Do Not Leave Us Out! Access to Sexual and Reproductive Health Rights for Women with Disabilities

A Review of Policies in Zimbabwe

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Introduction

A broad definition of disability that does not prioritise impairment as the primary cause of dysfunction is increasingly accepted in contemporary disability discourse. Disability is defined as long-term physical, mental, intellectual, or sensory impairments that, in interaction with various barriers, may impede full and effective participation in society (United Nations Convention on the Rights of Persons with Disabilities [UNCRPD], 2006). This chapter does not aim to examine access to sexual and reproductive health and rights (SRHR) for women with disabilities through a medicalised lens of disability (Riddle, 2020). Instead, it seeks to explore existing policies in Zimbabwe within the context of a society that is evolving towards greater inclusivity (Berghs et al., 2019). Access to SRHR is crucial for the empowerment of women to enable them to make informed choices regarding their personal lives.

The demand for SRHR for women with disabilities is particularly pertinent given their cultural perception as asexual and unworthy of the full rights afforded to their non-disabled peers. The recognition of the rights of women with disabilities is grounded in the principles enshrined in the UNCRPD (2006), which aims to address the injustices faced by persons with disabilities. Rugoho and Maphosa (2017) assert that the UNCRPD delineates extensive rights for persons with disabilities, including access to SRHR. However, it appears that the majority of women with disabilities in Zimbabwe are not availing themselves of these rights. This chapter seeks to review policies in Zimbabwe that align with the provision of healthcare services within the framework of international standards.

The utilisation and operationalisation of legal instruments are critical in safeguarding the rights of women, particularly those with disabilities. Women with disabilities are more likely to experience marginalisation and exclusion from mainstream public health initiatives than their non-disabled counterparts. The examination of policies related to quality health provision in Zimbabwe is prompted by the observation that women with disabilities appear to be excluded from access to SRHR. This article aims to review the Constitution of Zimbabwe, the Disabled Persons Act [17:01] as amended, the National Disability Policy, the National Reproductive Health Policy, and the 2016-2020 National Health Strategy (NHS). Additionally, the discussion considers the National Development Strategy (NDS) 1, the International Conference on Population and Development (ICPD) Programme of Action (POA), and the Age of Consent. A significant challenge that requires attention is the lack of studies that address the complex relationship between health policies, legislation, and access to or utilisation of **sexual and reproductive health** services for persons with disabilities in sub-Saharan Africa (Mac-Seeing et al., 2020).

Defining Sexual and Reproductive Health and Rights (SRHR)

SRHR encompass a broad spectrum of services that involve both physical and relational components of preventative health at minimal cost (Massay, 2021; Sundewall & Poku, 2018). These services include the reduction of unplanned pregnancies and unsafe abortions, the mitigation of the spread of HIV and other sexually transmitted infections (STIs), the prevention of sexual violence against minors and persons with disabilities, the provision of affordable contraceptive measures and counselling, pre- and postnatal care, access to skilled healthcare professionals during childbirth, the reduction of gender-based violence, and the increased uptake of condom use (Sundewall & Poku, 2018). Access to SRHR for women and girls, which includes the exercise of their agency in deciding if and when to engage in sexual intercourse, as well as if and when to bear children, is critical for achieving gender equality. Global studies conducted within the framework of the Sustainable Development Goals (SGDs) have highlighted the urgent need to enhance access to SRHR for women with disabilities, a need that remains inadequately addressed within the African context (Ganle et al., 2021). The primary challenge lies in effectively addressing the SRHR needs of women while simultaneously meeting the requirements of women with disabilities (Ganle et al., 2021).

SRHR for Women with Disabilities

There are over one billion individuals with disabilities worldwide, and global prevalence rates indicate that there are more women with disabilities than men, at 19% and 12% respectively (United Nations Entity for Gender Equality and the Empowerment of Women [UN Women], 2019). Specifically, one in five women globally has a disability (UN Women, 2019). The majority of women with disabilities reside in low- and middle-income countries (UN Women, 2019). While women with disabilities encounter similar barriers as non-disabled women, they face compounded obstacles, including

discrimination and environmental limitations that impede their rights (Cord, 2023). Unfortunately, women with disabilities are often excluded from activities that facilitate access to SRHR, such as screening, prevention, and healthcare services, due to the ongoing association of disability with asexuality and an inability to bear children (Gartrell et al., 2017). Consequently, healthcare facilities frequently lack the necessary infrastructure and expertise to address the needs of women with disabilities in accessing SRHR (Gartrell et al., 2017).

Globally, SRHR are often perceived as the sole responsibility of women, which may account for the low priority assigned to this broad area of health rights (Men Engage Alliance, 2020). The limited studies available indicate that women with disabilities encounter significant barriers to accessing SRHR in Africa, and more specifically Zimbabwe (Ganle et al., 2020). Women with disabilities worldwide have considerable unmet needs in accessing sexual and reproductive health services (Dean et al., 2017). These unmet needs are influenced by discourses that portray individuals living with disabilities, particularly women with disabilities, as lacking sexual needs or agency, implying that they do not require access to sexual and reproductive health services (Dean et al., 2017). Furthermore, studies have documented and acknowledged the marginalisation of women with disabilities in economic, political, and social participation compared to their non-disabled counterparts (Gartrell et al., 2017).

Furthermore, there is a dearth of literature on studies that provide narratives of sexuality among women with disabilities in Zimbabwe (Peta et al., 2017). It can be argued that this reflects a lack of clear policies and a legal framework that support women with disabilities in accessing SRHR. Globally, the SRHR of persons with disabilities have historically been substantially neglected, as evidenced by the lack of access to SRHR information and the right to decide whether to have a family (Gartrell et al., 2017). Gendered norms create expectations for women to bear children; however, the stigma that women with disabilities experience excludes them from fulfilling this expected role (Dean et al., 2017). A study conducted by Khan

and Alam (2019) on the intersections of gender, disability, and sexuality in Bangladesh indicated that women with disabilities expressed feelings of being stigmatised when they shared their thoughts and desires concerning their sexual lives. Some of the disabled women in the study rejected the socially expected passive role of a disabled woman who lacks agency concerning her own sexuality (Khan & Alam, 2019). Social norms and various forms of stigmatisation therefore need to be challenged through carefully crafted policies to ensure that women with disabilities have equitable access to SRHR.

The lack of comprehensive policies on disability and access to SRHR is another gap that exists in many societies. A study conducted in Sweden targeting healthcare professionals working with young people with intellectual disabilities and SRHR showed that the absence of well-documented guidelines and policies affected the effectiveness of their work (Wickström et al., 2020). Similarly, a review of policies on gender, disability, and tourism in Zimbabwe concluded that there are inconsistencies in some policies that could exclude women with disabilities from enjoying their full rights (Munodawafa & Zengeni, 2022). The presence of these policy gaps underscores the immediate need to re-evaluate the policy and legal framework in Zimbabwe, with the aim of ensuring the comprehensive inclusion of women with disabilities in all spheres of life. Furthermore, while there are international conventions on disability and sexual health, the manner in which countries decide to implement them differs substantially (Bahner, 2019). It is therefore imperative to review policies that support SRHR in Zimbabwe to assess whether these policies enable women with disabilities to access such rights.

Intersectionality Theory and SRHR

The review of policies is informed by the intersectionality theory, which posits that women's lives are influenced by intersecting systems of oppression (Carastathis, 2014). The term "intersectionality" explores how various forms of inequality and identity interact in different contexts and over time, such as the intersectionality of race, gender, and disability (Gillborn, 2015).

Intersectional discrimination is defined as "a situation in which people are discriminated against on different grounds, which taken together result in a level of prejudice that is higher than if these different grounds were taken separately" (De Beco, 2020, p. 593). Developed by Crenshaw (1989), the intersectionality theory incorporates an advocacy element aimed at forming coalitions among diverse groups to resist and transform the status quo (Gillborn, 2015). This theory necessitates that researchers examine the simultaneous effects of systems and structures of oppression. Mainstream feminist theories often categorise vulnerabilities into single categories; however, the intersectionality theory compels researchers to engage in critical reflection on inequalities, which suggests that women with disabilities encounter intersecting layers of inequalities that hinder their access to sexual and reproductive health rights.

This chapter argues that these intersecting layers of oppression also impede women with disabilities from being recognised as sexual beings with SRHR. The intersectionality theory has further been employed to analyse health inequities and enhance understanding of the multi-layered nature of disparities (Hankivsky, 2014). Feminist discourse has established that women with disabilities face specific challenges linked to intersectional forms of gender inequality, such as the type of disability, severity, poverty, and rurality (Gartrell et al., 2017).

Women with disabilities rely on the availability of healthcare facilities that provide appropriate services and infrastructure tailored to their needs. The complexity of inequities that affect women with disabilities necessitates an intersectional approach, whereby the interplay of various characteristics of vulnerable populations at both individual and structural levels, such as class, ableism, gender, and sexism, shapes people's lives (Hankivsky, 2014).

Objectives of the Policy Review

The purpose of this study was to review SRHR policies in Zimbabwe to evaluate whether they address the diverse needs

of women with disabilities. Central to this analysis are issues of accessibility, affordability, and availability of SRHR for women with disabilities.

Methodology

The study analysed whether the existing policies facilitate the availability, affordability, and accessibility of SRHR for women with disabilities. To achieve this, a policy review of SRHR was conducted employing document analysis in a qualitative research framework. Document analysis is defined as a "procedure for reviewing or evaluating documents, both printed and electronic material" (Bowen, 2009, p. 27). This method entails skimming, in-depth analysis, and interpretation of documents (Bowen, 2009). The researchers meticulously examined various policy and legislative documents to assess whether the diverse needs of women with disabilities were acknowledged and whether resources were allocated to address these needs. This paper scrutinises various pieces of legislation, international conventions, and policy documents pertaining to SRHR and disabilities in Zimbabwe, utilising a gender perspective.

Presentation and Discussion of Findings

The presentation and discussion of policies in this section concentrate on the available SRHR policies in Zimbabwe. Each policy is analysed and discussed in accordance with the study's objective. The discussion also employs a gender perspective to evaluate whether the legal and policy framework effectively mitigates gender disparities for women with disabilities in accessing SRHR. The following policies and Acts are discussed:

- Disabled Persons Act [17:01]
- National Disability Policy (2021)
- Universal Health Coverage
- The New Constitution (2013)
- The NDS 1: Vision 2020–2025
- National Reproductive Health Policy
- ICPD POA
- NHS 2021–2025

- Age of Consent

Review of Zimbabwe's Legal and Policy Frameworks on SRHR for Women with Disabilities

The Disabled Persons Act [17:01] of 1992

Zimbabwe was one of the first countries in Africa to enact legislation aimed at promoting the empowerment of individuals with disabilities; however, this legislation is now considered outdated and in need of repeal (National Disability Policy, 2021). The Disabled Persons Act is one of the pivotal legal frameworks established post-independence in 1980. The Disabled Persons Act prohibits the denial of access to public premises for individuals with disabilities, to which members of the public are ordinarily admitted. The Act explicitly stipulates that persons with disabilities are entitled to full access to community and social services. Access to SRHR is essential for the emancipation of women with disabilities. In Zimbabwe, women with disabilities encounter significant challenges in accessing quality sexual and reproductive health services due to service providers' limited knowledge and skills in effectively communicating with them. Ganle et al. (2016) assert that there is a lack of adaptation of health information to accommodate persons with disabilities. Privacy concerns, which are a critical component of health service delivery, are compromised, as deaf women require someone who is proficient in sign language to convey the information they wish to communicate to healthcare personnel. Burke et al. (2017) highlight the absence of privacy and confidential services at the point of access. While writing a message on paper could mitigate breaches of privacy, some deaf women may be illiterate or semi-literate. Criticism of the Disabled Persons Act centres on its lack of the use of first-person language. Specifically, the term "disabled persons" does not conform to the preferred first-person language; the acceptable terminology should be "persons with disabilities". Activists for the rights of persons with disabilities now consider the Disabled Persons Act to be moribund or outdated. Furthermore, it has been argued that the Act is rooted in the

medical model, which perceives individuals with disabilities as sick and in need of "fixing". This medical model is inadequate in addressing the intersecting forms of inequality and exclusion that women with disabilities encounter in accessing sexual and reproductive health services in Zimbabwe.

The National Disability Policy (2021)

The National Disability Policy was enacted against the backdrop of the government's commitment to fulfilling, promoting, protecting, and respecting the rights of persons with disabilities. Furthermore, the National Disability Policy was introduced at a time when the people of Zimbabwe were progressing towards the national vision of becoming an upper middle-income society by 2030. The purpose of the National Disability Policy is to guide the state and all institutions in formulating and supporting the implementation of laws, policies, and intervention strategies that facilitate the fulfilment of the rights of persons with disabilities in Zimbabwe. The policy explicitly stipulates that persons with disabilities must have access to free healthcare services in public health institutions, including in areas of sexual and reproductive healthcare and population-based programmes. Despite this robust policy framework for persons with disabilities, women with disabilities continue to be excluded from mainstream healthcare service delivery systems. Apolot et al. (2019) contend that there is limited availability of special outreach services for antenatal and postnatal care targeting persons with disabilities. Critical shortages of medications in public hospitals leave women with disabilities, who are generally economically disadvantaged, at risk of not receiving medical care for health complications that may arise. Moreover, the provisions of the National Disability Policy have yet to be fully operationalised to ensure that women with disabilities can fully access their SRHR. For instance, one of the objectives of the National Disability Policy explicitly states that the individual right to free and informed consent of persons with disabilities must be respected within healthcare settings and decision-making processes, including in the area of sexual and reproductive health.

Universal Health Coverage

It is encouraging to note that Zimbabwe subscribes to Universal Health Coverage, which stipulates that individuals should have access to the healthcare services they require without risking financial ruin or impoverishment (Mhazo & Maponga, 2022). Universal Health Coverage is conceptualised as a framework in which equity in healthcare provision is prioritised and disparities between the economically advantaged and the less advantaged are minimised. However, the situation for women with disabilities in Zimbabwe does not appear to reflect the successful implementation of Universal Health Coverage. Institutionalised discrimination, isolation, and stereotyping of women with disabilities persist unabated (Rugoho & Siziba, 2014). Women with disabilities are more vulnerable to sexual abuse and victimisation, as they are often perceived as weak and therefore easy targets (Rugoho & Maphosa, 2017). Many public institutions mandated to provide healthcare services in the country are characterised by infrastructural inaccessibility. Apolot et al. (2019) indicate the prevalence of prolonged waiting times and disability-unfriendly physical healthcare infrastructure. While the government is undertaking significant efforts to improve the accessibility of physical infrastructure at national and district hospitals, further actions are required to facilitate the movement of wheelchair users and individuals with varying physical disabilities. Additionally, the shortage of trained healthcare professionals who can assist persons with disabilities, depending on the nature of their disabilities, may compromise access to and the privacy of women with disabilities in relation to sexual and reproductive health services.

The New Zimbabwe Constitution (2013)

The Constitution of Zimbabwe serves as the foundational legislative framework that governs the nation within the context of the law. It explicitly establishes the right to healthcare in Section 74(1–4), which asserts that every citizen and permanent resident of Zimbabwe is entitled to access basic healthcare services. This constitutional provision unequivocally

affirms that no Zimbabwean citizen should be excluded from Universal Health Coverage.

Despite the Constitution's clarity regarding the accessibility of basic healthcare services, women with disabilities encounter significant barriers in obtaining healthcare services that cater to their specific needs. For example, women who are deaf require health-related services to be delivered in sign language; however, public hospitals in the country lack sign language interpreters among their staff, which results in a communication gap. The majority of hospital personnel are unable to converse in sign language, which hinders access to essential health services.

Moreover, women who are visually impaired do not receive health information in accessible formats, such as braille, which would enable them to fully engage with the information from the comfort of their homes. Additionally, women with physical disabilities face challenges due to inaccessible entrances to health service points in hospital environments. In rural communities, healthcare facilities are often located considerable distances from homesteads, which further complicates access for women with disabilities who must travel long distances to seek medical attention.

Cultural misconceptions regarding disability also contribute to the barriers faced by women with disabilities in accessing vital information related to SRHR. Healthcare providers may unconsciously overlook the importance of empowering women with disabilities with crucial information concerning their SRHR, which is often a consequence of deeply entrenched cultural fallacies about disability. Ganle et al. (2016) postulate that there is a lack of knowledge or limited capacity among staff regarding sexual and reproductive health issues that affect persons with disabilities.

The Constitution, in Section 83, clearly stipulates that the state must take appropriate measures, within the limits of available resources, to ensure that persons with disabilities can realise their full mental and physical potential, including access to medical, psychological, and functional treatment. While the

state is committed to taking appropriate measures to facilitate the realisation of the mental and physical potential of persons with disabilities, the phrase "within the limits of the resources available" may provide a convenient justification for insufficient funding of public hospitals, thereby impeding the accessibility and affordability of sexual and reproductive health services for women with disabilities.

The National Development Strategy (NDS) 1: Vision 2020-2025

The NDS 1 delineates the strategies, policies, legal and institutional reforms, and projects that will be executed over the five-year period from 2021 to 2025, with the aim of achieving accelerated, high, inclusive, broad-based, and sustainable economic growth, alongside socio-economic transformation and development. Through a comprehensive stakeholder consultative process, one of the numerous priorities identified is health and well-being in the NDS 1. Under the section on social protection, there is clear emphasis on the need to protect vulnerable groups, which include persons with disabilities, children, and the elderly. While the NDS 1 explicitly states the need for new interventions and modifications to existing programmes, no disaggregated data currently exist that demonstrate the specific targeting of women with disabilities in SRHR education. This absence of information complicates the understanding of the access that women with disabilities have to SRHR in public hospitals.

National Reproductive Health Policy

This policy is pivotal in the provision of services encompassing maternal health, family planning, treatment for STIs, including HIV and AIDS, and adolescent reproductive health (Rugoho & Maphosa, 2017). Although the policy is crucial for the prevention of STIs and HIV and AIDS, there is a paucity of information regarding the services extended to women with disabilities concerning maternal health. There appear to be no disaggregated data that clearly outline the services provided to women with disabilities in relation to SRHR. Such data would be instrumental in determining whether there has

been progress in incorporating women with disabilities into matters concerning SRHR or if there are gaps that require urgent attention. Rugoho and Maphosa (2017) note that very few studies have been conducted in Zimbabwe on sexual and reproductive health among women with disabilities, which results in a limited understanding of the challenges they encounter in accessing sexual and reproductive health services. The National Reproductive Health Policy serves as a significant instrument for advancing maternal health, family planning, and the management of STIs; however, there appears to be a lack of clarity regarding the inclusion of women with disabilities in this initiative.

International Conference on Population and Development (ICPD) Programme of Action (POA)

The government of Zimbabwe has been implementing the principles enshrined in the ICPD POA. Zimbabwe has committed to providing universal access to sexual and reproductive health services, which include universal primary health services. At the Nairobi Summit, held in November 2019 to commemorate the 25th anniversary of the ICPD, the Government of Zimbabwe reiterated its commitment to addressing the goals of the ICPD POA. Under SDG 4, which seeks to ensure access to comprehensive and age-appropriate information, education, and adolescent-friendly, comprehensive quality and timely services, the government of Zimbabwe pledged to ensure that hard-to-reach populations, such as persons with disabilities, have immediate access to comprehensive sexual and reproductive health services. While this commitment is commendable, the approach is notably gender-blind, as it fails to specify the distinct needs of women with disabilities, which differ from those of men with disabilities. The neglect of the sexuality of women with disabilities is argued to have resulted in the perpetuation of various myths that contribute to the perception that women with disabilities do not need to be acknowledged in discussions about sexuality (Peta et al., 2017).

National Health Strategy (NHS) (2021–2025)

The government of Zimbabwe has developed a national health strategy that has the potential to yield positive health outcomes for its citizens. For example, the government has explicitly outlined improvements in health emergency preparedness and response capacities, which could enhance the resilience of the population against unforeseen pandemics or natural disasters. Additionally, health sector priorities have been clearly defined to establish a coherent roadmap for implementing strategies that promote health for all in Zimbabwe.

It is noteworthy that the NHS articulates strategies aimed at enhancing reproductive, maternal, newborn, child, and adolescent health nutrition, which are critical interventions for health delivery in the country. The strategy also delineates approaches for mitigating the impact of both communicable and non-communicable diseases. However, while Strategic Intervention 3.2.1.9 addresses the improvement of early identification and prevention of childhood disabilities through the upscaling of the At-Risk Surveillance System, interventions specifically targeting women and girls with disabilities are not sufficiently highlighted. This demographic appears to be underrepresented in health interventions designed to enhance their quality of life.

Furthermore, issues regarding access to SRHR are not adequately addressed in the NHS. The significance of SRHR is particularly pronounced for women and girls with disabilities, who are often excluded from sexuality education. It is also encouraging that Strategic Intervention 3.4.2.5 outlines morbidity management and disability prevention, proposing the establishment of routine and organised morbidity management and disability programmes for conditions that lead to disability, including leprosy, trachoma, and lymphatic filariasis. However, given the resource constraints faced by government healthcare facilities, women with disabilities may still encounter barriers to accessing sexual and reproductive health services.

Age of Consent

The age of consent constitutes a contentious issue in Zimbabwe's legal and policy framework, which is characterised by a lack of harmonisation in laws. The age of consent is defined as the age at which an individual can legally consent to sexual activity. A recent constitutional ruling established the age of consent in Zimbabwe as 18 years. Prior to this ruling, the age of consent was set at 16 years, as indicated in the amendment to the Criminal Law (Codification and Reform) Act [Chapter 9:23]. The elevation of the age of consent to 18 years has significant implications for girls' access to contraceptives. This issue is further complicated for women with disabilities, who are not only frequently excluded from decisions regarding their sexuality but are also often regarded as either ill or as minors, irrespective of their actual age. According to Kika (2019), a report by the Justice for Children Trust highlights the absence of legislation that specifies the age threshold at which parental consent is required for a child to access sexual and reproductive health services. While no formal legislation exists, it is common practice to require parental consent for children under the age of 16 years who are seeking access to these services. Such practices adversely affect girls with disabilities below the age of 16 in obtaining contraceptives. Given that children below the age of 16 years cannot legally consent to sexual intercourse, this law perpetuates the assumption that minors do not have SRHR.

Conclusion and Recommendations

The review of existing policies reveals a fragmented approach to SRHR, as relevant provisions are dispersed across various legislative and policy frameworks. This disjointed approach hampers the establishment of consistency in addressing the needs of women with disabilities. Although the more recent National Disability Policy acknowledges intersectional issues that affect women with disabilities, other legislation, such as the Disabled Persons Act, remains outdated and lacks specific provisions that promote inclusivity in accessing sexual and reproductive health services for women with disabilities.

The study also established that certain policies, such as the Disabled Persons Act, are gender-blind and do not differentiate between the needs of women with disabilities and those of men with disabilities. This blanket approach is detrimental to women with disabilities in accessing reproductive and healthcare services, as specific provisions are overlooked. There is a pressing need for the Act to be reviewed to ensure that it contains appropriate language that empowers women with disabilities. An urgent revision of the Disabled Persons Act is necessary to move away from the medical model currently employed in the legislation. Recognising the intersectionality of gender, disability, race, ethnicity, and geographical location is essential and should be enshrined in laws and policies that provide for SRHR.

The policy review clearly indicates that the policies are not supported by financial resources, which are critical for guaranteeing women with disabilities access to SRHR. This is evidenced in Section 83 of the Constitution, which only guarantees the provision of services for persons with disabilities contingent upon the availability of resources. The government should prioritise the needs of women with disabilities, as they are disproportionately affected by poverty compared to individuals without disabilities and men with disabilities. The availability of necessary resources for women with disabilities at healthcare facilities is vital for their well-being, empowerment, and independence. This entails the state ensuring that healthcare facilities are staffed by personnel who can provide comprehensive assistance to women with disabilities.

There is a need for further studies on SRHR and disability. There is currently a lack of comprehensive information on sexuality and women with disabilities in Zimbabwe. Such studies are instrumental in informing policymakers about the needs of women with disabilities. While this trend is not unique to Zimbabwe, there is a need to bridge the knowledge gap in this area. These studies are critical as they empower women with disabilities to exercise their agency and assert their identities in articulating their sexuality. Women with disabilities are often

perceived as asexual or lacking the desire to marry and bear children. Such social norms must be eradicated.

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