in residential institution is that “people live in social isolation, unstimulated environment and they lose control over almost every aspect of everyday life.” Life in a residential institution is characterized by a strict day-to-day routine and schedule of activities, and everyone is expected to follow the imposed schedule of sleeping, waking up, eating, participating in daily activities and leisure time, if such activities are organized. In describing everyday life in the institution, women often use words “control”, “discipline” and “respect for the rules”.

_Institution is not the same as your own apartment. No one throws you in a cage, it’s not like that, but you have no freedom. I had some fear in myself there. When I arrived, I said “oh, this is a hospital.” I was scared, and I said, “I don’t want to be here.” It was terrible when I came. I cried and cried all the time, until I got used to it. (F, former client of a big residential institution)_

Aware of the fact that violation of privacy, prohibition of free movement, and prohibition of personal relationships equally apply to women and men with disabilities in residential institutions, we

---

want to emphasize specific position of women in such circumstances. We wanted to learn in which ways and to what extent institutionalization leads to an increased risk of gender-based violence.

When I was in the institution, nobody locked me, beat me, but everything had to be as they [staff] wanted. We had to do everything they say. Our rights were violated. There, you have to be in the group. We – girls – had to respect the rules. If you sleep longer or you’re late, there is no breakfast for you; If the caregivers say so, then it is so. You cannot say anything in your own name, “I want it so, or I want to wear what I want.” It was not like that... You have to be in the group, no separation. There is discipline and control. (E, former client)

Institutional setting wants people who do not remember, who do not think, who do not feel. That is why our task is difficult. Self-advocacy is a serious task. First, we need to show these people that they are recognized as people and then teach them self-advocacy. (employee at the institution)

VIOLATION OF THE RIGHT TO PRIVACY AND DISRESPECTING PERSON’S IDENTITY

“Here, a person cannot satisfy basic physiological needs when he/she wants, but when there is a scheduled time for that.” (M)

One of the characteristics of life in “total” institution is the lack of privacy or the gross violation of person’s privacy, which strongly influences the sense of personal autonomy and security. This practice is justified by the need to respect the rules of conduct in the institutions, the security rules, but also because of the easier functioning of the organization itself. Prejudices of institution staff often manifest in explanations that women with mental disabilities are not able to understand the right to privacy. Such assumptions reflect prejudice, deep expression of disrespect, and a lack of basic understanding of a person.

The lack of privacy manifests in overcrowded rooms, insufficient living space, lack of control over the choice of room or roommates. Although male and female rooms are separated in most institutions, in some institutions men and women share rooms. The institution management decides on who will share a room with whom, and women and men are placed across buildings depending on the level of support they need.

They did not allow me to go to school or leave the institution. There was nothing I could do; the caregivers were bad. I bathed once a week and I could not have my things. It was a very bad institution. There were twenty of us in one room. Some people defecated there in the room. During the meal some of them grabbed food from the plate. (N. spent over 20 years in different institutions)

People living in residential institution do not own their clothes or private things and there are no places and cabinets for holding private belongings. The women we talked with confirmed that they had to keep personal belongings in lockers because their things had been stolen. Some users carry the locker keys around the neck as a necklace, as pendants. In some institutions, we saw that the staff holds the keys of private cabinets, so clients have to ask to use their belongings. Most women report that they do not have their own wardrobe, but they take what is clean or available. They do not choose the clothes, but employees give them. Sometimes, clothes that women bought for themselves get lost in the laundry, so they decide not to buy clothes, and over time they stop paying attention to what they wear.

---

10 Goffman gives the following definition of total institution: A total institution is a place of work and residence where a great number of similarly situated people, cut off from the wider community for a considerable time, together lead an enclosed, formally administered round of life. In: Goffman, E., Asylums
Clients generally wear common clothes. Except for those who know how to keep their clothes or want to have their own. They are allowed. We’re really trying to keep their clothes separately from the central laundry. But, the fact is that we have many clients who do not know how to take care of their belongings, which is certainly not good. We have a problem, for example, when there is some skin disease and it is spreading at an abnormal rate. Just because they do not have their own personal belongings. Because the clients are labelled like that – whether they can or cannot take care of their things, instead of everyone having personal belongings precisely because of that. Well then, we have clients who are small and wear a huge wardrobe because this was the only thing they could find in the laundry. (employee in the institution)

All the women we interviewed confirmed that they did not have their own hygiene products, but they received a certain amount at the monthly basis. Sanitary pads are also part of the monthly rations, so women must ask from employees when they spend them.

Very small number of women buy their own sanitary pads, and generally most of them receive sanitary pads from nurses who monitor when a woman has a period. What’s really ugly is that to some women staff puts diapers instead of sanitary pads. (employee in the institution)

Bathrooms and toilets in institutions are frequently commonly used. Often there are no doors in the toilets, the doors cannot be completely closed or locked, there are no separate shower cabins, and showering is often performed in groups. As in other aspects of life in an institution, there is a big difference between women who are more functional and independent and women who need more intensive support in their day-to-day functioning. Since the latter depend more on the support of employees and other people in the institution, they often have different rules, such as bathing / showering once or twice a week.

Independent girls can shower every day. They help other children who cannot shower by themselves. And they take a shower in groups. It was not possible to lock the toilet door, because “something can happen.” When the girls take shower, nobody enters. They just close the door, and because everybody knows that the girls are showering, nobody comes in. (A, former client of the institution)

MDRI-S staff saw in an institution that about 20 women and men sat in the central room, completely naked and waiting for the shower line.

A caregiver helped in showering and dressing, and she worked like on the conveyor belt. A woman in wheelchair was completely naked, wet, and she sat so uncovered in the hallway and crying. She waited for the caregiver to dry and dress her. She was crying all the time. We had the impression that she was cold and embarrassed. (MDRI-S monitoring team)

In most institutions, mostly women work as nurses at women’s departments, but this is not always the rule and it often depends on the schedule and availability of staff. In one facility, we talked to a woman with physical disability, who says she always insists that female staff help her with changing and bathing, and that such requests are generally respected. However, this is not always the case with the care of women who need complex support, who are immobile, spend most of their days in bed or do not speak. The question arises as to how they communicate the need for caregivers to work with them and how this request is respected.

Who is available, works. It is not generally considered that female staff works with women, and male staff with men. Here, clients often help nurses and caregivers while they are working, and there are no rules. This system and approach must be changed. They have two diapers per day...

There are no curtains for changing. Bathing is in groups. Girls today, men tomorrow. And when clients see that it is bathing time, they take off their clothes and stand naked in the room, waiting. They got used to nudity, they have no
idea about it, because they constantly see each other and do not have any shame at all. (employee in the institution)

Privacy is closely linked with respect for the right to decide and choose, but also the basic identity of a person. Withdrawing or controlling an “identity set” (appearance, wardrobe, cosmetics) leads to the erasure of personality and dehumanization in a residential institution. In this way, the person is reduced only to a client identity and perceived exclusively through the prism of disability. Different forms of expressing multiple identities are restricted. This is especially important from the aspect of everyday activities and hygiene habits that most of us take for granted, and for many people in residential institutions, they represent an institutional schedule that has to be followed. This is also supported by the testimonies of women who had stayed in residential institutions for a long time, and now use supported living service:

And here [supported living service] is great. I stand for this supported living. I shower here whenever I want. (J, former client)

In this apartment [supported living], I shower whenever I wish. I can wear whatever I want and change whenever I want. (Z, former client)

DEPRIVATION AND RESTRICTION OF MOVEMENT

“They don’t allow me to go to the shops or in the village. And I would really like to go to the village sometimes.”

Freedom of movement is one of the most important human rights guaranteed to every person in Serbia and it can be restricted by law only if it is necessary for the conduct of criminal proceedings, protection of law and order, prevention of the spread of infectious diseases, or the defense of the Republic of Serbia. However, persons with mental disabilities who are placed in residential institutions are often denied or restricted the right to freedom of movement, although they are not prosecuted, do not jeopardize public order and peace, do not spread infectious diseases, nor are they a threat to security of the Republic of Serbia. However, they often stay in locked rooms and departments without the opportunity to freely leave the institution or even their own room on the pretext that many of them are deprived of their legal capacity, that their guardians do not allow them to leave the institution and/or it is decided so for the safety of clients and other people.

Regular practice in institutions, even those claiming to be “open” is strict control of movement.

You could go out, but only with a pass. The pass said how long you could stay outside. And if you’re late, they [staff] get very angry. (A, former client)

A woman we talked with said that exiting from the institution where she lived without permission was not allowed. Women have to ask for permission in advance, and only those who have been assessed by employees as sufficiently independent are allowed to go out. The women we discussed with said that this rule did not fully apply to men in the institution.

It is not fair. I need to ask them [staff] even if I want to go to the town in the morning. And if I want to go out in the afternoon or in the evening, I have to say how I will come back, who will bring me, when, everything. And they [some men] can just go out. (L, currently living in the institution)

The most commonly stated responses to the ban or control of leaving the institution are the security reasons and the issue of employee liability. Also, even when they go out, girls and women have a curfew.

11 Goffman, E., Asylums, Mediterran publishing, Novi Sad, 2011 (edition in Serbian language)

12 Article 39, paragraphs 1 and 2 of the Constitution of the Republic of Serbia
13 Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017
We could not go out, staff did not allow us. We were allowed only in the group, never alone, not even to the nearby store. Also, it was not allowed for a woman and a man to go out together to the store. Because they can “do something stupid,” or “make love”. If it happens that a girl leaves alone without asking, then she is punished. They insult you, tell all kinds of things... That’s why I do not like to be in the institution. (J, former client)

Different internal decisions and regulations of the institutions stipulate that clients can “temporarily (for several days consecutively), at the request of the guardian/legal representative, leave institution, with the knowledge and approval of a professional worker.” Different internal decisions and regulations of the institutions stipulate that clients can “temporarily (for several days consecutively), at the request of the guardian/legal representative, leave institution, with the knowledge and approval of a professional worker.”

The same practice applies to persons who are not under guardianship. An employee at one institution states that even when a person goes to visit parents (who are also guardians), the institution must inform the center for social work.

Although in Serbia it is possible that some individuals are kept in the institution against their will, this does not mean that they are deprived of the right to freedom of movement, that is, it does not automatically mean that they cannot leave their room or the institution building. The fact that persons are put under guardianship cannot at the same time mean deprivation of liberty. Even when a person is not under guardianship, but has spent a long period in a strict regime of institutional life, sometimes from the very birth, she has been de facto denied the possibility of making decisions and free choice. Practices and laws in Serbia have made it possible for one social welfare service to become deprivation of liberty.

14 Information gathered from internal procedures of residential institutions

15 Service of residential accommodation of persons deprived of their legal capacity can be contracted only on the basis of referral by the center for social work or on the basis of court decision (Article 78 of the Law on social protection). As for involuntary placement in psychiatric institution, decision can be made by a member of close or extended family or legal guardian (Article 20 of the Law on protecting people with mental health problems). Also, a person with mental health problems can be placed in psychiatric institution without consent of the legal guardian if the courts decides so (Article 27 of the Law on protecting people with mental health problems)

PARTNER AND SEXUAL RELATIONSHIPS IN RESIDENTIAL INSTITUTIONS: PRACTICE AND CONSEQUENCES FOR WOMEN’S LIFE

“Relationships in residential institution are not allowed. If a woman and a man were in love, they could see each other secretly in the backyard, behind the building.” (Z)

Studies and research on partner relationships of people with disabilities are scarce. One research on marriages and partnerships that included people with disabilities has shown that women with disabilities face many obstacles in starting an emotional relationship. As the biggest problem in achieving satisfactory emotional relationships, women listed societal attitudes and assumptions about women with disabilities, which prevented potential partners to contact these women fearing of what other people would say if they started a relationship with a woman with disabilities. Partner relationships and the sexuality of women with disabilities are often questioned by wider society, especially for women with intellectual and psychosocial disabilities.

The woman we talked to has been in an institution over 20 years. Before the institution, she was married and had children. She lived in violent marriage – “my husband used to beat me.” She wanted to divorce, so she asked her brother to come to live with him and their father in a family home.


17 Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017
Her father was seriously ill and immobile, so she thought she could take care of him. Her brother and employees in the center for social work said that she, as a daughter, should not take care of a father. She was placed in an institution, and father was cared for by a paid nurse. Her child was also placed in an institution. “I do not want to be here, but I have to.”

Majority of Serbian residential institutions have over 300 people living there at the same time. If we add isolation and no possibility of contact, closer acquaintances and interaction with people outside the institution, it comes as no surprise that adults in an institution enter into partnership and intimate relationships. However, interviews with women and employees in institutions show that there is generally no understanding for partner relationships, and especially for long-term relationships or family planning.

Through the work on collecting data and understanding violence against women in institutions, we noted that there were significant differences between institutions, from those where relationships were completely prohibited, through tacit admission, to open relationships about which employees were aware of. However, it is unclear how decisions about such rules are made and we assessed that it is largely based on the attitudes of the administration and employees towards the sexuality of people living in an institution.

In some institutions, relationships between clients are completely forbidden, although the reality is that they exist, and secrecy and hiding can pose a risk to a woman from partner violence. A woman who lived more than 25 years in institutions says she fell in love there for the first time. But the couple could only go for a walk in the yard and see each other at the open, outdoors.

Outside. And they look at us from the window. They did not allow us to see each other indoors so as not to do some things that we were not supposed to do. Make children, for example. Staff did not allow us so that we do not make stupid things, make love. (A, former institution client)

Our interviewees said that in some institutions it was not allowed for a woman and a man to go out together to the store or to stay alone. Couples saw each other in the yard, behind the pavilions, in the corridors, in the common rooms, and practically rarely had the opportunity to be alone. It is officially forbidden for men to sleep in women’s rooms, so that happened secretly. Stories of women made clear that neither the man nor the women in the relationship requested the permission of other women in the room to sleep there. Attention was put to the fact that staff did not find out about the situation, because such behavior was forbidden, and the clients feared consequences.

Apart from often repeating that relationships were prohibited, women report that institution employees threatened or punished clients if they violated this rule. Girls and women were often intimidated by very negative stories of abortion and in that way identified relationships with abortion which made them think love relationships were dangerous and undesirable. The impression is that some women who have been institutionalized in early childhood are still very scared of relationships and have been given the impression that closer, intimate contact between two people is negative and illicit.

N. was institutionalized as a child and she spent over 20 years in different residential institutions. When she was young, she had a relationship with a man, and they could see each other secretly, behind the pavilion, or when they ran into each other. She did not talk about it with no one except for a few people she fully trusted, because relationships were prohibited. She stayed in touch with him later, after she was transferred to another institution. Today, she uses supported living service and says:

“Everything is different here. You eat what you want, prepare and cook what you want. Even love is different here. There are couples and it’s allowed. Everything is allowed here. And there [in an institution] only if you behave and if you ask for permission.”
In some institution, this rule of prohibiting relationships is so strict that couples who arrive together are being separated which is completely unreasonable and questions the whole approach.

In the part of the institution where the immobile clients were placed, we saw a woman lying in her bed and a man who came to visit. He is also a client in the same institution. Others told us that he had been coming to see her every day and he sat with her for almost all day. She shares a room with four other women, he cannot sleep with her in the room, but he has permission to visit her. (MDRI-S staff during monitoring visit)

On the other hand, in this same institution, our associates got the information that there was a so-called “love room” in the backyard. Women and men could use this room if they wanted to be intimate, but they had to ask for the key from the staff. There are other examples of opening such rooms in other institutions. We’ve heard from employees that women and men were hesitant to ask for a key and rarely used the room. Some employees said that it was clear for them why clients felt uncomfortable about the situation, but the management could not find another solution. In the end, the love room was used for different purpose, and people who live in the institution were prohibited from establishing intimate relationships.

It should be stressed that when a social welfare institution opens “love rooms”, they mirror yet another feature of institutions for deprivation of liberty, that is, of prison.

In some other institutions, relationships are permitted, but there is no support for couples in planning a common life or a family. One woman told us that if a woman got pregnant, she had to leave the institution or had an abortion. If a couple decides to leave the institution and have a family, they generally do not get any support, enough financial resources, and eventually they have to give the child for adoption. When it comes to women and men with intellectual disabilities, in most cases the possibility of having a family is not even considered under pre-text that parents have mental difficulties, that they live in an institution, that there is no support, so children are in such cases placed with relatives, foster families, given for adoption, or they are placed in orphanage. We fully acknowledge that child’s best interest is not to be in a residential institution and we fully support complete deinstitutionalization. However, we question why other support options such as independent or supported living and family support are not being considered. It is important to emphasize that employees told us that when a woman had given a birth, it was only because pregnancy had been discovered at a later stage and there was a high risk of abortion.

In an institution we visited, relationships are open and allowed, and there is some kind of “pseudo-marriage” between women and men. Partners share the room, but often they are “assigned children” about whom women need to take care. Please note that these are not children but other clients, mostly people who cannot move independently or require constant and intense support. In one room, there was a couple and two adult persons who use wheelchairs. The couple referred to them as their children. The woman says she was very burdened with the concern of “children,” and during the conversation she cried and begged for help. At night she could not sleep from the “little one” (which is about the same age as her, while the “girl” whom she addresses as her daughter may be older than her), because he was restless, and she was constantly awake, and nobody helped her. She complained to the employees and asked for help, but no one has reacted so far. She says this is not what she wanted.

In some rooms, the couple lives together with a few more people. Researchers say they saw a room in which a man and a woman lived together with four other men. The beds of this pair are connected but they are in no way separated from others in the room. The partnership and sexual relationship of one couple, among other things, becomes a collective issue.

Inadequate attitudes and practices, and often humiliating and discriminatory situations in which persons reside in residential institutions, also indicate that the needs of organization are put before the
needs and rights of the persons living there. We heard from employees that the prohibition of relationships is also justified as a prevention of pregnancy or sexual abuse. As with other aspects, trust, respect for integrity, and any meaningful support for having safe and consensual relationships is lacking, which not only leads to violations of women’s rights, but also increases the risk of abuse.

FORCED INTERVENTIONS AND INCREASED RISK OF VIOLENCE AGAINST WOMEN

“If you get angry, you are given an injection, or some pill and you are calm as a plant.” (A)

Physical restraints and isolation (seclusion) are critical human rights violations in residential institutions. Isolation or seclusion of persons with mental disabilities, for any duration, constitutes cruel, inhuman and degrading treatment, and any form of restraint of people with mental disabilities, even for a short period of time, can amount to torture and abuse.\(^\text{19}\) Apart from the fact that such practices should be prohibited, they also increase the risk of additional forms of violence against women. The isolation of women in the rooms from which they cannot exit for various reasons\(^\text{20}\) opens a worrying possibility of abuse.

\(^{19}\) Special Rapporteur of the United Nations for torture, and other cruel, inhuman and degrading treatment and punishment

\(^{20}\) Besides placement in locked separated room, isolation also includes to leave a person in a bed/crib which she/he cannot leave independently. For example, a woman can be isolated in seduction room, which is locked, and it can be unlocked only from outside. She can also be alone in a room which is not locked, but if she is not mobile, she cannot speak or needs intensive support for moving and communication, she cannot leave the room by herself which puts her in risk of abuse and neglect.

At the end of the hall there is a room that has bars and it is called a “cage.” Clients say that they are put there as a punishment, and some of them spend up to two months in the cage. They can exit only to go to toilets and showers, but employees bring them food. They say that staff often shouts at them. Men and women stay together in that room, and sometimes they get into fight – “someone slaps you, someone hits you with a fist.” The room is permanently locked. While we were visiting, the room was unlocked, and one client stood at the door. He did not allow the woman, who was also inside, to come out. She screamed because she could not speak, and he yelled at her. He even ran to her several times so that we had to intervene to prevent greater violence. This man told us that the cage was unlocked because of our visit, “but do not say I told you so.” (MDRI-S monitoring team)

Report of the Special Rapporteur on Torture\(^\text{21}\) states that every woman deprived of liberty subjected to isolation suffers extremely serious consequences, including the possibility of repeated traumatization if she has been a victim of violence in the past. In addition, when a woman is isolated, she is at higher risk of physical and sexual abuse. If she needs support for moving or if she is not speaking, the risk of violence increases as well as the inability to protect herself. The isolation of women who are at risk of violence or who have already survived violence only further victimizes them, discourages reporting violence, and constitutes an act of torture or ill-treatment.\(^\text{22}\)

Physical restraint is any physical restriction that limits and constrains a person’s physical movements and reactions. Although the use of restraint has severe consequences for both physical and mental health of both men and women, this forced measure traumatizes women to a higher degree, especially if they previously survived

\(^{21}\) Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, United Nation, A/HRC/31/57, 2016.

\(^{22}\) Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017;
violence or if they are pregnant. Namely, if physical restraints are
used on a woman who has been sexually abused in the past, espe-
cially if her arms and legs are tied, a woman besides all other con-
sequences affecting all victims of confinement may experience this
measure as a repeated trauma of sexual abuse, which will further
scare and victimize her.23

Human Rights Oversight in Institutional Settings, Oana Georgiana Girlescu,

23

forms and manifestation of violence against women with disabilities in residential institution

“It’s very difficult. No one loved me in the institution. There, no one loves
anyone. They fight, argue. Teachers yell and beat us.” (Lj)

Research shows that the risk of ill-treatment for people with mental
disabilities is increasing the moment they are placed in the institu-
tion. The most worrying fact is that violence in institutions is often
considered justified, which creates a “culture of institutional viol-
cence” that becomes acceptable. Some authors24 believe that each
residential institution creates its specific culture of violence by iso-
lating users, intimidating them, and exercising poor control over
employee behavior. This creates an environment in which violence
is accepted as normal. Therefore, the causes of violence should be
sought within the institution itself, considering the nature and func-
tioning of residential institutions, as well as the attitudes of those
employed in them.25

Apart from the fact that placement of a person in a residential institu-
tion against her will constitutes a violent act, women with disabilities
in these institutions are additionally exposed or at risk of physical,

24 For example, Catherine Thornberry and Karin Olson from Alberta University
25 Beker K., Milosevic T., Violence against women with disabilities in residential
institutions, Mental Disability Rights Initiative MDRI-S, 2017;
verbal, psychological, and sexual violence. They can survive violence from other clients in the residential institution (horizontal violence), employees (vertical violence) and persons outside the institution.

**VERTICAL VIOLENCE: VIOLENCE THAT WOMEN SURVIVE FROM EMPLOYEES**

I am good. Obedient. I’m good to everyone, and everything is fine. (P.)

The most frequent manifestations of verbal violence in residential institutions, according to women we spoke with, are shouting, insults, and threats. Women report that almost any deviation from the established regime and failure to comply with certain rules imply a kind of threat that keeps people in institutions in control and in constant fear. The most common threat is that a woman will be placed in isolation (“cage”), evicted from the institution, transferred to another institution or psychiatric department.

*This is not a home. This is an institution and the rules must be respected. Otherwise, if they are not respected, you know what follows – moving to another institution. That’s how they threatened before.* (F, former client of a big institution)

In many institutions, due to the lack of staff, women who are independent often help staff in work, in bathing other clients, changing, taking out women who are elderly or do not walk independently. Frequently, women say that such voluntary help is treated as their job.

*A few days ago, I was sleeping. The nurse came to wake me up because I was late. She shouted at me that I was irresponsible. I was confused, I did not know what to say. Yes, I overslept, but she could have said that to me nicely. It’s not that I wanted to oversleep. And she yells, as if it [taking care of other clients] was my job now ...* (L, client of the institution)

Women talked about their own experience of punishments for “breaking the rules” which involved standing in the corner, kneeling, denying meals the next day, ban of going out, locking them in the room, all of which are often accompanied by insults, shouting, and physical violence like pulling their hair or slapping.

*The punishment for being late was recording a minus in a notebook. Minus, minus ... No breakfast, no lunch, no dinner. Everyone will have breakfast, lunch, and you watch. Because it was forbidden.* (K, former client)

It was not so bad at the first institution. But, there I found a bad company and fled from school. I did not like school so much. When I skipped classes, I used to walk with my friends in the city, or I would take a bus and I went to my parents’ house while my father was alive. For some time, I stay with them, and then the Center for social work returns me to the institution. They told me not to run away, because if I continue, I would be transferred to a “much worse institution.” But I did not listen to them. When I was 13, I was transferred to another institution. It was the worst place ever. We were all punished, no matter who did something wrong.

If something bad happens, I could complain to the caregivers, and if I had a problem with the staff, I could tell the director.

I had a problem with one caregiver. She made us go to bed very early. One night I smoked a cigarette, and she told me to go into the room. “I’m going, just to finish a cigarette.” Then she ran to me and started hitting me with a stick. She hit me so much that it hurt a lot, and she even called men to hold me while she was hitting me. I wanted to see the director, because he was on duty then, but she did not allow me. I could not wait for the morning to go to the director and tell him what had happened. And I went. That caregiver was later fired. (T, former client)
The testimony of another woman who were present at the same event: caregiver said to T. “Go to bed.” She said, “Here, I will go, just to smoke a cigarette, I will go to bed.” It was like that, I’m a witness. The caregiver then beat her. And she called men to hold her and hit her. She called two men (clients) to beat her. The first boy held her while the teacher hit her. The other boy did not accept it because he did not want to be guilty. The caregiver beat her so badly, she got very nasty beatings... Everyone found out about this, and she was momentarily fired.

All the women with whom we talked testify to the physical violence they survived in the institution from employees and other clients.

He hits, and yells, and threatens. If you do not do it as he says, he will give you injection and you fall asleep. (beneficiary of the institution)

The caregiver pulled my hair, slapped me, and did all sorts of things to me. And I never made a mistake, I never made a problem. (J, former client)

They pull your hair. They do all these things in front of everyone. They hit with their shoes. Everyone keeps silent about this. If you say something, you will also get it. There you cannot complain to anyone. They just kick you out and say, “In the pavilion!” And then the caregiver comes and beats you. (A., former clients)

The sense of women’s helplessness is evident as they remember situations of violence in residential institutions, but there is also a certain level of reluctance to verbal and physical violence due to the impossibility of changing the situation. This is especially important for women who are placed in an institution at an early age and have never lived in a family or cannot remember any other experiences. It is important here to look at the power relations between the authority of the employees over the people who are in an institution, because many of them are very dependent on the care and support they receive from the employees.

Horizontal violence in institutions is defined as the psychological, physical, and sexual violence that one or more clients carry out to punish, hurt, or control other clients. Given that this type of violence occurs in residential institutions, it often has the characteristics of violent behavior “in the clan” and shows much similarity to the manifestations of peer violence and domestic violence. The biggest problem is that the victim is forced to live with her abuser and cannot leave, and the fact that a joint life in the institution gives the perpetrator the opportunity to find out the most intimate information about the victim, such as her family situation, health condition, disability, which makes it easier for the victim to be intimidated and controlled.

The other girl beat me. I was distraught, sad, disappointed, scared. Then I reported to caregivers. They criticized the girl and punished her by not getting a lunch. My boyfriend warned her not to bully me anymore. (K, former client)

---

26 Submission to the Senate Inquiry into the violence, abuse and neglect against people with disability in institutional and residential settings, Advocacy for Inclusion, Australia, 2015.


28 Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017
When they survive physical violence from other clients, women generally choose not to report it because they themselves are often punished. They try to explain that the reason for punishing the victims themselves is that they have violated a rule, but they clearly show negative attitudes and disagreements with such behavior.

The roommate hit me and beat me. I told the teacher, and she was angry at both her and me. (Z, former client)

It happened sometimes that clients got into fight. Then I ran away from the situation, because I knew that I would be punished if I reported it. Such was the practice. Certainly, everyone gets punished – the one participating and the one who wants to prevent violence. (A, former client)

It happened that the clients got into fight, but this was sorted out quickly. Also, some men mistreated girls and women in the institution. Those more aggressive were also attacking the girls. This was solved by going to the management, and then they took him to a psychiatrist, gave him some medication, and sent him to another institution. Sometimes, he was sent to a psychiatric hospital. (F, former client)

Apart from the fact that violence is normalized in closed institutions, in time, clients develop resistance to the internal hierarchy. Although violence survived by the employees is not justified, women and men in residential institutions have a particularly bad attitude towards violence surviving from other clients. Research shows that people in residential institutions consider that employees in institutions are much more important than them and that they have more rights, that is, the institutions primarily provide jobs for employees, and only then takes care of the clients. The institution serves its own purpose, so the attitudes of employees towards people with mental disabilities are one of the causes of violence in institutions.

29 “The abuse of individuals with developmental disabilities” Catherine Thornberry and Karin Olson, University of Alberta, Canada, 2005

There was one man who spied on us and the staff. He imposed his own rules. Until two women [clients] beat him. He was exaggerating, acted as a boss, but he was a client, just like us. (F, former client)

Although various forms and manifestations of violence presented in this section can equally apply to women and men residing in residential institutions due to the nature and way of functioning of these institutions, it is important to emphasize that the situation of women with mental disabilities is more difficult and they are at higher risk of surviving violence from other clients, employees or people outside the institution. Although we do not claim that this is everyday behavior in all residential institutions, the fact that different women who have been living for many years in different institutions have told similar experiences infers that violence is widespread and there are no prevention programs or adequate responses to such behavior. Women who have survived domestic violence are in a particularly difficult situation, because institutional violence additionally victimizes and traumatizes them. Most of the women we interviewed talked about their experience of violence before they came to the institution, pointing out to partner violence or violence that they survived from other family members. It is very problematic that the official response to the violence they survived (combined with their life in poverty and the fact they have mental disabilities) was to place them in a residential institution that only opened possibilities for new and additional forms and manifestations of violence.

Besides physical, verbal, and sexual violence women with mental disabilities survive from other clients or employees, they are also exposed to additional forms of violence that can be characterized as gender specific, including sexual harassment and abuse, partner violence, serious violation of reproductive rights including forced abortions, administration of contraceptives without informed consent, and forced sterilization.
Gender-based Violence

“Stronger, bigger men beat you in the institution. And tell you bad words.” (Z.)

Violence against women is any act of gender-based violence that results or could result in a physical, sexual or psychological injury or the suffering of women, including threats that these acts will be committed, as well as coercion or arbitrary deprivation of liberty, regardless of whether these acts are done in public or private life.\(^{30}\)

The term “gender-based violence” in this context means that violence is committed against a particular person because she is a member of a certain gender and/or because she does not fulfill socially imposed gender roles\(^{31}\). Gender-based violence particularly highlights the gender dimension of violent acts, that is, the relationship between the subordinate position of women in society and their exposure to the risk of violence. Considering the incomparably higher number of women and girls who are victims of violence in comparison to men and boys, the concept of gender-based violence refers to violence survived by girls and women.

Undoubtedly, women are exposed to gender-based violence precisely because of gender. However, we should not ignore factors such as disability, race, social status, sexual orientation, and age that put women with these personal characteristics at greater risk of violence and fewer options for protection\(^{32}\). Many people consider that violence is less serious if it is suffered by a woman who is

---


\(^{32}\) Violence against Women, Boston Women’s Health Book Collective, Touchstone, USA, 1998.
poor, older or institutionalized, if she is a sex worker, a lesbian or a woman with a mental or physical disability. In this section, we will present women’s testimonies about sexual harassment and abuse, as well as about particularly worrying practices, such as sterilization, administration of contraceptives without informed consent and forced abortions. Women currently living in institutions were more hesitant to talk about such experiences. Also, given the sensitivity of the topic, and the lack of an adequate support programs for these women, MDRI-S associates were particularly attentive to conversations about reproductive health and sexual violence. The findings presented in this section also rely on the analysis of existing research and studies at the international level, as well as the key aspects of violence against women with disabilities recognized in the General Comment 3 of the Committee on the Rights of Persons with Disabilities.

SEXUAL HARASSMENT AND ABUSE

Women with intellectual and mental disabilities are at higher risk of surviving sexual violence in comparison to women without disabilities and women with physical disabilities. However, research shows that from the moment when a woman is placed in a residential institution, this risk is further increased. This is also explained by the fact that life in a residential institution for women means that they are isolated from the outside world, are vulnerable, and even “consent” to unwanted sex to fulfill their own needs that are denied in the institution. For example, the perpetrators offered cigarettes or a drive, in exchange for sex. Also, the problem is that employees in institutions perceive clients as asexual beings and do not provide them with any protection against abuse or they just use that prejudice to carry out their own violence, because they know that institutionalized women will not be widely believed to report violence.

Sexual violence experienced by women and girls with disabilities in residential institutions in Serbia is insufficiently visible in the public and is rarely discussed. Reports show that, in 2015, five cases of physical violence were reported in 15 institutions (horizontal violence). Not a single report mentions sexual violence, although women and employees we talk to spoke about different experiences. The same report states that “further sensitization and education of employees is needed to raising awareness of the presence and responses to violence in institutions.”

Due to the consequences of life in a closed institutional system and the fear of potential consequences, as well as feelings of helplessness, women generally choose not to report sexual violence. In interviews with employees we noticed that they are often unsure or do not recognize whether the sexual relationship between a man and a woman is forced or consensual. Sexually active women are often labeled as promiscuous, so each sexual relationship is considered consensual.

“Sometimes, a guy has three women here. Everybody knows. But, they allow us that here; employees don’t say anything.”

Some of our interviewees said that men were attacking women in big residential institutions, beaten them and forced into sex. Women mostly keep silent and continue to suffer violence. It has already been stated earlier that in some institutions men and women share rooms, and given that women cannot choose who will be in the room, they may be in the same room as the abuser and to survive continuous violence that goes unreported.

33 Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017
35 Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017
Although they mostly do not want to talk about it, one woman told us that a man (and from a further conversation, we realized they were a couple for a while) tried to rape her while she was with a friend in the courtyard of the institution. They managed to escape, and she reported the attack to the staff and the management. The man was punished, but also the girls because they went to that place “although it was forbidden.” Two other girls talked about similar experiences.

*Women sometimes do not report, and we do not have an idea of what actually happened and whether something happened at all. We had a rape report from one woman and we talked with her. We later found that she lived alone [before coming to institution] and that various people came to her house, so who knows what is in her head. And when we asked her about rape, she told us something completely different from what rape really is.* (employee in one institution)

We have noticed that the role of male relatives in these situations is important. Women who are in contact with brothers or other male relatives decide to first report violence to them. Several of the women we interviewed confirmed that they reported violence from staff to the brothers or father, who then reacted to the administration. During March, a report was published in the Serbian media that a technician at the psychiatric hospital harassed the clients, and one woman was forced to take off her clothes, while he touched her and poured coffee on her. Her husband informed the media about the incident the following day:

*He first appeared in the ward at midnight, woke up the patients and presented himself as a doctor from Nis. He started harassing them and lining them up in the hallway, and my wife was forced to strip. He touched her genitals and breasts. My wife complained that it was terrible – says husband Alexander. He says his wife confirmed that there was no sexual intercourse, but that he physically harassed her, slapped her, and forced her to take off her clothes. “My wife told me that there was no sexual intercourse, but that she was made to sit naked in his lap, that he spilled coffee over her body, touched her, and that everything was terrible. She is now in a worse condition than she was 20 days ago when she was admitted to the hospital, although there was some progress several days before the incident.”*

Given suffering and pain after sexual violence, and especially because of mistrust, the absence of adequate reactions or lack of information whom to contact for support, women in institutions do not report it. Also, usually no one believes women with intellectual and psychosocial difficulties or no one even asks about such experiences in the institution. Lack of contact with relatives or acquaintances diminishes the possibility of recognizing or reacting to violence. Over 70% of people in social care institutions in Serbia have no or very rare contacts with relatives, and only 7% of persons regularly visit the family.

**PARTNER VIOLENCE**

Domestic violence, in this context, refers to physical, psychological and sexual violence, as well as neglect by partners, family members, guardians or personal assistants of women with disabilities. In international theory of domestic violence against women with disabilities, the concept of family has been expanded because disabled women often depend on more people who assist them in performing various daily activities. Besides parents, intimate partners, and other family members, domestic violence is also extended to

---


personal assistants, that is, persons who provide help and support in their day-to-day functioning. These are, for example, personal assistants, drivers, interpreters, doctors and other medical personnel, social workers, therapists, counselors, as well as other employees in residential institutions. Therefore, women with disabilities living in residential institutions and women with severe forms of disability who require care and ongoing personal assistance are at higher risk of being exposed to violence because they depend on a larger number of people and it is difficult for them to leave the perpetrators.

*My first boyfriend in the institution beat me because I smoked. He did not like it. I complained to the caregivers, but they did not respond. A friend protected me. After that, my boyfriend was no longer allowed to beat me.* (T, former home user)

Women often survive partner violence in institutions, and it seems that employees do not have adequate responses to such situations. One woman told us that she had previously had a relationship with a young man from the institution that beat her, and once he strongly bit her breast. She complained to the caregivers and they threatened that he would go to the “cage” if he still touched her. As he continued with physical violence, “a friend advised her to leave him and find another boyfriend.”

She cooks and prepares food in the room. She says: “I was good and capable, so they [staff] placed this man with me in the room to keep him under control. They put a new client in the room with a smart one to keep him from running away from the institution.”

So, she started preparing food for him also. He got used to such a life. After a while, the administration wanted to split them, but he insisted that he stays with her in the room. He said, “I finally found myself a cook, and I’m not going anywhere.” They were together in the room for 16 years.

“I cook, wash, and iron for him. He goes to the store.”

As she told us, they separated them because they were fighting a lot. He was aggressive, and they got into fights.

“They did not even ask us but just separated us. And he cannot live without me, and I cannot live without him either.”

After this situation, the man spent some time in the psychiatric ward and he is now living in another pavilion. Our interviewee hopes that they will live together again, because he corrected his behavior. She visits him every day and brings him food. Sometimes, caregivers do not allow her to visit him. They tell her she cannot come in because she has to stay in “her building.”

We did not manage to get the information on how staff responds to partner violence in residential institutions, which of course does not mean that there are no efforts or activities in that direction. Some employees have told us that they tried to resolve such situations by talking with clients or separating partners into different rooms.

*[in the situation of violence] we inform all those who are in charge, and then we see what this person wants... And we try to talk through the situation to see what she wants – to get away from this room or to move him away. But, they do not complain so often. We do not have violence, but I think they don’t know how to recognize forms of violence.* (employee in one institution)

Although the issue of partner violence has become more visible and recognized in our society and various response mechanisms have been developed in such situations, partner violence against women with mental disabilities in residential institutions remains
completely invisible. If we consider that a residential institution for many people is a long-term placement and that couples in these institutions live together, the question arises as to whether the provisions of the new Law on the prevention of domestic violence will apply to these women as well. Given that the law defines domestic violence as "an act of physical, sexual, psychological or economic violence of the perpetrator towards the person with whom he/she is in present or earlier marital or extra-marital relationship,"39 there should be a discussion about partner violence in residential institutions until circumstances are changed for complete deinstitutionalization.

**REPRODUCTIVE HEALTH: PROBLEMATIC PRACTICES**

All our interviewees and employees in residential institutions confirm that gynecological examinations are organized regularly, once every six months or yearly, and they are performed either in the local clinic or in the institution itself. Medical staff keeps records of it. In some institutions, there are no regular and scheduled check-ups, but they are performed when "enough clients are gathered."40 Despite regular gynecological examinations, it happens that doctors do not see that women are pregnant, which, according to an employee, can also tell about the quality of gynecological examinations of women from residential institutions. In one institution, a woman was taken to gynecologists several times and her pregnancy was not established.

Recently we found a good gynecologist and he talks to women. Compared to the previous, it's a big change. Earlier, doctors barely looked at our women. But, this doctor is gentle and talking to them, I saw that. Girls who can understand, they know, and they often talk about it [contraception]. There is no intimacy, and not one girl asked so far to talk about these things privately or intimately. Everyone knows everything, everyone knows what happens to someone. (employee in the institution)

In one large institution, the doctor does not know the exact number of sexually active clients, because in addition to couples, "the majority is prone to promiscuous behavior." That is why records of menstrual periods are kept regularly and recorded in a special notebook. If nurses note that a woman is missing her period, a pregnancy test and a gynecological examination are required. Although examinations are organized, there is noticeable disrespect and lack of interest in the desires and decisions of women with disabilities living in residential institutions regarding their state of health, therapy, interventions. The fact that women are deprived of their legal capacity additionally complicates their position. Decisions on reproductive health are made by the staff in the institution with the consent of the guardian.

One of our interviewees states that the women from the institution went to the gynecologist organized (in groups) and always with someone’s support: "That's how they made us, as if we cannot do it alone." Today she uses supported living service, goes regularly to the gynecologist, monitors all controls and examinations. Women, who use the supportive support service today, state that they still regularly see gynecologists, and that a gynecologist talks to them about reproductive health. They know what medicines they are taking. They learned it, because while they were living in residential institution, nurses gave them medication without explanations.

---

39 Article 3 of Law on prevention of domestic violence, Official gazette of the Republic of Serbia, number 94/2016
40 Statement from a doctor in one residential institution during our monitoring visit
ADMINISTRATION OF CONTRACEPTIVES WITHOUT INFORMED CONSENT

“The moment you come to institution, they insert you with intrauterine device. And that’s it.” (S.)

Negative attitudes and prejudices towards sexuality of women with intellectual disabilities result in public policies that seek to control and manage sexual life of women with disabilities. Thus, these women are given contraceptives that will delay or control their menstrual period or even stop their normal sexual development. In this way, they are exercising “modernized” or hidden form of forced sterilization. According to the literature, other reasons attempting to justify administration of contraceptives to women with intellectual disabilities without their consent, among other things, are “best interest” of a woman because she is unable to fully understand what is happening to her body, pregnancy puts her health at risk, and especially her psychological state if her child was taken away. The forced administration of contraceptives is justified by the protection of family members of a woman with disabilities who, if the mother is not able to take care of the child, experience additional stress, because, apart from the woman with intellectual disability, they would be forced to take care of her child. Furthermore, the supporters of forced contraception consider that they also protect the rights of a child that a disabled woman could bear because they find it unfair and unhealthy for a child to grow up with a mother with intellectual disability. It is not rare to hear that women with intellectual disabilities are at higher risk of being sexually abused, and contraception is one of the ways to prevent potential pregnancies. Finally, as an “explanation,” supporters of such practice emphasize the protection of society, bearing in mind the cost of caring for the child, if the parents are not able to take care of him. All these explanations still resemble eugenic policies and completely disregard the right of women with disabilities to independently make decisions about their bodies, sexuality and parenting.

During the work on this project, we found that most women with disabilities who are sexually and reproductively active are given contraceptive pills or inserted intrauterine devices (IUD) without their consent or prior information on interventions and effects.

The gynecologist asks woman whether she is in a relationship and whether she needs contraception. (F, former resident of institution)

As soon as you get to the institution, they put IUD in you. And that’s it. Those who get pregnant, need to have abortion. (S, currently living in the institution)

They [women] are not generally asked. Their guardians are asked about the form of contraception at the recommendation of a gynecologist. Younger girls are given pills and older women are given intrauterine device. He [doctor] found everything, two devices in woman’s uterus. There was little concern about these women. Nothing has been done on this issue, because everyone is kind of shrugging their shoulders. And everyone blames others. (employee in the institution)

In one large institution that we visited, a third of women have built-in IUDs or use oral contraceptives, and in another institution half of women. We asked employees whether women were informed and whether they agreed to take pills, and they replied “We seek consent from their guardians. Whatever we do, we cannot do it without the consent of the guardian.” However, some employees state that the guardian’s consent is required for the insertion of IUDs, but not for administering contraceptive pills because they are regarded as part of the therapy, and guardians are only informed about it.

They put intrauterine device in me. They put it, they did not ask anything. They just asked me when they finished if I was OK, whether I want to vomit. (K, former client)

41 Developmentally Disabled Women and Forced Contraceptives, Professional Training Resources, USA

42 Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017
During the research, we were unable to get information about the decision-making process of giving contraception to women. There are several assumptions that we have recognized in all institutions through interviews with women and employees. Apart from monitoring the age of a woman, sexual activity is assessed in relation to whether they have a partner or whether “women behave promiscuously.” Depending on how long and with whom women spend time, the decision on contraception is made. For example, one of our interviewee says that for over 20 years of life in the institution “no one has tricked her” referring to a sexual relationship with a man. That’s why the staff did not bother to force her to have IUD because “they saw I was okay.” On the other hand, the other woman says that she liked to play and spend time with boys rather than girls. That’s why she was taken to the gynecologist for the first time when she was 12 years old. The doctor then said that he would not examine her: “Why have you brought her to me? She is still a child.”

Administrating contraception to a woman with disabilities without her informed consent is a form of abuse. It violates her right to informed consent, the right to physical integrity, care for her health and body, the right to express sexuality and parenting.

FORCED ABORTIONS

“If a girl gets pregnant, they call her ‘mommy’, say bad things about her, act badly towards her. And then, they do an abortion to her.” (D.)

All our interviewees state that women who can take care of themselves recorded their own menstrual period. Some recall that it happened that some women were pregnant, but they lied that they had a regular period. They also say that the caregivers monitored if the period was regular, and when pregnancy was detected, girls went to a gynecologist to determine the length of pregnancy and schedule an abortion. The girl’s consent is not sought.

One woman says she was “keeping a record of other women’s menstrual period.” Once, she noticed that one girl missed her period, so she reported it to the staff. The girl was already four months pregnant.

“\textit{She was barely alive, she could die [after the abortion]. She also had problems with the sinuses and she could not breathe. They cut her, because she could not deliver a baby. Terrible. No one asked if she wants it or not. But, she shouldn’t have done that. You cannot do that in the institution. You can have a boyfriend, but you have to be careful.} (D, former client)

A woman who has been living in an institution for 29 years told us her story.

Upon her arrival, she refused to have IUD administered. She had a partner at the institution and then she got pregnant. They wanted to leave the institution and live with their child as a family. His parents opposed that, and institution staff said that she would be kicked out of the institution if she did not have an abortion. She decided to have an abortion and stay in the institution. After a while, her partner committed suicide.

She states that several women gave birth to children regardless of threats of being evicted from the institution. They gave birth because staff did not even know that they were pregnant. One woman found out when she was seven months pregnant. They were not thrown out of the institution.

When it comes to reproductive health, families and health workers often send a message to women with disabilities that they should not have children and that they themselves will give birth to a child
with disabilities. This view of sexuality and the potential parenting of women with disabilities leads to the application and justification of different methods such as forced sterilization, forced abortion, denial or inadequate provision of health care related to reproductive health. In addition to the belief that a woman with intellectual disability is not able to be a good mother, nor is she able to make an informed decision about her health and parenting, a forced abortion is also related to the fact that the organization of a residential institution is above need and respect for the rights of women living there. While women all over the world fight for the right to abortion, women with disabilities fight, as feminists with disabilities call it “the right to decide not to decide.”

**FORCED STERILIZATION**

In the past two centuries, it was common around the world for people with intellectual and mental disabilities to be victims of forced sterilization. By 1939, more than 30 countries forcibly sterilized almost 39,000 people with disabilities. The main reason for forced sterilization was the belief that these people were “defective” and that their condition was inherited. In the mid-20th century, in some countries, the sterilization of people with disabilities became a prerequisite for leaving the residential institution.

Unfortunately, forced sterilization is still being carried out today on many girls and women with disabilities. Forced sterilization is an act of violence against women, a form of social control and violation of the right to freedom from torture and other cruel, inhuman and degrading treatment and punishment. Throughout the world, girls and women with disabilities are subjected to forced sterilization for various reasons and justifications, including eugenics (to increase the participation of “good” genes in the human population), controlling menstruation and “taking care” of women’s health, as well as preventing pregnancy of women with disabilities. However, this concern for the human population and the health of women with disabilities represents a systemic denial of sexual and reproductive health rights, denial of contraceptive methods, focusing on suppressing menstruation and denying a possibility for disabled women to be pregnant and give birth. The practice of forced sterilization also reflects the traditional attitude that disability is a personal tragedy or a condition that needs to be treated. Women with intellectual and mental disabilities are particularly at risk of being subjected to forced sterilization, especially if they are under guardianship, because guardian can give consent for this intervention. In many countries, there are on-going debates on justification of forced sterilization, and those who support such statements explain that forced sterilization is “in the best interest” of a woman with disabilities. Of course, “the best interest of women” in this case is completely contrary to her human rights, and it is a consequence of social factors, such as the lack of adequate measures to protect women from sexual abuse and exploitation, and the lack of adequate and purposeful support services for women with disabilities who want to have and raise children.

During the data collection, we received information about only one woman with intellectual disability who was sterilized in the past few years, after she gave birth to the fourth child and then placed in a social care institution. In another institution, a woman got pregnant and her mother was appointed as temporary guardian for the event of giving birth. Mother/guardian insisted that the woman (her daughter) be sterilized.

---

44 Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017
45 Ibid. reference to author Anne Finger
46 Contraceptive choices for women with learning disabilities, The Open University, UK, 2015
48 Beker K., Milosevic T., Violence against women with disabilities in residential institutions, Mental Disability Rights Initiative MDRI-S, 2017
The mother insisted that sterilization be done after her birth. We tried to talk her out of this, that it was not a good idea, that nobody would accept such intervention. We struggled to keep her off this intervention. They [women with intellectual disabilities] do not have the same treatment at all as other patients, for sure. (employee of the institution)

There are many limitations and obstacles to get information about sterilization, such as women’s unwillingness to talk about it, the fact that they are not informed, and there is a public perception that such interventions are socially unacceptable and generally no one wants to talk about it. However, in its Concluding Observations for Serbia, the Committee on the Rights of Persons with Disabilities expressed concern that persons with disabilities, especially those deprived of their legal capacity, were subjected to contraceptive treatment, forced abortions, and sterilization without consent49.

“Prevention and Protection from Violence”

“If someone bullies me, I turn my head and keep quiet.” (JE)

Given the prevalence of various forms of violence against women with disabilities in residential institutions, an important part of the research includes availability of internal and external mechanisms for the prevention and reaction to violence. A detailed analysis of the international and national legal framework and the country’s response to gender-based violence and violence in residential institutions is given in the study “Violence against Women with Disabilities in Residential Institutions” by authors Kosana Beker and Tijana Milosevic. Our conversations with women focused on their awareness of the protection mechanisms in institutions. We also surveyed service providers that support women victims of violence with an aim of analyzing different opportunities for supporting women survivors of violence in residential institutions.

Each institution for children and adults with disabilities is obliged to establish an internal team for violence50. This team exists in 11 institutions for adults with disabilities (from 15) and in five (all) institutions for children with disabilities. The specific tasks of the internal team are to receive reports on the knowledge or concern about situations of violence, collect information, take measures for the safety of the clients, and work closely with anyone who, during the examination process, develops a protection plan for a survivor.

---

49 Concluding observations on the initial report of Serbia, Committee on the Rights of Persons with Disabilities, 21.04.2016. CRPD/C/SRB/CO/1

50 Special Protocol on protection of children in social care institutions from abuse and neglect, Ministry of labor, employment and social welfare of the Republic of Serbia, 2006
of violence. The obligation of the institution is to clearly and publicly announce the names of the members of the internal team, as well as their telephone numbers. Team members must be available 24 hours a day.

**NOT ONE WOMAN WE SPOKE WITH HAVE EVER HEARD ABOUT THE INTERNAL TEAM FOR VIOLENCE.**
**THERE WAS NO PUBLIC INFORMATION ABOUT INTERNAL TEAM IN ANY OF THE INSTITUTIONS WE VISITED.**

However, it should be noted that ten women we interviewed lived in institutions at the time when the internal team mechanism did not exist, but the testimonies of women who live in institutions now and the insights of our monitoring team nevertheless confirm that the internal team is an unknown and insufficiently visible mechanism. This is supported by the fact that in 2015, 15 institutions for adults with disabilities, in which 4,415 people lived during that year, reported only five cases of violence (horizontal violence). Internal teams recorded violence in only three institutions, and the report of the Republic Institute for Social Protection states that “for the past seven years records are being kept for: physical abuse, sexual, emotional abuse, negligent conduct towards the clients, exploitation of clients, as well as types of abusers.”51 Also, from five institutions for children with disabilities, only one reported five cases of violence to the internal team and all related to horizontal violence. Other institutions did not record any situation of violence52. Considering the number of people living in institutions, their testimonies of various forms of violence, but also the prevalence of violence in other areas of public life in Serbia, this extremely low number of reports is a result of under-reporting of violence within the institutions, normalization of violence, and inadequate functioning of internal teams.

The employees we interviewed claim that the internal team cannot function properly in the way it is now being designed. They consider this mechanism to be set up to meet procedural requirements. For example, employees claim that they often refuse to leave their phone numbers in a visible place, as this may mean that they will constantly receive calls that are not connected to situations of violence, primarily because women and men placed in institutions are not fully informed about violence, protection measures or prevention. A visible telephone number would not reduce the incidence of violence without previous continuous work and providing information to clients. Some employees consider that trust is an important issue, i.e., whether users have confidence in the person who is in the team.

**The internal team for protection against violence has no real role. It has a more administrative role than an essential one. Perhaps clients do not have confidence in people in the team. How then to report violence? It is generally believed that staff should not give their phone numbers to clients. Clients are not informed about their rights. There is a lack of accountability. If I were to be held accountable for whether I gave information to the clients or not, then it would be a very different story. For example, information on how to deal with living in an institution, how to respond to some things. (employee of the institution)**

From interviews with women we conclude that violence among clients is reported to caregivers, nurses, or social workers, that is, employees who are in daily contact with them.

“The stronger one wins. If someone stronger bullies her, she tells it to someone who is even stronger... and so it goes, in circles” (N).

In cases of vertical violence, we have identified two ways of reporting violence. When they survive violence from employees, women 1) report to the administration of the institution, or 2) talk to relatives, if any, most often with men (brother, father), who then call the institution, come, and complain to the management. However, it should be emphasized that in most cases there is no reporting.

We could report it, if it’s worth it. And sometimes it doesn’t matter, because they [management] listen to what the staff says, not clients. (F, former client)

He [employee] beat me. I called my brothers who live in nearby villages and told them all about it. Then, previous manager was in the institution and she allowed me to make phone calls from her office. My brothers told me that he had no right to beat me. They called the institution and told the manager. And, now, when someone bullies me, I call my brothers and they call the manager. The manager then tells employees that they cannot behave like that. (client in one institution)

The role of the Center for social work is very important in this area, because experts from the centers should participate in the individualized support plan and provide support and information to the beneficiaries, as well as to provide external expert supervision for employees in the institution. This is especially important when one of the employees in the Center for social work is appointed as a guardian to a person in the institution. However, all the women we talked with state that the representatives of the Center for social work do not visit them regularly and do not inform them about important aspects of their life. Many women do not know who their guardian is or whom they should contact if they need support.

Women who are isolated in residential institutions have no information on other mechanisms of protection against violence. However, women now living in the community or those who can go out and participate in activities of local civil society organizations are more informed and more aware of the protection mechanisms. They all mention that in cases of violence, they would contact the police, Center for social work, service provider or the Ombudsman.

ACCESSIBILITY OF PROTECTION MECHANISMS

Besides the internal team for violence, we also considered other ways of protection, such as service providers supporting victims of violence. We have considered several key areas of accessibility that hinder women’s adequate and full access to protection services and mechanisms, primarily relating to physical/architectural, informational, and financial accessibility.

PHYSICAL AND ARCHITECTURAL ACCESSIBILITY

Most social welfare institutions are either in smaller villages or often in completely derelict areas of the country, which is the first accessibility issue that hinders protection from violence. In this way, people living in institutions are kept in isolation from the outside world and are unable to maintain contact with family and friends, and they do not have a possibility of establishing new acquaintances and contacts in the local community. As already mentioned, over 70% of beneficiaries of social care institutions in Serbia do not contact or very rarely have contacts with relatives, and only 7% of persons regularly visit the family53. Lack of contact with relatives or acquaintances reduces chances for addressing violence. People living in institutions to a large extent depend on the support of employees in the institution. Life in isolation makes it impossible for them to access information about mechanisms for protection against violence, but also contacting a service provider. Even when institutions are in populated areas, there are frequent controls of

---

movement. All the women we talked with, for which we can confirm that they are independent, say that exiting the institution is usually forbidden.

Prohibition and limitation of free movement makes very difficult for a woman to contact existing local service providers who support victims of violence.

INFORMATIONAL ACCESSIBILITY

All women say that they have never talked to anyone about violence in the institution, how to protect themselves or react when violence occurs. Some of them mention the names of caregivers with whom they are close, but there is an evident absence of any organized approach to this topic in form of an individual or group discussion. Information about protection depends on a good relationship with employees or on personal ability to manage in this environment.

There was no talk of violence in the institution. I think there were some documents about that, but these were only for the employees. There was no information for us. (N, former client)

Employees also confirm that there are no organized discussions on the topic of violence.

We do not work with the clients on violence. In addition, we [staff] do not know what constitutes violence and we do not agree on what kind of behavior is violence. (Employee of the institution)

An important part of information accessibility is to provide ways of communicating with the outside world, so that women can contact relatives, other services or institutions, and report cases of violence. The women we talked with mostly do not use mobile phones. If they use public phone at the institution, they say that there is always someone listening their conversations, and they do not feel free to talk about the problems and challenges they face in the institution. Control is present in every aspect of their life.

I could not call anyone from the institution. Once, I secretly called my brother and someone “snitched me” to the staff. They called me for a private interview and warn me to ask them first the next time I want to call someone. (E, former client)

I could not call anyone from the institution. I could only receive phone calls. If someone called me, the teachers told me, and I could talk for a while. (G, former client)

I could call my mother from the reception, but the receptionist was dialing the phone and then standing and listening to my conversation. I was not alone. (J, former client)

Women who have a mobile phone generally do not have enough money to pay for it. They do not have access to the Internet in the institutions, mainly because they do not have computers available or they do not know how to use them.

In one large institution with 105 clients (64 women), our interviewee says that there was a computer with access to the Internet in a TV room. Clients could use it. But, now it is in the office and it can be used only briefly, if you announce it and ask for a permission. “It was fine while it was in the TV room. We also played music on YouTube. And I could be on Facebook, and be in contact with people. But not anymore. And I cannot always pay for my mobile phone bill.” (L, currently living in the institution.)

It should be noted that most women living in residential institutions have never gone to schools, they are not educated and that most of them are illiterate. Women with hearing or vision impairment, or those who are non-verbal are also in a very difficult and risky situation. By talking to women, visiting institutions, and interviewing the staff, we found out that there are no established communication
procedures and support programs for women who have severe disabili-
ies or are non-verbal.

In one room we found a woman who does not hear, and when asked about how they communicate with her, the staff said, “we sort of manage.” Neither she nor the staff uses sign language. When asked if a woman can report the situation of violence or something she dislikes, the employees answered that they certainly would have understood if she wanted to report something, but that there were no such situations so far. (MDRI-S monitoring team)

There is no written information on violence in institutions, and there are no materials in accessible formats. In one institution where many persons with visual impairment live, there is no information in Braille. Also, there is no available written material in an easy-to-read and easy-to-understand format.

The issue of violence against women with disabilities in residential institutions has not been visible at all so far. There were no trainings or workshops with employees and beneficiaries, as well as written or electronic material on protection mechanisms that would be available to women in institutions. The Republic Institute for Social Protection estimates that “further awareness-raising and education of employees is needed to increase the awareness about the presence and response to violence in institutions.”

FINANCIAL ACCESSIBILITY

Initial analyses of the legislative policy framework, interviews with women, and surveying local service providers have shown that existing mechanisms for protection against violence are not available and accessible to women with disabilities in institutions. Financial accessibility was not addressed in interviews with women, as this is particularly complex issue and it was difficult at this stage of the project to find an adequate response to financial accessibility.

Existing support services for victims of violence are free of charge, but these services are not always accessible to women in institutions for many reasons – women do not have information about services, it is difficult for them to leave the institution and visit a service provider, barriers in communication, the cost of a SOS help-line (unless a free line is provided). Some social workers working in large-scale residential institutions provide support to users in procedures to review their legal capacity before the courts by supporting them during the trials, preparing them for hearing, and expert witnessing. This is a very important step in Serbia, but it does not specifically refer to support in situations of violence. However, this support model may be further developed and used.

Although complaint procedures to independent institutions such as the Protector of Citizens and the Commissioner for the Protection of Equality are free and simplified, they are nevertheless insufficiently visible and clear to women in residential institutions. It is therefore important that these institutions have a proactive approach to the protection of the rights of women with disabilities in institutions, and provide information about violation of rights and help in filing a complaint by going to these institutions and having direct contact with women.

During the research, we also surveyed civil society organizations that provide services to women who survived violence to determine which are the best ways for women to leave the isolation of a residential institution and establish contact with providers. This survey included 23 civil society organizations in Serbia, and the services they provide include individual and group psychological


55 14 civil society organizations filled in the questionnaire, and phone survey was conducted with nine service providers. From 23 service providers, 11 supports women victims of violence for over ten years, seven organizations have been working from five to ten years, two organizations from three to five years, two organizations from one to three years, and one organization have been working for less than a year. Data are given for 2015/2016.
support and counseling for women victims of violence and women who are at risk of violence, SOS phone, legal aid, economic empowerment, humanitarian and medical assistance.

The main challenges in providing services to women with disabilities we detected are:

- Architectural accessibility of organizations and institutions (police, centers for social work, safe houses);
- Financial difficulties in providing specialized services (e.g. sign language interpreters, information packages in Braille or other accessible formats);
- Financial sustainability of services;
- Lack of human resources and experts;
- Lack of understanding of the local self-governments and failure to provide civil society organizations with support and assistance.

Also, service providers believe that it is better for women with disabilities to address specialized services. As reasons, they also state that they cannot perceive the scope of the problem, that they are not sufficiently trained to provide psychological support to women with disabilities, have no experience in working with them. Multiple discrimination is cited as a major challenge in providing services, especially when it comes to Roma women with disabilities.

An organization that provides a SOS help-line believes that the inaccessibility of this service for women with hearing and speech difficulties is a major challenge. People working on the SOS helpline send text messages to the number from which they received the call if communication could not be established with the person who called. They consider this to be one of the ways to ask, support, and inform women with hearing or speech impairment. Also, some organizations think that their activities and services are not sufficiently visible for minority women, such as Roma women and women with disabilities.

Due to the inaccessible mechanisms for protection against violence outside the residential institution, as well as the non-functional internal mechanism, women with disabilities in institutions are at greater risk of violence, and violence remains invisible. Women who have spent their whole lives in the institution and have no experience of interaction with the community are in a particularly sensitive and difficult situation, as well as those with severe disabilities and need for intensive and complex support, women with a different way of communication, girls and elderly women, women who did not attend school and are illiterate.

A key step is to find a way for a woman with mental disabilities in a residential institution to establish a first contact with a service provider or an official institution. In current living circumstances of these women, this is a very difficult step. Afterwards, it is necessary to work on establishing trust and planning support for a woman.
Freedom from violence that amounts to torture, inhuman or degrading treatment and other forms of ill-treatment (control, isolation...) is a positive obligation of the state and presents a systemic issue on which Serbian institutions must provide clear and adequate ways of reacting, prohibiting such practices, planning mechanisms for prevention, and compensation of victims. The Committee on the Rights of Persons with Disabilities in its Concluding Observations⁵⁶ in 2016 expressed concern about the position of women with disabilities in Serbia and made several clear recommendations:

- Include the perspective of women and girls with disabilities in policies, programs, and strategies of gender equality, as well as a gender perspective in disability strategies;
- Take appropriate measures to prevent and combat multiple and intersectional discrimination against women and girls with disabilities, especially in access to justice, education, health care, employment and protection against violence and abuse;
- Prohibit impairment-based detention, including involuntary hospitalization and forced institutionalization, as well as accelerate deinstitutionalization;
- Protect adults and children with disabilities in an institutional setting from violence, abuse and ill-treatment of any kind;
- Ensure accessibility and availability of effective and independent monitoring mechanisms and transparent procedures for reporting violence, including sexual violence against persons with disabilities, especially women with disabilities, and to develop training programs for prevention of violence and abuse of persons with disabilities;
- Prohibit medical interventions without a prior consent of a person with disabilities and ensure that the right to informed and free consent is exercised before any measure that could affect a person with disabilities, regardless of his/her legal capacity;
- Review all procedures in which women with disabilities whose right to parenthood is restricted and provide them with necessary support in exercising the right to parenthood, home and family;

⁵⁶ Concluding observations on the initial report of Serbia, Committee on the Rights of Persons with Disabilities, 21.04.2016. CRPD/C/SRB/CO/1
Any form of violence against women is unacceptable, including violence against women with disabilities in residential and psychiatric institutions. These women have been invisible in our society and exposed to various forms and manifestations of violence. All the women we talked to have testified about various forms of violence that they have survived or are still surviving in residential institutions, from verbal violence, such as threats, humiliation, shouting, through physical violence from other clients and employees, to sexual violence and gross violations of reproductive rights.

Women with disabilities, especially intellectual and psychosocial, who are in residential institutional are exposed to violent and/or involuntary pregnancies or sterilization, contraception and abortion without free and informed consent. Sexual harassment and sexual violence is a form of gender-specific violence. We frequently heard that forced contraception or sterilization is used “as a measure to prevent sexual violence” which clearly shows ill-treatment and difficult situation of women with disabilities in residential institutions. Instead of preventing cases of sexual violence and rape, contraception is used to avoid potential pregnancies that could have resulted from sexual violence. Women with disabilities face barriers to access to justice, including justice in cases of violence and abuse, they are stereotyped and discriminated, and there is a lack of adequate procedural safeguards, which can lead to doubts about the credibility of their statements and the rejection of their complaints. All this can lead to impunity and invisibility of the problem,

57 Testimonies and experiences of women with disabilities, parents, staff in institutions
which allows the violence to continue. In addition, disabled women are sometimes afraid to report violence because they are worried that they may lose the necessary support. The situation is more difficult for women in the institutions because perpetrators are aware that there is a small risk of disclosure and punishment, given that support services are not available to these women.  

When policies for improving the situation of persons with disabilities are created, women with mental disabilities are often left out, and when creating policies in gender equality or the prevention of violence against women, these women stay invisible again. They are left out of policies and support programs, and existing services are inaccessible to them. As a society we have no response to violence against women with disabilities in residential institutions and there is no unanimity and clarity about violence against these women, especially sexual and partner violence.

Each residential institution creates its “institutional culture of violence” and the solution to this complex issue should be sought in planning and continuing work on deinstitutionalization in Serbia by ensuring the sustainability of community-based services that have a multidisciplinary and person-centered approach. Community living is not just provision of housing and better living conditions, but ensuring access to all rights, de-facto equality before the law, inclusion in programs for protection against gender-based violence, empowering women and strengthening self-advocacy initiatives.

Now, I can freely say what I think. And that’s the most important thing. I feel as if I’m fully independent, and I don’t have any fear. Indeed, I dread of returning to the institution, but I would fight. God forbid I go back there. I would like that everyone leaves residential institutions. That there are no residential institutions. (F. spend over 20 years in institutions, and now uses a supported living service in the local community)

In the publication, we use a definition of an institution given in the Common European Guidelines on the Transition from Institutional to Community-based Care, according to which the institution is not defined only by its capacity, that is, the number of clients, but also by the institutional culture. More precisely, the institution is any “resident-type service” within which:

- People are isolated from the wider community and they are forced to live together;
- People do not have control over their lives and decisions that concern them;
- The needs of the organization are above the personal needs of the client.

The purpose of the research of gender-based violence in residential institutions is to gain additional insight into the forms and manifestations of violence against women and girls with mental disabilities,  

58 Committee on the Rights of Persons with Disabilities, General Comment no. 3 on Girls and Women with Disabilities, CRPD/C/GC/3 from 2 September 2016  
59 Common European Guidelines on the Transition from Institutional to Community-based Care, European Expert Group on the Transition from Institutional to Community-based Care, November 2012
so as to find ways to support them, determine the roles and responsibilities of various actors in this process, and give additional initiative for a comprehensive deinstitutionalization process in Serbia. Our aim is to make gender-based violence more visible, to tell publicly the testimonies of women who have survived violence, and to define the necessary steps to change legislation and policies by involving various actors in this process. The approach is based on the human rights and fundamental freedoms of girls and women with disabilities on an equal basis with others.

For the purposes of this research, the following activities were carried out:

- a detailed analysis of the legislation and policies, international standards and existing research on the situation of women with disabilities in institutions at the international and national level;
- defining a methodology, developing data collection tools, and preparing guidelines for interviews with women with disabilities and employees in social care institutions;
- interviews with women with disabilities who have a history of institutionalization or are currently living in an institution;
- interviews with employees in residential institutions;
- survey of service providers;
- analysis of collected data, writing reports, and formulating recommendations.

A comprehensive analysis of legislation and policies is given in the study "Violence against Women with Disabilities in Residential Institutions" by authors Kosana Beker and Tijana Milošević. The aim of this study was to examine whether and to what extent are women with disabilities residing in residential institutions protected from violence through review of the international and national legal and policy framework. In addition to reviewing legislation, the study also includes an analysis of the available research and reports in this area, in order to better understand the situation of women and girls with disabilities in residential institutions, that is, the difficulties they face during their life and exposure to violence. Parts of the study were used in this publication.

MDRI-S team has conducted several group interviews and 13 individual interviews with women with disabilities who had a history of institutionalization or lived in an institution at that moment. The women we interviewed were between 25 and 60 years old, and had spent about 20 years on average in various residential institutions. Several of our interviewees lived in different institutions in Serbia. Participants had different types of difficulties, including motor, sensory, intellectual and cognitive disabilities. We conducted conversations with women who were more independent, had a high level of functioning, and could verbalize their stories. Women who had serious difficulties and who needed intensive support were included through interviews with employees or other women staying with them in the institution. In the testimonies, there is a very pronounced difference in the position of women with light and more severe types of disability and, as the women who were more independent told us, it was easier for them to manage in the institution, their situation was better compared to women with serious difficulties (women who are immobile, do not speak, have a severe form of disability).

Interviews with women with disabilities encompass behavior and knowledge. Behavior relates to the general conditions under which women with disabilities live in an institution, the fulfillment of basic needs, and treatment such as restraint and isolation, abuse, enabling/denying access to rights. Knowledge implies awareness and being informed about violence and the ability to use different protection mechanisms.

Through interviews with women we followed the so-called "points of transition," that is, different activities, the influence of individuals and institutions, or events that have changed the life situation of women with disabilities. For example, this can be the moment when they left institution, started independent life, accessed self-help or self-advocacy groups, connected with civil society organizations or service providers. It is equally important to consider the life of a
woman before she came to a residential institution, especially in terms of losing control over life decisions, attempts to adapt, normalization of violence, and the effects of institutionalization. Life circumstances and changes, such as leaving an institution and living in a community, can lead to personal transformation, empowerment, learning, increased self-confidence and security, which can reduce the risk of various forms of violence.

In addition to interviews with women with disabilities who survived violence in residential institutions, our team also visited several institutions as part of the National Preventive Mechanism for Torture. We also conducted interviews with several employees in institutions. Participation in the research was on a voluntary basis, and the consent of the women with whom we talked individually was ensured. In this publication, we do not present data on individual institutions, nor we give the names of our interviewees to ensure their safety and privacy. This particularly applies to women who still live in residential institution and express fear of consequences after talking to our team.

_They [women] turn around as they talk to us, watch if employees are near. They are hiding. Then they change the subject or begin to whisper. Also, during the visit we are told that the employees already asked them what they were telling us and what we talked to them about. (MDRI-S monitoring team)_