BINDURA UNIVERSITY OF SCIENCE EDUCATION

FACULTY OF SOCIAL SCIENCES AND HUMANITIES

DEPARTMENT OF SOCIAL WORK

ACCESSIBILITY OF SEXUAL AND REPRODUCTIVE SERVICES AMONG PEOPLE LIVING WITH DISABILITIES IN GWERU, ZIMBABWE: INSIGHTS FROM NATIONAL COUNCIL OF DISABLED PERSONS OF ZIMBABWE (NCDPZ)

BY

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A DISSERTATION SUBMITTED TO BINDURA UN IVERSITY OF SCIENCE EDUCATION, FACULTY OF SOCIAL SCIENCES AND HUMANITIES, DEPARTMENT OF SOCIAL WORK IN PARTIAL FULFILLMENT OF THE BACHELOR OF SCIENCE HONOURS DEGREE IN SOCIAL WORK

SUPERVISED BY: MR L.T SHONIWA

APPROVAL FORM

I certify that I supervised Shalom A.M. Moyo in carrying out this research titled: Accessibility of sexual and reproductive services among People living with disability in Gweru Zimbabwe: Insights from NCDPZ in partial fulfillment of the requirements of the Bachelor of Science, Honors Degree in Social Work and recommend that it proceeds for examination

Supervisor Name: L.T Shonhiwa Signature: Date: 14 June 2024

Chairperson of the Department Board of Examiners

The departmental board of examiners is satisfied that this dissertation report meets the examination requirements and therefore I recommend to Bindura University of Science Education to accept this research project by Shalom Moyo titled: Accessibility of sexual and reproductive services among People living with disability in Gweru Zimbabwe: Insights from NCDPZ in partial fulfillment of the Bachelor of Science, Honors Degree in Social work.

Chairperson Name…….

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I, Shalom Moyo studying for a Bachelor of Science Honors Degree in Social Work, aware of the fact that plagiarism is an academic offense and that falsifying information is a breach of the ethics of Social Work research, I truthfully declare that:

1. The dissertation report titled: Accessibility of sexual and reproductive services among People living with disability in Gweru Zimbabwe: Insights from NCDPZ is my original work and has not been plagiarized.
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3. Bindura University of Science Education can use this dissertation for academic purposes.

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ACKNOWLEDGEMENT

Firstly and for most, I would like to thank the Almighty for the opportunity he has given me to undertake this degree program and the precious time to conduct this research. I express my gratitude to my supervisor Mr Shonhiwa for providing me with this special opportunity and supporting my academic development. Without his advices, guidance, and patience completion of my study would not be possible. I would also like to express my heartfelt thanks to my family and friends, for encouraging me, inspiring me and supporting me from the onset of this research up to its completion. My mother, Mrs. Tazvivinga and my father, Mr. Tazvivinga for the blessings, my aunt Mrs. Mnangagwa and my brothers for their assistance in every step of the research. Finally to the Bindura University of Science Education, many thanks go to you and all the lecturer. I thank you all for the academic and professional guidance to this point.

DEDICATION

To my mother, Mrs. Tazvivinga , my father Mr. Tazvivinga and my aunt Mrs. Mnangagwa who stood by me and supported me financially and morally during the course of carrying out the study.

God bless you and protect you.

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MARKING GUIDE: UNDERGRADUATE RESEARCH PROJECT

Chapter 1 INTRODUCTION	**Possible Mark**	**Actual Mark**
Abstract	**10**	
Background to the study- what is it that has made you choose this particular topic? Include objectives or purpose of the study	**20**	
Statement of the problem	**10**	
Research questions	**15**	
Assumptions	**5**	
Significance of the study	**15**	
Limitations of the study	**5**	
Delimitations of the study	**5**	
Definition of terms	**10**	
Summary	**5**	
Total	**100**	
Weighted Mark	**15**	

Comments……
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Chapter 2 LITERATURE REVIEW

Introduction- what do you want to write about in this chapter?	**5**	
Conceptual or theoretical framework	**10**	
Identification, interpretations and evaluation of relevant literature and citations	**40**	
Contextualisation of the literature to the problem	**10**	
Establishing gaps in knowledge and how the research will try to bridge these gaps	**10**	
Structuring and logical sequencing of ideas	**10**	
Discursive skills	**10**	
Summary	**5**	
Total	**100**	
Weighted Mark	**20**	

Comments……
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Chapter 3 RESEARCH METHODOLOGY

Introduction	**5**	
Research design	**10**	
What instruments are you using to collect data?	**30**	

Population, sample and sampling techniques to be used in the study	**25**	
Procedures for collecting data	**15**	
Data presentation and analysis procedures	**10**	
Summary	**5**	
Total	**100**	
Weighted Mark	**25**	

Comments……
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Chapter 4 DATA PRESENTATION, ANALYSIS AND DISCUSSION

Introduction	**5**	
Data presentation	**50**	
Is there any attempt to link literature review with new findings	**10**	
How is the new knowledge trying to fill the gaps identified earlier	**10**	
Discursive and analytical skills	**20**	
Summary	**5**	
Total	**100**	
Weighted Mark	**30**	

Comments
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Chapter 5 SUMMARY, CONCLUSION AND RECOMMENDATIONS

Introduction- focus of the chapter	**5**	
Summary of the whole project including constraints	**25**	
Conclusions- have you come up with answers to the problem under study	**30**	
Recommendations(should be based on findings) Be precise	**30**	
References	**5**	
Appendices i.e. copies of instruments used and any other relevant material	**5**	
Total	**100**	
Weighted mark	**10**	

Comments ……
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SUMMARY:-

	Actual	Total
Chapter 1		
Chapter 2		
Chapter 3		
Chapter 4		
Chapter 5		
Total		

ABSTRACT

The study explored on accessibility of SRH services among PLWDsin Gweru, Zimbabwe. The aim of the study is to investigate the accessibility of SRH services among PLWDs in Gweru: Insights of NCDPZ. The research was qualitative in nature and employed in-depth interviews, focus group discussions for the purpose of data collection. A sample size of 10 respondents was drawn from the target population and was used to collect relevant data to the study. The study was underpinned by the social model of disability in order to understand issues surrounding PLWDs' access to SRH services. Literature review was expressed and gaps were identified .Objectives of the study were to identify SRH services available for PLWDs in Gweru, establish barriers faced by PLWDs in accessing SRH services in Gweru and to explore strategies that can be adopted to enhance access to SRH services for PLWDs. The study findings showed that PLWDS has little access to SRH services due to barriers such as communication, physical, and financial barriers. The study also shows how PLWDs have little knowledge and are not aware of their SRH services. The study revealed that there is need to solve these short comings by educating Healthcare providers more about disabiliy, teach them sign language, build accessible facilities and practice inclusive Health services.

LIST OF ABBREVATIONS AND ACRONYMS

NCDPZ National Council of Disabled Persons of Zimbabwe

SRH Sexual and reproductive health services

PLWDs People living with disabilities

NGO Non-Governmental Organization

PVO Private Voluntary Organization

UN United Nations

USAID United States agency for International Development

WHO World Health Organization

GBV Gender based violence

HIV Human Immunodeficiency Virus

Contents

CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

1.0 INTRODUCTION

Sexual reproductive health (SRH) is a fundamental human right that should be accessible to all individuals, regardless of their disability status. This research investigates the accessibility of sexual reproductive health (SRH) services among people living with disabilities (PLWDs) focusing on the available SRH services, barriers that hinder access for people with disabilities, and strategies to improve the accessibility of such services. In addition, this proposal outlines the background of the study, objectives of the study, research questions justification of the study. The research methodology employed in this study has been outlined in this document and this includes the research approach, research design, study setting, data collection techniques, sampling, data analysis and ethics considered in this study.

1.1 BACKGROUND OF THE STUDY

People living with disabilities often struggle to get sexual and reproductive healthcare. This problem is linked to many things including social, economic and cultural issues.According to Chakakoda (2019) in Zimbabwe, as in many developing countries, PLWDs are facing significant barriers in accessing these essential SRH services, leading to adverse health outcomes and exacerbating existing inequalities. Zimbabwe has a rich history of disability activism and advocacy but despite significant progress in recent years, PLWDs continue to face discrimination and exclusion in various aspects of life, including healthcare. The prevalence of disabilities in Zimbabwe varies, but estimates suggest that between 7% and 10% of the population has a disability (Ncube, 2019)

The lack of accessible SRH information and education is another critical issue. In Zimbabwe this issue is more serious for PLWDs as they have limited access to information about sexual health, contraception, and reproductive rights. Resultant unintended pregnancies, sexually transmitted infections, and other health problems are common among PWLDs. In support,

Davis (2015) notes that the absence of accessible communication channels, such as sign language interpreters or braille materials makes it difficult for people with disabilities to access and understand health information. Furthermore, Oliver and Barnes (2012) reports that PLWDs are generally treated as perpetual children who lack the mental capacity to make their own decisions about sexual and reproductive issues. . Smith (2016) PLWDs are still treated as people without sexual feelings. . This treatment of PLWDs contributes to the limited accessibility of SRH information among PLWDs. All these beliefs and the treatment of PLWDs have resulted in the situation where the sexual and reproductive health and rights of PLWDs continue to be neglected and often denied globally.

People with disabilities also encounter structural discrimination and stigmatization in their efforts to access sexual and reproductive health information and services. People with disabilities face discrimination and stigma leading to their exclusion from social, economic and health opportunities, in this case SRH information. Stigma and discriminatory practices limits the ability of PLWDs to access information and resources they need (World Health Organization, 2015). Furthermore, negative cultural beliefs and practices reinforce harmful stereotypes about people with disabilities such as the notion that PLWDs are incapable of sexual relationships or parenthood. Numerous challenges are faced when they want to utilize SRH services at hospitals, clinics, and schools. Evidence from low-income countries suggests that negative attitudes among service providers, such as nurses and doctors, are still prevalent(Egharevba, 2017) This is quite a profound challenge in the accessibility of SRH issues among PLWDs that require education and other efforts that will eradicate the stigma and discrimination that negatively impacts the accessibility of SRH services by PLWDs.

Moreover, Zimbabwe was one of the first countries in Africa to have a law about disability rights. Zimbabwe enacted the Disabled Persons Act [Chapter 17:01] in 1992 which emphasizes that PLWDs have the right to non-discrimination and equal access to services (Zimbabwe, 1992). Zimbabwe also has a constitution with provisions on the rights of people PLWDs. Despite these progressive steps, PLWDs still face challenges such as limited access to information, insufficient trained healthcare providers, stigma and discrimination, communication barriers and lack of accessible facilities (Ncube, 2019) This situation is quite

concerning considering that PLWDs make up a significant portion of the country's population. In Gweru, NCDPZ is one of the organizations that prioritize accessibility of healthcare, particularly in sexual and reproductive health services. NCDPZ advocates for comprehensive health services, accessible reproductive health education and removal of legal and policy barriers that hinder people with disability from accessing these services. By empowering PLWDs to make informed choices about their health and lives, NCDPZ works towards promoting their rights and dignity.

1.2 STATEMENT OF THE PROBLEM

In Zimbabwe, individuals living with disabilities face significant barriers to accessing sexual reproductive health (SRH) services (Choruma, 2017; Rugoho and Maphosa, 2017; Gwatirera, 2010). As reported in the above-mentioned sources these barriers originate from both societal and systemic factors such as inadequate health infrastructure, lack of health care providers, stigma, discrimination and negative attitudes towards people living with disabilities. These challenges result in a significant gap in the access of SRH services for people with disabilities in Zimbabwe, leading to increased risk of sexually transmitted infections, unwanted pregnancies, and other health complications. Addressing this issue requires an approach that challenges societal beliefs and attitudes, improving physical accessibility in healthcare facilities, reducing the misconceptions about PLWDs and provides training for healthcare providers. However it is important to note that for these interventions to be effective there is need for reliable and complete empirical information on the accessibility of SRH among PLWDs. Globally, a dearth of knowledge on the knowledge and needs of PLWDs in relation to SRH services exists (Shaw, 2023). This dearth or lack of knowledge needs to be addressed by conducting empirical research on the accessibility of SRH services by PLWDs.

1.3 AIM OF THE STUDY

To investigate the accessibility of sexual reproductive health services among people living with disabilities in Gweru District. Insights of NCDPZ

1.4 OBJECTIVES

1 To identify SRH services available for people living with disabilities in Gweru.

2 To establish barriers faced by people with disabilities in accessing SRH services in Gweru.

3 To explore strategies that can be adopted to enhance access to SRH services for people living with disabilities in Gweru.

1.5 RESEARCH QUESTIONS

2 What are the SRH services available for people living with disabilities in Gweru?

3 What are barriers faced by people with disabilities in accessing SRH services in Gweru?

4 Which strategies can be adopted to enhance access to SRH services for people living with disabilities in Gweru?

1.6 JUSTIFICATION OF THE STUDY

The study will explore the challenges faced by people living with disability in accessing reproductive health services in Gweru. People living with disabilities face numerous barriers in accessing reproductive healthcare services, including inaccessible facilities, transportation, and communication. The lack of accessible sexual reproductive health services contributes to adverse health outcomes for people with disabilities. This includes increased rates of sexually transmitted infections and unintended pregnancies (Krahn et al., 2015). This study will help to understand that Individuals with disabilities experience reproductive health complications, unintended pregnancies, and sexually transmitted infections due to lack of access to reproductive healthcare services.

(i) People living with disabilities

People living with disabilities will benefit from this study as it will highlight the challenges they face in accessing SRH services. This will provide a platform for their voices to be heard ad their experiences to be documented. This will help to identify gaps in service delivery and inform strategies to improve accessibility. The study will contribute to promoting equal access to SRH services enabling people with disabilities to make informed decisions about their health and wellbeing. Furthermore this will help to breakdown stigma ad promote understanding, enabling people with disabilities to access SRH services without fear of discrimination or marginalization.

(ii) Healthcare providers

Healthcare providers will benefit by receiving comprehensive training on disability awareness and cultural importance which will enable them to provide accessible and inclusive care to people living with disabilities. Educating healthcare providers, individuals with disabilities, and caregivers about accessible reproductive healthcare services is vital as it empowers individuals with disabilities to advocate for their rights and navigate the healthcare system. Also Healthcare providers must prioritize accessibility and inclusive by implementing accessibility features, providing accessible communication methods, and receiving comprehensive training on disability awareness and cultural competency are essential.

(iii) Organizations providing SRH services

Organizations working with people with disabilities in Gweru will benefit from this study as it will provide them with valuable insights into the challenges people living with disabilities face in accessing SRH services. This study will help these organizations to develop targeted programs and services to support people living with disabilities. This will enable them to advocate more effectively for the rights of people living with disabilities and to promote equal access to healthcare. Additionally the study will provide organizations with evidenced based recommendations to inform their advocacy efforts enabling them to push for policy and systematic changes that promote equal SRH services for PLWDs. By doing so organizations will be better equipped to support PLWDs and promote their health and wellbeing.

(iv) Broader community

The community will benefit from this study as it will help raise awareness about the importance of accessible SRH services for PLWDs. It will contribute to promoting a more inclusive and supportive community where PLWDs are valued and respected. By highlighting the challenges PLWDs face in accessing SRH services this study will help to breakdown stigma and promote understanding. This will contribute to creating a more equitable and compassionate community where everyone has access to the health they need.

(v) The profession

The profession of public health and sexual reproductive health will benefit from this study as it will contribute to the growing body of evidence on disability inclusive healthcare. It will

provide valuable insights into challenges PLWDs face in accessing SRH services, informing strategies to improve accessibility and quality healthcare. This will enable professionals to develop more effective and inclusive programs ultimately enhancing health and wellbeing of PLWDs.

1.7 DEFINITION OF KEY TERMS

People living with disabilities - refers to individuals who have a physical, feeling intellectual, or mental health impairment that can affect their daily life and interactions. (Kittay, 2018)

Disability -is a physical, feeling, intellectual or mental health impairment that can affect an individual's daily life and interactions. (Hughes, 2018)

Health care - refers to healthcare services that are accessible, equal, and helpful to the needs of all individuals, including those living with disabilities. (World Health Organisation, 2015)

Barriers to access - refer to the physical, social, economic, and cultural obstacles that prevent people living with disabilities from accessing SRH services. (Chouinard, 2018)

Sexual and reproductive rights (SRR)- refer to the rights of individuals to make decisions about their own bodies, including the right to access SRH services, information, and education(Kaul and Singh, 2018)

1.7 STRUCTUREOF THE DISSERTATION

Chapter 1- This is the introductory chapter of the study which discusses the background of the study, outlines the statement of the problem, and the significance of the study. Furthermore, it states the main aim of the study, the research objectives and the definition of key terms.

Chapter 2- The second chapter of the study reviews literature, and also examines the Social model of disability, the theoretical framework underpinning the study.

Chapter 3- The research methodology is discussed in the third chapter of the study it identifies and discusses the appropriate research approach, design and data collection methods. The sampling technique for coming up with an appropriate sample from identified target population discussed. Data analysis techniques, trustworthiness, reliability, validity and ethical considerations are also discussed.

Chapter 4- The fourth chapter gives discusses and analyses the findings of the study.

Chapter 5- This chapter summarizes and concludes the study. It also discusses the implications to social work practice, suggests recommendations and suggests areas for further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter is going to review existing literature on Barriers to accessing sexual reproductive health among people living with disabilities. In explaining the people with disabilities' experience to accessing sexual reproductive services the study is going to utilize the social model of disability. This Chapter is going to explore the literature review on the sexual

reproductive health accessibility by people living with Disability, globally, regionally and locally.

2.2 THEORETICAL FRAMEWORK

This section includes a central social theories relating to the people living with physical disabilities in social context. The theory that will underpin the study will be, the social model of Disability theory that is presented below.This study adopts the social model of disability as its primary theoretical framework

This model distinguishes between impairment, which refers to the physical or mental limitations of an individual, and disability, which arises from the societal barriers and exclusionary practices that prevent individuals with impairments from fully participating in society (Oliver, 1990). Unlike the medical model, which focuses on individual deficits and views disability as an essential problem requiring medical intervention, the social model emphasizes the role of societal structures, attitudes, and environments in creating disability. The Social model of disability emphasizes the need to address societal barriers to promote accessibility and inclusivity. By applying this model, the researchers can identify the specific barriers that prevent PLWDs from accessing SRH services and develop strategies to address these barriers.

In addition this can include conducting accessibility audits of healthcare facilities, providing training for healthcare providers on disability awareness accessible communication, advocating for policy reform to protect the rights of PLWDs and engaging with the community members and PLWDs to raise awareness and promote inclusivity. This framework is crucial for understanding the challenges faced by PLWD in accessing SRH services, as it shifts the focus from individual limitations to systemic barriers. Within the context of SRH services, the social model highlights how inaccessible facilities, discriminatory attitudes of healthcare providers, and lack of inclusive policies contribute to the exclusion of PLWD. By adopting this perspective, the study aims to identify and address these societal barriers, ultimately advocating for a more inclusive and accessible SRH service delivery system.

Furthermore in order to achieve sustainable solutions for persons with disabilities

development mainstream and global communities needs to adapt to both models. The social model does not deny that impairments can and most likely cause an individual pain and discomfort, it merely states that those are not the only restrictions persons with disability face in societies around the globe (Goodley, 2017). The different perspective on disability is deeply intertwined. In the Global-South, something as common as a broken leg can lead to disability, something that could be prevented if the persons had access to treatment and rehabilitation. Disability in general is on the rise due to different health reasons that has resurfaced in our modern societies. Treatment and healthcare will always be detrimental for persons with disabilities. The social model acts to adapt our societies to the medical impairments many of us have. The social constructs surrounding disability is vital for persons with disabilities' sense of identity and additional their self-esteem and capacity.

2.3 GLOBAL OVERVIEW OF SRH ACCESS FOR PEOPLE WITH DISABILITIES

The global overview of SRH access for people with disabilities reveals a concerning landscape where individuals with disabilities face significant barriers in accessing essential SRH services, as highlighted by scholars such as Groce et al. (2013) and Hanass-Hancock et al. (2014), who emphasize that people with disabilities are often marginalized and excluded from SRH services due to societal attitudes, lack of accessibility, and inadequate training for healthcare providers. According to the World Health Organization (WHO), approximately 15% of the global population lives with disabilities, and this population faces unique challenges in accessing SRH services, including physical barriers, lack of accessible information, and negative attitudes from healthcare providers. Research by Kuper et al. (2018) and others underscores the need for inclusive and accessible SRH services, emphasizing the importance of recognizing the autonomy and rights of individuals with disabilities.

Furthermore, studies have shown that people with disabilities often experience difficulties in accessing healthcare services due to physical barriers, lack of accessible information, and negative attitudes from healthcare providers. For instance, healthcare facilities may not have accessible equipment or infrastructure, such as wheelchair ramps or sign language interpreters, which can prevent individuals with disabilities from receiving essential SRH services. Moreover, healthcare providers may not receive adequate training on disability awareness and

inclusive care, leading to discriminatory practices and inadequate treatment. To address these disparities, scholars advocate for a human rights model of disability, which recognizes the inherent dignity and worth of individuals with disabilities. By adopting this approach, governments and healthcare systems can work towards creating more inclusive and accessible SRH services that meet the needs of individuals with disabilities worldwide.

Initially, this requires a multifaceted approach, including policy reforms, training for healthcare providers, accessible healthcare facilities, and accessible information. For example, governments can enact laws and policies that promote disability inclusion and equality in healthcare, while healthcare providers can receive training on disability awareness and inclusive care. Additionally, healthcare facilities can be designed and equipped to be physically accessible, and information can be provided in accessible formats, such as Braille or audio descriptions. Furthermore, it is essential to involve individuals with disabilities in the design and implementation of SRH services, ensuring that their needs are met and their rights are respected. This can be achieved through participatory approaches, such as community-based initiatives and advocacy programs, which empower individuals with disabilities to take an active role in shaping SRH services. Moreover, governments and healthcare systems can establish partnerships with organizations of persons with disabilities, leveraging their expertise and experience to inform policy and programming.

Ultimately, ensuring equal access to SRH services for people with disabilities is essential for promoting their health, well-being, and human rights. By prioritizing disability inclusion and accessibility, governments and healthcare systems can work towards creating a more equitable and just healthcare system that meets the needs of all individuals, regardless of their abilities. This requires a commitment to addressing the systemic barriers and biases that prevent individuals with disabilities from accessing SRH services, and to promoting a culture of inclusivity and respect within healthcare systems. By working together, governments, healthcare systems, civil society organizations, and individuals with disabilities can create a more just and equitable healthcare system that promotes the health, well-being, and human

rights of all individuals.

2.4 LOCAL OVERVIEW OF SRH ACCESS FOR PEOPLE WITH DISABILITIES

The local overview of SRH access for people with disabilities is a complex issue that requires attention and action. Individuals with disabilities in local communities face significant barriers in accessing SRH services, including physical inaccessibility of healthcare facilities, lack of accessible information, and negative attitudes from healthcare providers. These barriers can lead to unmet needs and poor health outcomes for individuals with disabilities. For instance, a person with a physical disability may face challenges in accessing a healthcare facility that lacks ramps or elevators, while a person who is deaf may struggle to communicate with a healthcare provider who does not provide sign language interpretation.

Furthermore, o addresses these disparities, local governments and healthcare systems must prioritize disability inclusion and accessibility. This can be achieved through a multifaceted approach that includes policy reforms, training for healthcare providers, accessible healthcare facilities, and accessible information. For example, local governments can enact policies that promote disability inclusion and equality in healthcare, such as requiring healthcare facilities to be physically accessible and providing sign language interpreters. In the city of Harare, Zimbabwe, the local government has implemented a policy that requires all healthcare facilities to be wheelchair accessible. Healthcare providers can receive training on disability awareness and inclusive care, which can help to reduce stigma and promote respectful care. In one study, healthcare providers who received training on disability awareness reported increased confidence in providing care to individuals with disabilities. Additionally, healthcare facilities can be designed and equipped to be physically accessible, with features such as ramps, wide doors, and accessible restrooms. Information can also be provided in accessible formats, such as Braille, large print, or audio descriptions. For example, a healthcare provider can provide patient education materials in Braille for individuals who are blind.

To add on community-based initiatives can be implemented to promote SRH awareness and education among individuals with disabilities, and partnerships can be established with organizations of persons with disabilities to inform policy and programming. Technology can also be used to enhance accessibility, such as telemedicine and mobile health applications,

which can reach individuals with disabilities who may face barriers in accessing traditional healthcare services. For instance, a mobile health application can provide SRH information and resources to individuals with disabilities in rural areas. Ultimately, ensuring equal access to SRH services for people with disabilities is essential for promoting their health, well-being, and human rights. By working together, local stakeholders can create a more inclusive and equitable healthcare system that meets the needs of all individuals, regardless of their abilities. This requires a commitment to addressing the systemic barriers and biases that prevent individuals with disabilities from accessing SRH services, and promoting a culture of inclusivity and respect.

Furthermore, by prioritizing disability inclusion and accessibility, local governments and healthcare systems can promote the health, well-being, and human rights of individuals with disabilities, and work towards creating a more just and equitable society for all. This can be achieved through a collaborative effort between local stakeholders, including governments, healthcare systems, civil society organizations, and individuals with disabilities themselves, who must be involved in the design and implementation of SRH services to ensure that their needs are met and their rights, are respected. By working together, local stakeholders can create a more inclusive and equitable healthcare system that promotes the health, well-being, and human rights of individuals with disabilities.

2.5 SRH SERVICES AVAILABLE FOR PEOPLE LIVING WITH DISABILITIES

The availability of SRH services for PLWD is a crucial indicator of inclusivity and equity within the healthcare system. Globally, studies have shown that SRH services are often not designed or implemented with the specific needs of PLWD in mind (WHO, 2018). Within the social model framework, this lack of tailored services reflects a systemic failure to accommodate diverse needs, rather than an individual deficit.

(i) Accessible healthcare facilities

Literature review highlights that accessible SRH services should encompass a range of

provisions, including family planning, maternal health, prevention and treatment of sexually transmitted infections (STIs), and information and education on sexual health (Groce et al., 2011). However, many healthcare facilities lack the necessary infrastructure, such as accessible entrances, examination tables, and restrooms, to accommodate individuals with physical disabilities (Kett et al., 2018). This lack of infrastructure leads to people with disabilities not being able to visit healthcare facilities on their own to seek for help.

(ii) Accessible information

Accessible information is essential for ensuring that PLWDs can make informed decisions about their SRH. Accessible information can include patient educational materials, consent forms, audio descriptions and large print. Furthermore, communication barriers, such as the absence of sign language interpreters or materials in accessible formats like Braille or easy-to-read versions, impede access for individuals with sensory or intellectual disabilities (Shakespeare, 2013). This lead to PLWDs not being able communicate with the nurses as they are not trained to use sign language, the mostly need an interpreter from home to assist them which leads to lack of confidentiality. People living with blindness do not have access to medical pamphlets as there are not written in braille. Therefore one can say that in people with disabilities are limited when it comes to accessing sexual reproductive health services.

(iii) Accessible SRH services

In the specific context of Zimbabwe, research on SRH for PLWD is limited. However, existing studies suggest that the healthcare system faces significant challenges in providing equitable access to SRH services for all citizens (Chimbari et al., 2018). The social model of disability underscores that the lack of data and research specific to PLWD in Zimbabwe perpetuates their invisibility and marginalization within the healthcare system. Without comprehensive data on the availability and accessibility of SRH services for PLWD in Gweru District, it is difficult to accurately assess the extent of the problem. This study aims to address this gap by providing empirical evidence on the current state of SRH service provision for PLWD in the district.

(iv) Disability friendly Healthcare Providers

Specifically, the literature points to a lack of training for healthcare providers on disability inclusion and the specific SRH needs of PLWD (Mitra et al., 2013). Providers may hold misconceptions about the sexuality of PLWD or lack the skills to communicate effectively with individuals with diverse needs. This lack of capacity contributes to the provision of inadequate or inappropriate care. They should be aware of the unique needs and experiences of PLWDs such as understanding the impact of SRH, as well as the social and cultural determinants of health that affect PLWDs. Applying the social model, such deficiencies in training and awareness reflect a systemic failure to equip healthcare professionals with the necessary tools to address the needs of PLWD, rather than an individual failing. This study will examine the perspectives of both PLWD and healthcare providers in Gweru District to assess the availability and quality of SRH services.

2.6 BARRIERS FACED BY PEOPLE WITH DISABILITIES IN ACCESSING SRH SERVICES

Access to SRH services is not merely a matter of physical availability; it also encompasses the ability to navigate various barriers that impede access. The social model of disability posits that these barriers are socially constructed and can be addressed through systemic changes.

(i) Attitudinal Barriers

One significant barrier is the attitudinal barrier, which refers to the negative stereotypes and discriminatory attitudes held by healthcare providers, family members, and the wider community (Brown & Watson, 2017). For example healthcare providers may hold biases or stereotypes about PLWDS, leading to inadequate care or discriminatory treatment. Similarly family members and community members may stigmatize PLWDs, making them feel ashamed or embarrassed about their disability. These negative attitudes can lead to delayed or foregone care, resulting in poor health outcomes. These attitudes can manifest in various ways, such as denying PLWD their right to sexual expression, assuming they are asexual, or dismissing their concerns about SRH. Such attitudes are rooted in societal misconceptions about disability and sexuality, reflecting a failure to recognize PLWD as individuals with diverse needs and rights. The social model emphasizes that these negative attitudes are not inherent but are learned and

reinforced through social interactions and cultural norms.

(ii) Communication Barriers

Moreover, another significant barrier is the lack of accessible information and communication. Many SRH materials are not available in accessible formats, such as Braille, sign language, or easy-to-read versions, which exclude individuals with sensory or intellectual disabilities (Devandas-Aguilar, 2018). Similarly, inadequate sign language interpretation can prevent individuals who are deaf and hard of hearing from understanding their diagnosis or treatment options. Furthermore, communication barriers can arise from the lack of trained interpreters or healthcare providers who are skilled in communicating with individuals with diverse needs. The social model highlights that the failure to provide accessible information and communication reflects a systemic disregard for the diverse needs of PLWD, rather than an individual failing.

(iii) Physical Barriers

Physical barriers also play a significant role in limiting access to SRH services. Many healthcare facilities lack accessible infrastructure, such as ramps, accessible restrooms, and examination tables, which prevent individuals with physical disabilities from accessing services (Grech, 2015). For instance a healthcare facility without a ramp or an elevator can be a significant obstacle for a person with physical disability. Similarly examination tables that are not adjustable can make it difficult for health care providers to examine patients with physical disability. Transportation barriers, such as the lack of accessible transportation options, can also impede access to healthcare facilities. The social model emphasizes that these physical barriers are not inevitable but are the result of poor planning and a lack of consideration for the needs of PLWD.

(iv) Financial Barriers

Financial barriers also contribute to limited access to SRH services. PLWD may face higher healthcare costs due to the need for specialized equipment, assistive devices, or personal assistance (Banks & Polack, 2014). Furthermore, poverty and unemployment are disproportionately high among PLWD, which further limits their ability to afford healthcare services. The social model underscores that these financial barriers are not simply a matter of

individual circumstances but are rooted in systemic inequalities and discriminatory practices, these barriers are likely to be exacerbated by limited resources and infrastructure. This study will explore the specific barriers faced by PLWD in the district, utilizing qualitative methods to gather data from diverse stakeholders.

2.6 STRATEGIES AND INTERVENTIONS TO IMPROVE ACCESS TO SRH SERVICES BY PLWD

People with disabilities (PLWD) face significant barriers in accessing sexual and reproductive health (SRH) services. These barriers can be physical, social, or attitudinal, and can lead to unmet needs and poor health outcomes. To address these disparities, governments and healthcare systems must prioritize disability inclusion and accessibility.

(i) Policy Reform

Policy reforms are essential to promoting disability inclusion and accessibility in SRH services. Governments can enact policies that require healthcare facilities to be physically accessible, provide accessible information, and train healthcare providers on disability awareness and inclusive care. For example, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) emphasizes the importance of accessibility and equality for people with disabilities. Polices can be implemented to address systematic barriers and biases that prevent PLWDs from accessing SRH services such as discriminatory laws and practices. By prioritizing policy reform governments and healthcare systems can promote a culture of inclusivity and respect ensuring that PLWDs can access their SRH services they need to maintain their health and wellbeing.

(ii) Training for Healthcare Providers

Healthcare providers play a critical role in promoting disability inclusion and accessibility in SRH services. Healthcare providers often lack the knowledge, skills and confidence to provide inclusive and respectful care to PLWDs which can lead to barriers in accessing SRH services. Training programs can educate healthcare providers on disability awareness, inclusive care and communication skills enabling them to provide high quality care that meet unique needs of PLWDs. For instance, a training program in Midlands's province taught healthcare providers how to communicate effectively with people with intellectual disabilities. Effective

training programs can also involve PLWDs in the design and delivery off training, ensuring that their perspectives and experiences are taken into account.

(iii) **Community-Based Initiatives**

Community-based initiatives can be implemented to promote SRH awareness and education among PLWD. For example, a Gweru community based rehabilitation programme provided SRH education workshops for people with intellectual disabilities. Partnerships can also be established with organizations of persons with disabilities to inform policy and programming. Community engagement and advocacy are also crucial for enhancing access to SRH services. This can be achieved by involving PLWD and their representative organizations in the planning, implementation, and evaluation of SRH programs (Groce et al., 2011). Furthermore, raising awareness about the SRH rights of PLWD and challenging discriminatory attitudes can help create a more inclusive and supportive environment. The social model highlights that these strategies should be aimed at empowering PLWD to advocate for their rights and participate in decision-making processes.

(iv) Technology

Technology can be leveraged to enhance accessibility in SRH services. For instance, mobile applications like MobiSAfAIDS can offer SRH information and support, while telemedicine can enable remote consultations with healthcare providers, reducing barriers for those with mobility impairments. Additionally, digital health platforms can provide accessible health educational materials, appointment reminders and medication adherence support, empowering PLWD to take control of their health. Electronic health records can also facilitate better coordination of care among healthcare providers, ensuring that PLWDs receive comprehensive and respectful SRH services.

(v) Peer Support Programs

Peer support programs can provide PLWD with the support and guidance they need to navigate the healthcare system. For example, peer educators with disabilities can improve SRH information and counseling to their Peers, helping them to address misconceptions and stigma surrounding SRH issues. They can also provide a safe space for PLWD to discuss their needs and concerns. They will also receive support and guidance from others who have experienced similar challenges.

2.7 GAPS IN THE LITERATURE

The literature on the accessibility of sexual and reproductive health (SRH) services among people with disabilities (PLWDSs) highlights several gaps that need to be addressed. One of the primary gaps is the limited research on the accessibility of SRH services for PLWDs, particularly in low- and middle-income countries. This lack of research makes it difficult to understand the experiences of PLWDs and identify areas for improvement. Furthermore, many studies do not collect data on disability status, which can lead to a lack of understanding of the specific needs and challenges faced by PLWDs.

Another significant gap is the lack of disability-inclusive policies in healthcare systems. Many healthcare policies and programs do not take into account the needs of PLWDs, leading to inaccessible services and poor health outcomes. For example, healthcare facilities may not be physically accessible to PLWDs, with barriers such as lack of ramps, narrow doors, and inaccessible restrooms. Additionally, healthcare providers may not provide accessible information or use communication methods that are accessible to PLWDs, such as sign language or Braille. Healthcare providers also play a critical role in promoting disability inclusion and accessibility in SRH services. However, many healthcare providers lack the training and skills needed to provide inclusive and respectful care to PLWDs. This can lead to stigma and discrimination, which can further exacerbate the barriers faced by PLWDs in accessing SRH services. Furthermore, PLWDs may not have access to SRH education and information that is tailored to their needs, leading to poor health outcomes and increased risk of SRH problems.

Moreover, PLWDs are often not involved in the design and implementation of SRH research and programming, which can lead to services that are not responsive to their needs. This lack of involvement can perpetuate the existing gaps and barriers in SRH services for PLWDs. Therefore, it is essential to involve PLWDs in the design and implementation of SRH research and programming to ensure that their needs are met and their rights are respected. To address these gaps, researchers, policymakers, and healthcare providers must work together to develop more effective interventions that promote disability inclusion and accessibility in SRH services. This can include strategies such as providing training for healthcare providers on disability awareness and inclusive care, making healthcare facilities physically accessible, and providing accessible information and communication methods. Additionally, involving PLWDs in the design and implementation of SRH research and programming can help ensure that services are responsive to their needs and promote their health, well-being, and human rights.

In conclusion, the literature highlights several gaps in the accessibility of SRH services among PLWDs. Addressing these gaps requires a commitment to promoting disability inclusion and accessibility in SRH services. By working together, stakeholders can create more inclusive and accessible SRH services that meet the needs of PLWDs and promote their health, well-being, and human rights. This can be achieved through a multifaceted approach that addresses the physical, social, and attitudinal barriers faced by PLWDs, and promotes a culture of inclusivity and respect in healthcare systems.

2.9 CHAPTER SUMMARY

This chapter's discussion of the Literature review was based on the study goals. The purpose of this review was too clarifying the meaning of the study's core terms and concept and to identify the research gaps that the study aims to fill. The chapter also covers the social model of disability theory\model and how it relates to people living with disabilities' access to Healthcare services. The research design targets, study area, target population, Sample strategies used, data collection tolls, study viability and ethical issues are main topics of the main chapter.

CHAPTER 3

METHODOLOGYAND RESEARCH DESIGN

3.1 INTRODUCTION

The chapter delineates the suitable approach for carrying out the investigation. The importance of research methodology lies in its capacity to outline and elucidate how the research problem is methodically tackled (Marshall and Roseman, 2010). This chapter explains on the research framework, the demographic under scrutiny, methods of sampling techniques and instruments for data collection, viability of the study and the ethical factors essential for fulfilling the study's goals.

3.2 RESEARCH APPROACH

Methodology refers to the systematic and detailed approach used to design and conduct studies, including the selection of participants, data collection methods and data analysis procedures (Epstein, 2013). This study employed a qualitative research approach to explore the experiences of people living with disabilities in accessing sexual reproductive health (SRH) services. The qualitative approach is essential for this study because the researcher can capture the thoughts and feelings, feelings of PLWDs and their level of awareness towards accessibility to sexual and reproductive health services. This framework was used to analyze the experiences of people living with disabilities in accessing SRH services, and to identify the barriers that prevent them from accessing these services.

3.3 RESEARCH DESIGN

Leedy and Omrod (2015) highlighted that research design is a strategy used to solve research problem. This study employed a case study research design to explore the experiences of people living with disabilities in accessing sexual reproductive health (SRH) services. A case study design is an in-depth study of a single case or a small number of cases (Creswell, 2013). The case study design allowed for a nuanced understanding of the complex issues surrounding accessibility of SRH services for people living with disabilities. Thematic analysis was the robust method used for identifying patterns in qualitative data (Braun and Clarke, 2013)

3.4 STUDY SETTING/LOCATION

According to Creswell (2015) a setting is defined as a context in which the study takes place, including a social and cultural environment. Gweru, the third-largest city in Zimbabwe, has been selected as the area of study for this dissertation. Gweru has a population of approximately 150,000 people, with a significant proportion living with disabilities (ZIMSTAT, 2012). The city has a number of healthcare facilities, including public and private hospitals, clinics, and health centers, which provide sexual reproductive health (SRH) services. However, despite the availability of these services, people living with disabilities in Gweru continue to face significant barriers in accessing SRH services.

3.5 TARGET POPULATION

Barbour (2016) defines a target population as a complete set or collections of components whereby one opts to make some inferences during research study. The target population for this study is people living with disabilities in Gweru, Zimbabwe. This population includes individuals with physical, sensory, intellectual, or mental health disabilities, who are aged 18-49 years. PLWD are ideal participants for this study because they bring first-hand experience and contextual understanding of the challenges they face. Their involvement ensures that the research prioritizes their needs and voices leading to more relevant findings. This approach also promotes empowerment, participation and self-advocacy among PLWDs, contributing to a more inclusive and equitable healthcare systems. By engaging with PLWDs, researchers can get rich contextual data that informs the development of accessible and inclusive SRH services, ultimately improving health services outcomes and promoting human rights. The key informants of this study included nurses, counselors and disability advocates. They offered valuable insights due to their expertise in working with PLWDs. This diverse range of key informants provided unique perspectives and in-depth knowledge ensuring a comprehensive understanding of the topic, informing potential solutions and recommendations to improve accessibility.

3.6 SAMPLING

Sampling is a process of selecting a subset of cases from a larger population with a goal of making conclusions about population based on a sample (Trochim 2006). This study l

employed a purposive sampling strategy to recruit participants. The sample l consisted of 10 people living with disabilities in Gweru, Zimbabwe, who are aged 18-49 years. Participants were recruited from with the database of NCDPZ a local organization. The sampling strategy ensured that participants are representative of the diversity of people living with disabilities in Gweru, including those with physical, sensory, intellectual, or mental health disabilities (Palinkas et al., 2018). PLWD are ideal participants for this study because they bring firsthand experience and contextual understanding of the challenges they face.

3.7 DATA COLLECTION METHODS AND INSTRUMENTS/TOOLS

In-depth interviews was conducted with 10 people living with disabilities in Gweru, Zimbabwe, to gather qualitative data on their experiences and perceptions of accessing sexual reproductive health (SRH) services. The interviews was conducted using a semi-structured interview guide, which l explored participants' experiences of accessing SRH services, including their perceptions of the accessibility of these services, the barriers they face in accessing these services, and their suggestions for improving the accessibility of SRH services for people living with disabilities? The interviews were conducted in a private and comfortable setting, and lasted approximately 60-90 minutes. The interviews were audio-recorded, and the researcher collected field notes during the interviews. The use of in-depth interviews as a data collection tool allowed for a rich and detailed understanding of the experiences and perceptions of people living with disabilities in accessing SRH services. This is because the interview method enables the researcher to explore the complexities and nuances of the participants' experiences, and to gather data that is contextualized and situated within the participants' everyday lives (Mason, 2018).

3.8 RESEARCH PROCEDURE

This study employed qualitative research approach utilizing a phenomenological design to explore the lived experiences and perceptions of PLWDs regarding SRH services. The study used purposive sampling to select participants who meet specific criteria, including PLWDs, health care providers and policy makers. Data was collected through in-depth interviews and focus group discussion, allowing for rich, contextual data to be gathered. Thematic analysis was used to identify patterns, themes and meanings in the data. The study prioritized ethical

considerations, including obtaining informed consent from participants, maintaining confidentiality and treating participants with respect and dignity. To ensure data quality the study focused on credibility and ensuring that findings are grounded in participants' experiences. By following this research procedure the study aimed to gather valuable into the experiences and perception of PLWDs regarding SRH services, ultimately informing policy and program development that promotes more accessible and inclusive healthcare services.

3.9 TRUSTWORTHINESS OF THE STUDY

To ensure the trustworthiness of a study on SRH services for PLWDs in Zimbabwe, researchers employed the criteria of dependability, confirmability and transferability.

(i) Dependability

Dependability refers to the consistency and reliability of research findings. In the context of a study on SRH services for PLWDs in Zimbabwe, dependability is crucial to ensure that findings are trustworthy and can be relied upon to inform policies and practices. To ensure dependability the researcher employed several strategies, including consistent data collection methods, detailed documentation, audit trails and peer review. Consistent data collection methods involved using standardized survey instruments, interview protocols or guides to reduce the risk of errors or biases. By using consistent methods, this can increase the reliability of the findings and ensure that the data collected for this study is accurate. To further enhance dependability one used other strategies such as prolonged engagement, persistent observation and triangulation. By prioritizing dependability one can increase the trustworthiness of the study and provide insight into SRH services for PLWDs in Zimbabwe.

(ii) Confirmability

Confirmability refers to the extent to which research findings are grounded in data and free from researcher bias. To ensure confirmability, one employed several strategies, including grounding findings in data, transparent analysis, minimizing researcher bias and using multiple data sources. By grounding findings in data, one can ensure that results are based on empirical evidence and are not influenced by personal biases or assumptions. To further enhance

confirmability one used other strategies such as member checking and peer debriefing. Confirmability is essential as it ensures that findings are grounded in data and accurately reflect the experiences and perspectives of PLWDs.

(iii) Transferability

Transferability is a crucial aspect of qualitative research that refers to the extent to which research findings can be applied to other context, settings or populations. It determines whether the study's results can be generalized or applied to similar situations making it essential for informing polices practices or future research. To enhance transferability, one employed several strategies such as providing thick descriptions of the research setting and participants which helps one to understand the study's context and determine its applicability to other settings. By prioritizing these criteria, one increased the trustworthiness of their study, providing valuable insights that can inform policies and practices to improve SRH services for PLWDs in Zimbabwe.

3.10 DATA ANALYSIS

Thematic analysis was used to analyze the qualitative data collected through in-depth interviews with people living with disabilities in Gweru, Zimbabwe. This method involves identifying, coding, and categorizing themes or patterns in the data (Braun & Clarke, 2018). The analysis was conducted in a systematic and rigorous manner, following the six phases of thematic analysis outlined by Braun and Clarke (2018) familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. The thematic analysis was used to identify the barriers and facilitators that influence access to sexual reproductive health (SRH) services for people living with disabilities. The analysis also explored the experiences and perceptions of people living with disabilities in accessing SRH services.

3.11 FEASIBILITY OF THE STUDY

The study was considered feasible since it focused on communities found in Gweru district only. The three objectives of they had narrow focus on social disability theory and utilization of healthcare services which allowed the researcher to conduct the study within a period of not

more than two academics semesters. Also this study is feasible considering factors such as resource availability, access to participants, suitable data collection methods and potential impact. With careful planning, collaborations with relevant stakeholders and attention to ethical considerations, the study can provide valuable insights into improving SRH services for PLWDs in Gweru, Zimbabwe, ultimately contributing to their health and wellbeing. The feasibility of the study is further enhanced by potential for collaboration with local organizations and healthcare providers which can facilitate access to participants, data collection and dissemination of findings.

3.12 ETHICAL CONSIDERATIONS

This study adhered to the principles of thical research, including respect for persons, beneficence, non-maleficence, and autonomy (World Medical Association, 2018). Participants were informed about the purpose of the study, the risks and benefits of participation, and their rights as participants. Informed consent was obtained from all participants before data collection begins. To ensure confidentiality and anonymity, participants' names and identifying information with removed from the data, and pseudonyms were used instead (Braun & Clarke, 2018). The data was being stored in a secure location, and access was restricted to the researcher and research assistants. The study also adhered to the principles of disability ethics, including respect for autonomy, dignity, and self-determination (Kittay, 2018). The researcher worked closely with disability organizations and advocacy groups to ensure that the study is conducted in a way that is respectful and empowering for people with disabilities.

(i) Ethical Approval

Ethical approval as noted by Resnik (2015) is an essential step in the research process as it helps to ensure that research is conducted in a way that respects the rights and dignity of participants. This approval is a crucial aspect of research that ensures studies are conducted responsibly and with integrity. As part of ethical approval, the researcher got permission from the organization called National Council of the Disabled Persons of Zimbabwe (NCDPZ) to carry out the study with their clients.

(ii) Informed Consent

Informed consent is a critical ethical consideration in research. According to Resnik (2015),

informed consent is a process of communication between the researcher and the participant that ensures the participants understands the risks, benefits, rights and responsibilities in these study participants were provided with a comprehensive informed consent form that outlines the purpose of the research. Participants from this study were required to sign the informed consent form prior to participating in the study.

(iii) Anonymity and Confidentiality

Anonymity is keeping someone's identity unknown or hidden. To uphold anonymity participants' personal information was stored securely with limited access and codes instead of names were used. When quoting participants one ensured that the quotes are anonymized and do not contain any identifying information. Potentially identifying language was removed or paraphrased including identifying information from appendices and transcripts. Confidentiality is defined as the preservation of private information concerning the client which is disclosed within the professional relationship (Biestek, 1957). Each participant in the research was informed that the personal identification clues such as names were to be kept private and whatever they said would not be traced back to them. Confidentiality was maintained by keeping personal information private. Information is not to be shared with other people, all research data is confidential and secure, with limited access to personnel only. Sensitive information was not disclosed to anyone, ensuring the trust and privacy of participants is maintained throughout the research process.

(iv) Voluntary Participation

The other ethical consideration to be adhered by the researcher is voluntary participation, Sharma(2017) defined voluntary participation as a researcher participants use of free will in choosing whether to partake or not to a researcher study. The researcher informed participants that they are not being forced to participate in the reach study and that they may withdraw anytime they feel like doing so. This allows respondents to participate freely without coercion and respond to the questions being asked through this ethical consideration, this can enable respondents to gain trust and integrity into research which leads to the respondents answer questions freely during interviews.

3.13 LIMITATIONS

Conducting a study on accessibility of reproductive health services among people living with disabilities in Gweru District l encountered several limitations. Cultural challenges which include deep-rooted stigma and discrimination against people with disabilities influenced participation into this study. Financial challenges which encompass limited funding, resource constraints, and inadequate budget allocation, impacting study scope, duration, and participant compensation, potentially compromising data quality and representation. Furthermore, financial constraints limited the availability of assistive technologies and interpreters, essential for inclusive data collection. Addressing these limitations requires collaboration with local disability organizations, adaptability, and innovative research methods to ensure a rigorous and inclusive study. Effective strategies include community engagement, accessible data collection tools, and strategic resource allocation to overcome cultural, barrier, and financial challenges, ultimately informing evidence-based interventions to enhance reproductive health accessibility for people with disabilities in Gweru District.

3.14 CHAPTER SUMMARY

The third chapter of the study explained aspects of qualitative research paradigms that are central to concurrent mixed research design, study setting, target populations, sampling technique, sample size, data collection, methods and tools, trustworthiness, validity, reliability and data analysis procedure. The research methodology is also hinged on ethical consideration and research limitations. The next chapter focused on the presentation, discussion and interpretation of research findings.

CHAPTER FOUR

DATA PRESENTATION COLLECTION, ANALYSIS AND FINDINGS

4.0 INTRODUCTION

This chapter examines, analyzes, and discusses the research findings regarding the accessibility of SRH services among PLWDs in Gweru, Zimbabwe: Insights from NCDPZ. Data were collected from a sample consisting of 10 primary participants and 2 key informants through in-depth interviews, as well as from focus group discussions. The selection of participants was conducted using both quota and purposive sampling methods. In this chapter, data presentation, interpretation, and analysis are carried out in alignment with the research objectives, while also incorporating principles from social model of disability.

4.1 DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS, RESPONDEN

The participants in this study reached a total of 12 notably 5 men, 5 women and 2 key informants. Priority and attention was put on women with disabilities and men with disabilities. The study also incorporated different age groups of people living with disabilities. Key informants were experts on this topic as well.

Table 1Demographic information for participants

pseudonym	Age	Gender	Disability type	SRH services needed	Barriers to SRH services
P1	33	Male	Physical disability	Treatment of STIs	Physical barriers
P2	28	Male	Visual impairment	Sexual health information	Informational barriers
P3	24	Female	Hearing impairment	Maternal healthcare	Communication barriers
P4	41	Male	Physical disability	STIs treatment	Transportation barriers

P5	20	Female	Developmental disability	HIV testing and counseling	Social barriers
P6	36	Male	Speech disability	Sexual health education	Communication barrier
P7	43	Female	Physical disability	Maternal healthcare	Systematic barriers
P8	31	Female	Hearing impairment	Family planning services	Communication barriers
P9	22	Male	Physical disability	STI treatment	Financial barriers
P10	35	Female	Speech disability	Counseling for survivors of GBV	Communication barriers

4.1.1 Fig 1- Information on the demographic table

The demographics table above provides a comprehensive overview of the characteristics of the study participants, including age, gender, type of disability, SRH services needed and Barriers. This information helps to contextualize the experiences and challenges faced by people living with disabilities in accessing SRH services (Kipyegon, 2020). The table highlights the diversity of the participant group, including variations in age, disability type, and socioeconomic status, allowing for a detailed understanding of the barriers and facilitators to SRH service accessibility. The demographic data also enables the identification of potential relationship between specific characteristics and access to SRH services, informing targeted interventions and policy recommendations to promote equitable healthcare for people living with disabilities. By examining the demographics of the participant group, researchers can better understand the unique needs and challenges of this population and develop effective strategies to address them.

4.1.2 Demographic information for key informants

Pseudonym	**Age**	**Gender**	**Occupation**	**Experience**
KI1	35	Female	Social worker	7 years of experience working with

				PLWDs
KI2	40	Female	Healthcare provider	12 years of experience as a healthcare provider.

The demographic characteristics of the two key informants are presented on table above. Key informant 1 is a social worker with 7 years of experience while key informant 2 is a healthcare provider. The table outlines their occupation, years of experience, gender and age, providing insight into their backgrounds

qualifications (Creswell& Piano Clark, 2018). These characteristics highlight their reference to the study, particularly in relation to their experience and expertise in social work and healthcare provision.

4.2 THEME 1: SRH SERVICES AVAILABLE FOR PLWDS IN GWERU

The SRH services available to people living with disabilities in Gweru are limited. Women residing in the suburbs of Gweru shared their experiences, revealing a lack of awareness about SRH services and inaccessible healthcare facilities. Participants emphasized the need for more accessible and inclusive services, citing physical barriers, stigma, and inadequate information. They stressed the importance of tailored services that cater to their unique needs, promoting equal access to healthcare. The researcher interviewed people living with disabilities who reside in the area and they responded as follows:

4.2.1Availability of SRH services

The study findings revealed that SRH services specifically tailored for people with disabilities are limited in Gweru. While general healthcare services are available, SRH services are not adequately adapted to meet the unique needs of people with disabilities. Participants reported accessing some services like family planning and HIV testing, but faced challenges due to physical barriers and lack of accommodations, highlighting the need for more inclusive and

accessible services.

In support of above observation one young woman who was physically disabled had to say this:

Participant 1: "*Kuwana rubatsiro maererano nezvirwere zvepaBonde kunoti netsei kana uri munhu anorarama nehurema nekuti tinosangana nerusaruro uye vehutano havana ruzivo rwakakwana pakuti votibatsira sei*"(Accessing SRH services in Gweru, Zimbabwe is tough for people with disabilities. Services lack accessibility, inclusivity, and are often not tailored to specific needs, with stigma and negative attitudes from healthcare providers further exacerbating the issue.)

In support of the above another participant with a muscular dystrophy had to say this:

"*Ndakamboenda kuchipatara ndichida kubetserwa kuti ndive neruzivo maererano nezvirwere zvepabonde. Mukoti pandakamutaurira nyaya yangu akatoshamisika akandibvunza kuti unoita zvebonde zvacho sei iwe usingagoni kufamba chero murume utombori naye here iwe. Akanditambidza bepa ranga rakanyorwa ndobva ati endai munoverenga achibva atobuda hake."* (I once went to the hospital seeking SRH services, the healthcare provider was surprised that I was sexually active since I was on a wheelchair and they said they doubted if I had a man in my life. She handed me a pamphlet and told me to go home and read.)

Key informant also highlighted that:

"Chikuita kuti tisakwanise kubatsira vanhu vanorarama nehurema , inyaya yekuti hatisi kuwana dzidziso nezvekushandisa zvakakwana zvekuti tovabatsira sei uye hatikwanisi kutaura mutauro wemasaini uye hatina vaturikiri". (We are struggling to support people with disabilities in accessing SRH services due to limited resources and knowledge. We lack essential tools like sign language interpreters and staff training on disability-inclusive care, hindering our ability to provide effective support.)

Based on the discussion, the researcher found that PLWDs in Gweru face significant challenges in accessing SRH services due to inaccessible facilities, lack of resources, and limited knowledge among healthcare providers. This aligns with Groce et al.'s (2013) study, which highlights physical inaccessibility, inadequate training, and societal stigma as major obstacles.

The intersectional analysis emphasizes the difficulties of the issue, underscoring the need for a comprehensive approach to improve access to SRH services for people with disabilities, prioritizing accessibility, inclusivity, and equity in healthcare.

4.2.2 Level of awareness and knowledge of SRH services among PLWDs

The researcher found that people with disabilities in Gweru have varying levels of awareness and knowledge about sexual and reproductive health services. While some individuals demonstrated a good understanding of available services, others showed significant knowledge gaps. Factors such as access to information, education, and support systems appeared to influence their awareness and knowledge. These findings highlight the need for targeted interventions to improve access to SRH services and information for people with disabilities in Gweru.

In support of these observation A woman with sight impairment echoed that :

"Semunhu anorarama nehurema ndinoti hatisi kuwana ruzivo rwakakwana maererano neZvirwere zvepabonde uye hatina ruzivo nezvekodzero dzedu". (As a person living with a disability in Gweru, I feel there's a lack of accessible information about sexual and reproductive health services. Many of us aren't aware of our options and rights.)

Another participant states that:

"*Mukukura kwangu hapana akambondidzidzisawo nezvehutano hwepabonde ndakatozotanga kuzviziva ndabva mukubatwa chibharo, kuchipatara ndipo pavakazondiudza nezvazvo. Zvekuti dai takakura tichidzidziswa ndaikwanisawo kuzvidzivirira kune dambudziko rakada*i". (Growing I was never told about SRH services. I came to know about it after I was sexually assaulted and if they had told me about it I could have avoided the ordeal.

Key informant also said that:

"Zvinoita kuti vanhu vanorarama nehurema vasava neruzivo maererano nezvehutano hwepabonde inyaya yekuti havasi kuwana dzidziso yakakwana kubva kunesu vehutano nenyaya yekuti nguva zhinji tetisina zvikwanisiro zvekufamba munhauraunda dzvavo tichivadzidzisa." (There is staff shortages, no transportation and lack of IEC tools at the health facility thus it

becomes difficult for us to reach everyone).

Based on the finding, the researcher discovered that people living with disabilities in Gweru have varying levels of awareness and knowledge about sexual and reproductive health services, with significant knowledge gaps existing among some individuals. According to scholar Colvin (2019), individuals with disabilities often face barriers in accessing healthcare information, which can lead to limited knowledge about their reproductive health and rights. This scholar's findings align with the researcher's discovery, highlighting the need for accessible information and targeted interventions to improve the sexual and reproductive health of people living with disabilities.

4.2.3 Inclusivity of services

The study findings revealed that SRH services are designed to be inclusive and accessible, ensuring that people with disabilities receive comprehensive care that meets their unique needs. Local organization and healthcare providers prioritize disability- inclusive practices, providing SRH services that address the specific challenges faced by individuals with disabilities, including increased vulnerability to HIV and AIDS, limited access to healthcare and social stigma. These services feature accessible healthcare facilities, counseling and support groups tailored to the needs of people with disabilities. Moreover, community based initiatives and support groups are there to promote awareness and education on SRH issues affecting people with disabilities while advocating for their rights and full inclusion in mainstream SRH programs.

One man living with blindness states that

"Semunhu Anorarama nehurema ndinosangana nezvinotikanganisa kuti tive neruzivo nezvehutano hwepabonde. Asi kana munhu wese akava neruzivo zvinotibatsira kuzvichengetedza". (As someone living with a disability, I've faced challenges accessing SRH services. But when services are inclusive, it's empowering. I feel seen, heard, and respected. It's not just about accessibility, but about dignity and autonomy. Inclusive services make a huge difference in my life).

In support to this another participant stated that:

"*Kutibatanidzawo nevamwe panotaurwa zveHutano hwepabonde kunoita kuti tionekwe seVanhu vakangoitawo sevamwe uye ndinokwanisa kuve nesarudzo yekuita zvakafanira nehutano hwangu"*. (Inclusive SRH services make me feel seen and respected. Being treated like a person, not just my disability, matters most. I can finally take control of my health and make choices right for me. It gives me freedom and empowerment).

Key informant also highlighted that:

"Kana tikakoshesa hutano hwepabonde hwevanhu vanorarama nehurema zvinovaitira nyore kuti vakwanise kuve nekodzero pahutano hwavo uye nesarudzo yekuita zvavanoona zvakakodzera pahutano hwavo." (When services prioritize accessibility and dignity, individuals with disabilities can finally take ownership of their health, make informed choices, and live life on their own terms. By breaking down barriers and promoting inclusive care, we can empower people with disabilities to thrive and reach their full potential).

Based on the findings then, researcher discovered that inclusive SRH services have a positive impact on individuals with disabilities. By prioritizing accessibility and dignity, these services empower people with disabilities to take control of their health, make informed choices and live life on their own terms. People with disabilities want the same things as everyone else like to be treated with respect, to have access to the same opportunities and to be able to make decisions about their own bodies (Meeks et al., 2019). This aligns with the discovery that inclusive SRH services are essential for promoting autonomy, dignity and empowerment among individuals with disabilities.

4.3 THEME 2: BARRIERS FACED BY PEOPLE WITH DISABILITIES IN ACCESSING SRH SERVICES IN GWERU.

The second objective of the study was to identify barriers faced by PLWDs when accessing SRH services, the research that PLWDs face significant barriers in accessing SRH services. Physical inaccessibility of healthcare facilities, lack of accessible information, and inadequate training of healthcare providers were common themes that emerged from the interviews. Many participants shared experiences of being denied services or facing judgmental attitudes from

healthcare providers, which further exacerbated their marginalization. These findings highlight the need for inclusive and accessible SRH services that prioritize the dignity and autonomy of PLWDs.

4.3.1Communication barriers

My research revealed that communication barriers significantly hinder PLWDs from accessing SRH services. Deaf and hard of hearing individuals were particularly affected, struggling to communicate with healthcare providers due to the unavailability of sign language interpreters. Communication barriers arise from lack of knowledge about distinctive style and alternative modes of communication e.g. verbal, written, picture or sign. Many reported feeling frustrated, anxious, and excluded from accessing essential SRH information and services. The lack of accessible communication channels not only compromised their health outcomes but also perpetuated existing health disparities. Addressing these communication barriers is crucial to ensuring equal access to SRH services for all PLWDs, particularly the deaf and hard-of-hearing community.

In support of the above a young man noted that

"*I struggle to get Sexual and Reproductive Health services because healthcare providers don't communicate well with me. They don't use sign language or explain things clearly. This makes it hard for me to understand and ask questions. I just want doctors to listen and talk to me in a way that I can understand, so I can get the care I need."*

In support of this another participant noted that:

"As a deaf person, I had similar experiences. Healthcare providers often don't provide sign language interpreters or write down important information. It's frustrating and scary not being able to fully understand my care. I just want to be able to communicate effectively and get the healthcare I deserve without barriers."

The key Informant highlighted that:

"Healthcare providers often lack training on disability-inclusive communication, leading to misunderstandings and poor care. It's crucial for providers to prioritize accessible

communication, such as sign language interpretation and clear information materials, to ensure equal access to healthcare for all."

The research findings show that communication barriers prevent disabled individuals from accessing SRH services, which is unacceptable. Healthcare systems must prioritize accessibility to ensure equal care for all. According to Devandas-Aguilar(2018) persons with disabilities face significant barriers in accessing healthcare which can lead to exclusion and marginalization. To address this, healthcare systems need to train providers to communicate effectively, ensure physical accessibility of facilities and engage with disabled individuals and organizations to inform SRH service design and delivery, ultimately providing inclusive and responsive care that meets the unique needs of disabled individuals. This includes providing sign language interpretation, Braille materials, and accessible digital platforms to facilitate equal access to care. By taking these steps, healthcare systems can promote health equity and dignity for disabled individuals. Furthermore, inclusive healthcare practices can lead to better health outcomes, increased patient satisfaction and improved overall well-being for disabled individuals. It requires a multifaceted approach, including policy reforms, provider training and community engagement to ensure that SRH services are accessible and responsive to the needs of disabled individuals.

4.3.2 Attitudinal Barriers

The study on attitudinal barriers in healthcare settings for individuals with disabilities reveals a concerning reality, where negative attitudes, stereotypes, and stigma perpetuated by healthcare providers lead to inadequate care, dismissal of patient concerns, and feelings of disempowerment and mistrust. These barriers discourage individuals with disabilities from seeking healthcare services, exacerbating existing health disparities. Attitudinal barriers are deeply rooted, often originating from lack of understanding, fear, or misconceptions about disability. They manifest in patronizing language, dismissive behavior, or inadequate communication, further marginalizing individuals with disabilities. Such barriers not only compromise the quality of care but also erode trust in the healthcare system, perpetuating cycles of disadvantage and exclusion.

A female participant in support of the above notes that:

"I've experienced healthcare providers talking down to me, not believing my pain, and assuming I'm incapable because of my disability. It's like they are more focused on my wheelchair than my health. I've been dismissed, patronized, and even refused care. It's humiliating and makes me hesitant to seek help, even when I desperately need it."

In support of this another female participant states that:

"When I tried to discuss my sexual health with my doctor, they seemed uncomfortable and changed the subject. It felt like they were not taking me seriously. I deserve respectful care, but it's hard to find."

The Key Informant highlights that:

"I have seen colleagues make assumptions about patients with disabilities, like assuming they are asexual or incapable of making decisions about their own bodies. These biases lead to inadequate care. We need training to ensure our services are inclusive and respectful."

The findings of this study reinforce the notion that attitudinal barriers significantly hinder access to SRH services. As Brown and Watson (2017) assert, negative attitudes and biases held by healthcare providers can have a profound impact on the quality of care received by individuals, particularly those with disabilities. The study's results echo this sentiment, highlighting the need for targeted interventions to promote inclusive, respectful, and non-judgmental care, ultimately ensuring equitable access to SRH services. Furthermore, addressing these attitudinal barriers requires a multifaceted approach, including provider training, policy changes, and community engagement. By prioritizing the needs and experiences of individuals with disabilities, healthcare systems can work towards creating a more inclusive and supportive environment, thereby improving health outcomes and promoting human rights. This study underscores the importance of ongoing efforts to address these barriers and ensure that SRH services are accessible and equitable for all.

4.3.3Physical Barriers

Based on the research findings, physical barriers in healthcare settings reveal a concerning reality: many healthcare facilities are not designed to accommodate the needs of disabled individuals. Through in-depth interviews with disabled individuals and healthcare providers, I

found that physical barriers, such as inaccessible entrances, narrow doorways, and lack of wheelchair-accessible examination rooms, significantly hinder access to Sexual and Reproductive Health (SRH) services. One participant poignantly shared, "I had to wait for an hour just to get someone to help me get onto the examination table because the lift was broken." These physical barriers not only limit access to care but also perpetuate feelings of marginalization and exclusion. Moreover, the lack of accessible medical equipment, such as height-adjustable examination tables and wheelchair accessible scales, further exacerbates these challenges. These findings underscore the urgent need for healthcare facilities to prioritize physical accessibility and inclusivity in their design and infrastructure, ensuring that all individuals, regardless of their abilities, can access quality SRH services with dignity.

A man with physical impairment noted that:

"As a physical disabled man, I face constant barriers in healthcare. Narrow doorways, inaccessible facilities, and inadequate equipment make me feel like my disability defines me, not my health needs. Simple changes like ramps and adjustable tables would make a huge difference."

In support of this another participant mentioned:

"Physical barriers in healthcare settings are not just a minor issue, they are a major obstacle. Inaccessible buildings, exam rooms and equipment send a clear message that disabled individuals are not a priority. We need change and we need it now. Accessible healthcare is a fundamental right, not a privilege."

The key Informant mentioned that:

"I have seen firsthand how physical barriers limit access to SRH services for PLWDs. Inaccessible clinics, lack of adjustable exam tables and inadequate signage in Braille or large print hinder their ability to receive quality care. These barriers perpetuate health disparities and marginalization, underscoring the need for inclusive design and accessible infrastructure in SRH services."

Based on the findings it shows that the research reveals that physical barriers significantly limit

access to SRH services for individuals with disabilities, echoing Grech's (2015) assertion that disability is often rendered invisible in mainstream development agendas. The findings highlight inaccessible healthcare facilities, inadequate equipment and lack of accommodations, which collectively perpetuate exclusion and marginalization. This aligns with Grech's argument that disability is deeply entrenched in societal structures, requiring a critical examination of power dynamics and social relationships. To address these barriers, it's essential to adopt a rights-based approach, prioritizing accessibility, inclusivity, and disability-inclusive policies in SRH service design and delivery, ultimately promoting equitable access to care. Furthermore, this requires healthcare providers to recognize and challenge their own biases, and to engage with disabled individuals and organizations in the design and implementation of SRH services. By doing so, we can ensure that SRH services are tailored to meet the unique needs of disabled individuals, promoting dignity, autonomy and well-being. This approach can lead to improved health outcomes and increased patient satisfaction.

4.4 THEME 3: STRATEGIES AND INTERVENTIONS TO IMPROVE ACCESSIBILITY OF SRH SERVICES AMONG PEOPLE WITH DISABILITIES

The third objective of the study was to improve access to SRH services for PLWDs. Strategies and interventions should focus on provider training to address attitudinal barriers, enhance communication skills, and promote disability awareness. Additionally, healthcare facilities should prioritize physical accessibility, ensuring wheelchair accessible infrastructure and adaptable equipment. Implementing inclusive policies, such as sign language interpretation and Braille signage, can also facilitate better care. Furthermore, community-based initiatives, peer support programs, and advocacy efforts can help raise awareness and promote the rights of PLWD, ultimately fostering a more inclusive and supportive environment for SRH services. Partnerships between healthcare providers, disability organizations, and community groups are crucial for developing effective strategies. By engaging PLWD in the design and implementation of SRH services, healthcare systems can ensure that interventions are tailored to their unique needs, promoting equitable access and improved health outcomes. This collaborative approach can lead to more effective and sustainable solutions.

4.4.1 Policy reform

The research findings highlight policy reform as a critical strategy to improve access to SRH services for people living with disabilities (PLWD). Through interviews with key stakeholders, it became clear that existing policies often perpetuate barriers, and reform efforts are necessary to ensure inclusive and accessible care. Participants emphasized the need for policies that mandate disability training for healthcare providers, ensure physical accessibility of healthcare facilities, and provide guidelines for accommodating diverse needs. Moreover, policies should prioritize the rights of PLWD, promoting autonomy, dignity, and non-discrimination. Effective policy reform requires collaborative efforts between governments, healthcare providers, and disability organizations to create and enforce policies that address the unique needs of PLWD, ultimately enhancing their access to SRH services.

In support of this a participant noted that:

"We need policies that prioritize our rights and dignity. If healthcare providers were trained and facilities were accessible, it would make a huge difference in getting the SRH care we deserve."

In support of this another participant states that:

"We're constantly fighting for our rights to access SRH services as PLWDs. If policies were enforced to ensure accessibility and non-discrimination, we wouldn't have to beg for basic care like family planning or STI treatment. It would be our right, not a privilege."

The Key Informant mentioned that:

"Good policies can make a big difference in ensuring people with disabilities get the sexual and reproductive health care they need. It's about making sure healthcare facilities are accessible and staffs are trained to provide inclusive care."

Policy reform is a crucial strategy to enhance access to SRH services, especially for people living with disabilities. Developing and enforcing inclusive policies that prioritize accessibility, non-discrimination, and training for healthcare providers is essential to bridging the gap in SRH service delivery. According to Yamin and Boulanger (2014), policies that promote human

rights can have a significant positive impact on health outcomes and dignity for vulnerable populations. Therefore, effective policy reform requires a multi-faceted approach, including revising existing laws and guidelines to address gaps in accessibility and quality of care, ultimately leading to improved health outcomes and enhanced overall well-being for people living with disabilities. This can involve implementing policies that ensure physical accessibility of healthcare facilities, provide guidelines for accommodating diverse needs, and promote autonomy and dignity in healthcare decision-making. By doing so, healthcare systems can better meet the SRH needs of people living with disabilities, leading to increased access to care, reduced health disparities, and improved quality of life. Moreover, policy reform can also help to address systemic barriers and biases that contribute to health inequities, promoting a more inclusive and equitable healthcare system for all. By prioritizing the needs and rights of people living with disabilities, policy reform can play a critical role in advancing SRH and promoting human rights.

4.4.2 Training for Healthcare providers

The research findings highlight the critical role of training for healthcare providers in improving access to SRH services for PLWDs. Through interviews with healthcare providers and PLWDs, the researcher found that lack of training and awareness about disability specific needs is a significant barrier to accessing SRH services. Healthcare providers who received training on disability inclusive care reported increased confidence and competence in providing accessible and respectful care to PLWDs. The training emphasized the importance of communication, accessibility, and autonomy, enabling providers to better understand and address the unique needs of PLWDs. Consequently, PLWDs who received care from trained providers reported improved experiences, increased satisfaction, and enhanced trust in the healthcare system. These findings suggest that investing in training for healthcare providers is a crucial strategy for improving access to SRH services for PLWDs, promoting equitable healthcare, and upholding their rights to dignity and quality care.

In support of this one of the participants states that

"Training healthcare providers in disability-inclusive care transform SRH services for PLWDs. They learn to communicate effectively, provide accessible care, and promote autonomy and

dignity, ultimately improving our health outcomes."

Another participant notes that:

"When healthcare providers receive disability training, I know I will receive the care I need with dignity and respect. It's a huge step towards equitable SRH services for people like me."

The key Informant highlighted that:

"Disability inclusive training for healthcare providers is crucial for delivering respectful and effective SRH care to people with disabilities, reducing health disparities and promoting health equity."

Based on the findings, Training healthcare providers in disability-inclusive care is a vital strategy for improving SRH services for people living with disabilities. According to Kroll and Neri (2003), such training can address healthcare disparities and promote equitable access to care, ultimately enhancing health outcomes for individuals with disabilities. By equipping providers with the necessary knowledge and skills, we can bridge the gap in healthcare quality and accessibility, ensuring that people with disabilities receive the respectful and effective care they deserve. This approach can lead to increased trust, improved health outcomes, and enhanced overall experiences for individuals with disabilities, aligning with the broader goal of achieving health equity. Effective training can also foster a more inclusive healthcare environment. Ultimately, this shift towards inclusivity benefits not only individuals with disabilities but also the broader community.

4.4.3 Community Based initiatives

The research findings highlights that community based initiatives, led by trained community health workers and peer support groups, are a promising strategy to improve access to SRH services for PLWDs. Through in-depth interviews with PLWDs, caregivers, and healthcare providers, the research found that community-based initiatives helped bridge the gap in healthcare access by providing tailored support, education, and navigation. These initiatives fostered trust, increased health literacy and empowered PLWDs to take control of their SRH. Notably, peer support groups provided a sense of community and solidarity, helping to break down stigma and promote SRH seeking behavior. By leveraging community-based initiatives,

we can reach PLWDs in their own environments, address unique barriers, and ultimately enhance their SRH outcomes.

In support of this another participant states that:

"Community-based initiatives will improve SRH services for people living with disabilities by providing accessible, tailored support and education, fostering trust, and empowering individuals to take control of their health."

In support of the above another participant also said

"Community-based initiatives are a breakthrough for people with disabilities, bringing SRH services directly to their doorstep and providing the support and understanding they need to make informed choices about their health."

The key Informant highlighted that:

"As someone who has worked closely with PLWDs, I can attest that community-based initiatives are a transformative approach to improving SRH services. By bringing services to the community level, we can increase accessibility, reduce stigma and empower individuals to take control of their health."

Based on the findings, Community based initiatives are a vital strategy for improving access to sexual and reproductive health (SRH) services for PLWDs. As Groce et al. (2011) emphasize, community-based approaches can address the unique barriers faced by individuals with disabilities, increasing accessibility and promoting inclusive healthcare. By leveraging community health workers and peer support groups, these initiatives can foster trust, enhance health literacy, and empower individuals to take control of their SRH. This approach aligns with the broader goal of promoting health equity and human rights, ultimately enhancing the overall well-being of people living with disabilities. Effective implementation of such initiatives requires collaboration between healthcare providers, community organizations and individuals with disabilities to ensure tailored and responsive services.

CHAPTER SUMMARY

This chapter presents the analysis and findings of the data collected for this study. This chapter

begins by outlining the demographic characteristics of the primary participants and key informants, highlighting their relevance to the study. The data analysis section describes the themes and patterns that emerged from the interviews, focusing on accessibility of SRH services among PLWDs. The findings reveal PLWDs face barriers accessing SRH services, including physical, informational and attitudinal obstacles. The findings also highlight the need for tailored services, inclusive polices and improved accessibility to promote equal access to SRH services for PLWDs.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter provides the summary of research findings on the accessibility of SRH services among PLWDs. This chapter begins by giving a summary of the research findings. The deductions of the study are discussed and these include the implications of the study to social work practice. Recommendations are also highlighted which can improve legal framework for future studies.

5.1 SUMMARY OF FINDINGS

The study revealed that people with disabilities in Gweru have varying levels of awareness about SRH services, with some being well informed while others lacked knowledge. Available SRH services in Gweru include family planning, maternal healthcare, STI testing and treatment, and HIV counseling. However, despite these services, individuals with disabilities face significant barriers in accessing them due to lack of inclusivity. Inclusive SRH services, such as sign language interpretation, accessible facilities, and trained healthcare providers, are essential to cater to the unique needs of people with disabilities. Unfortunately, these inclusive services are often lacking, highlighting the need for improved accessibility and awareness to promote the health, dignity, and autonomy of individuals with disabilities

The research findings highlight that PLWDs in Gweru face significant barriers in accessing SRH services. Communication barriers, such as lack of sign language interpretation and inaccessible information, hinder effective interaction between healthcare providers and PLWDs. Attitudinal barriers, including stigma and negative attitudes from healthcare providers, further exacerbate the issue. Physical barriers, such as inaccessible healthcare facilities and lack of adapted equipment, also limit PLWDs' access to SRH services. These barriers result in exclusion and marginalization, emphasizing the need for healthcare systems to prioritize accessibility and inclusivity. To address this, healthcare providers should receive training on

effective communication, facilities should be made physically accessible, and PLWDs should be engaged in the design and delivery of SRH services. By taking these steps, healthcare systems can promote health equity, dignity, and better health outcomes for PLWDs.

The study's findings highlight that training healthcare providers in disability-inclusive care is a crucial strategy for improving SRH services for people living with disabilities. This training can address healthcare disparities, promote equitable access to care, and enhance health outcomes for individuals with disabilities. By equipping providers with the necessary knowledge and skills, healthcare quality and accessibility can be improved, ensuring respectful and effective care for people with disabilities. Additionally, strategies such as providing sign language interpretation, Braille materials, and accessible digital platforms can facilitate equal access to care. Ensuring physical accessibility of healthcare facilities, engaging with disabled individuals and organizations to inform SRH service design and delivery, and promoting awareness and understanding of disability rights can also help. Furthermore, inclusive care benefits not only individuals with disabilities but also the broader community, promoting a culture of respect, empathy, and understanding. By prioritizing disability inclusive care and implementing these strategies, healthcare systems can better meet the unique needs of people with disabilities, leading to increased trust, improved health outcomes, and enhanced overall experiences.

5.2 CONCLUSION

This study sheds light on the significant challenges people with disabilities face in accessing sexual and reproductive health services in Gweru, Zimbabwe. The findings reveal that individuals with disabilities encounter various barriers, including inaccessible healthcare facilities, lack of understanding from healthcare providers, and inadequate support systems. To address these issues, it is essential that healthcare providers receive comprehensive training on disability-inclusive care, enabling them to provide respectful and effective support to people with disabilities. Moreover, healthcare facilities should be made physically accessible, with features such as ramps, accessible restrooms, and sign language interpreters. This would ensure that people with disabilities can easily access the services they need without facing unnecessary obstacles.

Additionally, involving people with disabilities in the planning and delivery of sexual and reproductive health services is crucial. By doing so, healthcare providers can gain a deeper understanding of the unique needs and experiences of people with disabilities, ultimately leading to more effective and inclusive care. By implementing these changes, Zimbabwe can take a significant step towards promoting health equity and ensuring that people with disabilities receive the care and support they deserve. This, in turn, would lead to improved health outcomes, increased trust in the healthcare system, and a better overall quality of life for people with disabilities. Ultimately, this study highlights the importance of prioritizing disability-inclusive care and working towards creating a more just and equitable healthcare system for all.

5.3 IMPLICATIONS TO SOCIAL WORK PRACTICE

The study's findings have significant implications for social work practice. Morales, Sheafor and Scott (2010), social work is a comprehensive natural helping human service profession which focus on the specific needs of clients and require specific knowledge, values and skills. Social workers will be encouraged to receive training on disability-inclusive practices to effectively support individuals with disabilities. This training will encompass understanding various disabilities, communication strategies, and accessible service delivery methods. Furthermore, this will encourage social workers to advocate for policy changes and service improvements that promote accessibility and inclusivity for people with disabilities. By empowering individuals with disabilities to assert their rights and make informed decisions, social workers can facilitate their access to healthcare services that cater to their unique needs. Effective collaboration with disability organizations, healthcare providers, and community stakeholders is also essential in ensuring comprehensive and inclusive services. Ultimately, it will help social workers in promoting social justice, equality, and human rights for people with disabilities, enhancing their overall well-being and quality of life. By adopting disability inclusive practices, social workers will make a meaningful difference in the lives of individuals with disabilities.

5.4 RECOMMENDATIONS

In line with research findings, summary and conclusion, in this study the researcher proffers

the following recommendations to specific concerned stakeholder.

5.4.1 for social work practice

1. Social workers should prioritize disability inclusive training for their staff to ensure that PLWDs receive respectful and effective care.
2. The training should cover various aspects, including understanding different types of disabilities, effective communication strategies, and accessible service delivery methods.
3. Providing such training, Social workers can equip their staff with the necessary knowledge and skills to cater to the unique needs of people with disabilities.
4. Additionally, healthcare facilities should be made physically accessible, with features such as ramps, accessible restrooms, and sign language interpreters.
5. Social workers should develop tailored services and programs that cater to the specific needs of people with disabilities, ensuring that they receive comprehensive and inclusive care hence promoting health equity and improve health outcomes for PLWDs.

5.4.2 for Policymakers

1. Policymakers play a crucial role in promoting accessibility and inclusivity in healthcare services, to achieve this such as developing and implementing policies that prioritize the needs of people with disabilities.
2. This could include allocating resources to support disability-inclusive healthcare initiatives, such as training programs for healthcare staff and infrastructure development to improve physical accessibility.
3. Policymakers should also ensure that healthcare facilities comply with accessibility standards, providing a framework for accountability and enforcement.
4. Policymakers should engage with disability organizations and other stakeholders to inform policy development and ensure that the needs and rights of people with disabilities are respected.

5. Prioritizing disability-inclusive policies, policymakers can promote health equity and improve health outcomes for people with disabilities, ultimately contributing to a more just and equitable society.

5.4.3 for Disability Organizations

1. Disability organizations are vital stakeholders in promoting accessibility and inclusivity in healthcare services.
2. One key recommendation is for these organizations to collaborate with healthcare providers to inform service design and delivery through working together.
3. Disability organizations should also advocate for the rights and needs of people with disabilities in healthcare settings, pushing for policy changes and service improvements that prioritize accessibility and inclusivity
4. . Additionally, these organizations can provide support and resources to people with disabilities, empowering them to navigate the healthcare system and access the services they need.
5. Through taking these steps, disability organizations can play a critical role in promoting health equity and improving health outcomes for people with disabilities.

5.4.4 for Community Stakeholders

1. Community stakeholders, including community leaders and members, can play a significant role in promoting accessibility and inclusivity in healthcare services.
2. One key recommendation is for community stakeholders to promote awareness and understanding of disability rights and needs.
3. By raising awareness and challenging stigma and stereotypes, community stakeholders can help create a more inclusive and supportive environment for people with disabilities.
4. Community stakeholders can also support initiatives that promote accessibility and inclusivity in healthcare, such as advocating for infrastructure development or supporting disability-inclusive training programs for healthcare staff.

5. Furthermore, community stakeholders can encourage community involvement in promoting disability-inclusive healthcare practices, fostering a sense of collective responsibility and ownership.
6. Through taking these steps, community stakeholders can contribute to promoting health equity and improving health outcomes for people with disabilities, ultimately building a more just and equitable community.

5.5 Future study

Despite efforts made in carrying out this study there are areas that are still open for future research. Future studies could build on the findings of this research by investigating the effectiveness of disability inclusive training programs for healthcare providers. This could involve evaluating the impact of such training on healthcare outcomes for people with disabilities and identifying best practices for implementation. Additionally, research could explore the experiences of people with disabilities in accessing healthcare services in rural areas, where challenges may be even more pronounced. Other potential areas of study include evaluating the impact of accessible healthcare facilities on health outcomes for people with disabilities and examining the role of technology in improving healthcare accessibility. Furthermore, assessing the effectiveness of policy interventions aimed at promoting disability-inclusive healthcare could inform advocacy efforts and policy development. By pursuing these research directions, future studies can contribute to a deeper understanding of the complex issues surrounding disability-inclusive healthcare and identify strategies for promoting more equitable and effective care.

5.6 CHAPTER SUMMARY

This chapter of the study gave the summary and conclusion of the study and proffered recommendations of the study gave the summary and conclusions of the study. The summary of the entire study provided a rundown of the whole study from objectives, theoretical framework, literature review methodology and findings of the study. This chapter highlighted the implications of the study to social work and suggested areas for future research were discussed.

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APPENDICES

APPENDIX 1: INFORMED CONSENT

Researcher: Shalom Moyo

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Title of Research: Accessibility of sexual and reproductive health services among people living with Disabilities in Gweru, Zimbabwe: Insights from NCDPZ

Degree: Bachelor of Science Honours Degree in Social Work

University: Bindura University of Science Education

1 Procedure

In-depth interviews will be employed by the researcher to collect data from the individuals. One-on-one interaction with participants is necessary for in-depth interviews because it enables them to discuss their opinions on the topics posed, builds rapport with the researcher, and permits probing. The interview will be audio recorded and the researcher will collect field notes during interviews.

2. Potential risk and discomforts

The dangers connected to this research study are unclear. However participants may face stress, psychological dangers, or other emotional issues as a result of exploring their experiences. To assist them in that situation, the research will utilize the referral system.

3. Potential benefits of the research

The study has several benefits including improving accessibility and inclusivity of SRH services for people with disabilities, enhancing understanding of their experiences and reducing disparities in SRH outcomes. It can contribute to the development of more effective SRH services and provide evidence to support advocacy efforts, ultimately promoting better health

services and wellbeing for people with disabilities.

4. Confidentiality

In order to protect participant names, the researcher will code the data they collect for this study and employ pseudonyms. The names of the participants will not be used when the data is presented. Participants' information will only be accessible to the researcher and the study supervisor.

5. Voluntary participation

Client participation will be entirely voluntary; no one will be coerced into taking part in the study. If you decide to stop participating in the study, there won't be any consequences. The participant is free to withdraw whenever they so desire without worry.

6. Permission for Participation

Please tick where applicable

Will you participate in the study? YES NO

Would you allow me to record your voice through the audio recorder? (This is strictly confidential and anonymity is guaranteed). YES NO

If yes then sign the consent form and proceed if no stop.

Is there anything you want to know before we start?

I have read the above and I understand the nature of the study. I am willing to participate and give my consent.

Participant's Signature……

Researcher's Signature……

Thank you for participating and sparing your time

APPENDIX 2: IN-DEPTH INTERVIEW FOR GUIDE FOR PRIMARY PARTICIPANT'S

Research question 1. What are the SRH services available for people living with disabilities in Gweru?

Probing questions

1. Can you describe your experiences in accessing SRH services in Gweru?

2. What challenges or difficulties have you faced in accessing SRH services and how did you overcome them?

3. What kind of SRH services do you feel are missing or inadequate in Gweru and how do you think they can be improved?

Question 2: What are the barriers faced by people with disabilities in accessing SRH services in Gweru?

1. How do healthcare facilities in Gweru meet your needs as a person living with disabilities?

2. Have you experienced difficulties communicating with healthcare providers about your SRH needs?

3. Are there any policies or procedures that you think hinder your access to SRH services and can you describe them?

4. Have you ever experienced any negative attitude or behaviors from healthcare providers when seeking SRH services and can you describe the experiences?

Research question 3: Which strategies can be adopted to enhance access to SRH services for people living with disabilities in Gweru?

Probing questions

1. What kind of training or support do you think healthcare providers need to improve their services for people with disabilities?

2. How can healthcare facilities be designed or modified to be more accessible for people with disabilities?

3. How can people living with disabilities be more involved in decision making process about SRH services?

4. What policy changes or guidelines would you recommend to improve access to SRH services for people living with disabilities?

APPENDIX 3: IN-DEPTH INTERVIEW GUIDE FOR KEY INFORMANTS (Social workers, health care providers)

Research question 1. What are the SRH services available for people living with disabilities in Gweru?

1. What sexual and reproductive services do you offer to people living with disabilities?

2. What challenges do you face in providing SRH services to people living with disabilities?

3. How do you that your services are accessible and available to people living with disabilities?

4.What challenges do you use to communicate effectively with people living with hearing and visual impairments?

Question 2: What are the barriers faced by people with disabilities in accessing SRH services in Gweru?

1. Can you describe any challenges health care providers face in communicating with people with disabilities about SRH needs?

2. What training or support do healthcare providers need to better serve people living with disabilities?

3. How do health care providers' attitudes and biases impact care for people living with disabilities?

4. What barriers prevent people with disabilities from accessing SRH services?

Research question 3: Which strategies can be adopted to enhance access to SRH services for people living with disabilities in Gweru?

Probing questions

1. How can SRH services be made more accessible for people with disabilities?

2. How can healthcare providers be trained to better serve people with disabilities?

3. What role can organizations play in promoting accessible SRH services?

4. What innovative approaches can improve SRH services delivery?

Thank you for your time?

FACULTY OF SOCIAL SCIENCES AND HUMANITIES
DEPARTMENT OF SOCIAL WORK

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BINDURA, Zimbabwe

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BINDURA UNIVERSITY OF SCIENCE EDUCATION

Date: 2/05/25

TO WHOM IT MAY CONCERN

RE: REQUEST TO UNDERTAKE RESEARCH PROJECT IN YOUR ORGANISATION

This serves to introduce the bearer, Shalom A.M Moyo, Student Registration Number B210556B, who is a BSc Social Work student at Bindura University of Science Education and is carrying out a research project in your area/institution.

May you please assist the student to access data relevant to the study, and where possible, conduct interviews as part of a data collection process.

Yours faithfully

E.E. CHIGONDO
CHAIRPERSON

BINDURA UNIVERSITY OF SCIENCE EDUCATION
DEPARTMENT OF SOCIAL WORK
CHAIRPERSON
11 APR 2025
FACULTY OF SOCIAL SCIENCE & HUMANITIES
PRIVATE BAG 1020, BINDURA, ZIMBABWE

NATIONAL COUNCIL OF DISABLED PERSONS OF ZIMBABWE

W.O 16/75

PHYSICAL ADDRESS:
NATIONAL OFFICE
FREEDOM HOUSE
OLD FALLS ROAD
BULAWAYO
+26329208023
Opp: Mpilo Chest Hospital

28 May 2025

CORRESPONDENCE TO BE ADDRESSED TO:
UTIVE DIRECTOR
P.O BOX 1952
BULAWAYO
ZIMBABWE.
TEL: +263 719 310 125 / 0772 770 221
Email: director@ncdpz.org.zw

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Bindura University

Bindura

I am writing to grant permission for Shalom to conduct research on access to Sexual and Reproductive Health Rights (SRHR) Services for Persons with Disabilities at NCDPZ. The student will collect data through qualitative methods. All data collected will be kept confidential and used solely for academic purposes.

We understand the importance of this research and its potential to contribute to improving SRHR services for persons with disabilities.

Please feel free to contact me if you require any further information. Thank you for considering our request.

Sincerely

Mrs Lizzie Longshaw

The Executive Director

National Council of Disabled Persons of Zimbabwe (NCDPZ)

Mobile: +263719310125

Email: director@ncdpz.org.zw

NATIONAL COUNCIL OF DISABLED PERSONS OF ZIMBABWE
P.O. Box 1952
BULAWAYO
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Signature