BINDURA UNIVERSITY OF SCIENCE EDUCATION

FACULTY OF SOCIAL SCIENCE AND HUMANITIES

DEPARTMENT OF SOCIAL WORK

EXPERIENCES OF WOMEN WITH DISABILITIES IN ACCESSING SEXUAL REPRODUCTIVE HEALTH SERVICES IN DOMBOTOMBO WARD 2, MARONDERA

BY

B210677B

A Dissertation Submitted to the Department of Social Work in partial fulfilment for the requirements for the Bachelor of Science Honours Degree in Social Work

Bindura, Zimbabwe

June 2025

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Supervisor	Mr Nyamaka
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Thank you all.

APPROVAL FORM

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Name: **Mr Nyamaka** Signature: Date: **20 JUNE 2025**

Chairperson of the Department Board of Examiners

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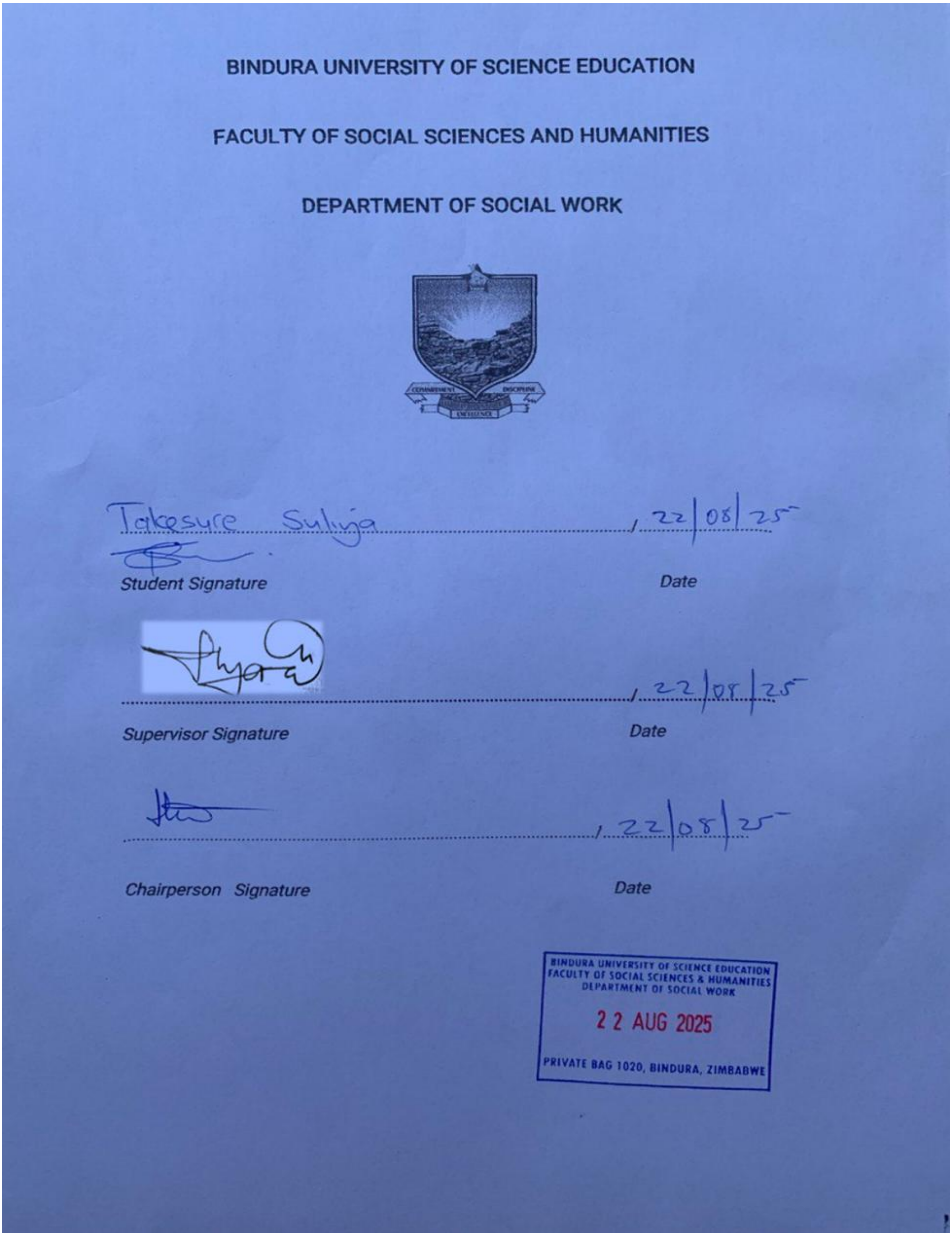

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DEPARTMENT OF SOCIAL WORK
22 AUG 2025
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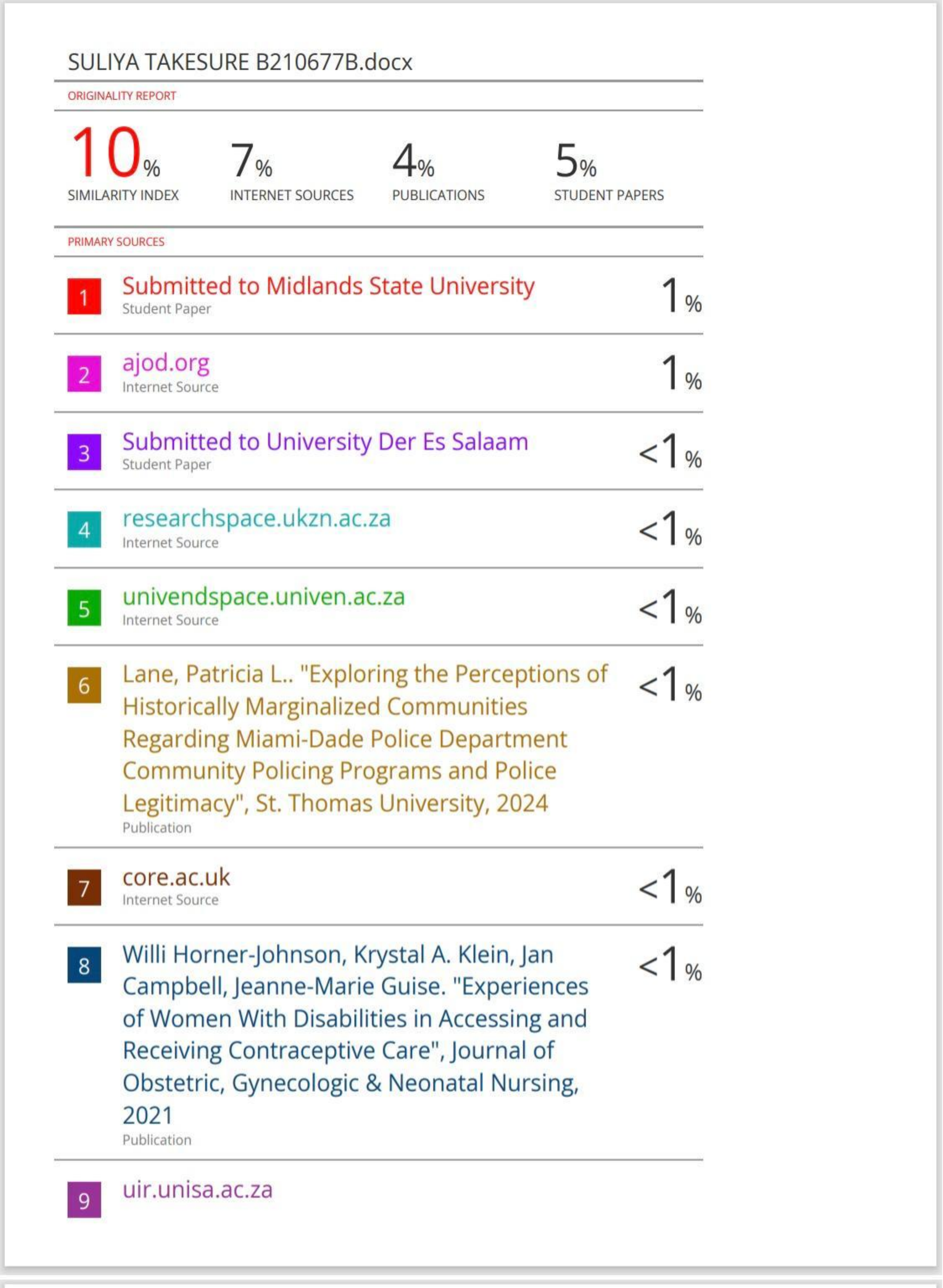
DEDICATION

I dedicate this work to my beloved parents, whose unwavering support, trust and belief in me have constant source of strength. Your faith and encouragement even during the most difficult times have carried me through. To my sisters Esnath and Patricia thank you for your continuous love and support through this journey. Finally, my twin brother Trust Suliya your steadfast encouragement and presence have meant more than words can express. This accomplishment is as much yours as it is mine.

PLAGIARISM REPORT



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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**	

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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**	

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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**	

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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:-

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Chapter 1		
Chapter 2		
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Chapter 4		
Chapter 5		

ABSTRACT

This study investigates the lived experiences of WWDs seeking SRH services in Dombotombo Ward 2, Marondera. Despite worldwide and national policy commitments to health equity and disability rights, WWDs continue to encounter severe barriers to accessing their SRH rights. As such, the study's specific objectives were to analyse the SRH services available for WWDs in Dombotombo Ward 2, to investigate the challenges faced by WWDs in accessing SRH services, to examine the coping mechanisms adopted by WWDs in response to challenges, and to propose potential measures that can be implemented to improve WWDs' access to SRH services. An interpretative phenomenological research design was used in this qualitative study, which was informed by intersectionality theory. The purposive sampling technique was used to pick 14 participants, and the sample size was determined by applying the data saturation principle. WWDs, caregivers, and key informants were all surveyed using semi-structured interview guides and focus-group discussion guides, respectively. The acquired data was analysed using interpretative phenomenological analysis. The findings show that, while SRH services such as HIV testing, STI treatment, family planning, maternal care, and cancer screening are technically available, WWDs face multiple barriers to access and utilization, including attitudinal, communicational, infrastructural, economic, and systemic factors. Participants reported using a variety of coping techniques, such as avoidance, traditional medicine, peer support, and self-advocacy. The study concludes that inclusive service delivery, policy reform, training of healthcare workers, and mobile clinics are all urgently required. The study adds to the small body of evidence on SRH and disability in Zimbabwe, providing actionable suggestions and proposing an innovative paradigm to influence policy, practice, and advocacy for inclusive health services.

ACRONYMS

ADA – Americans with Disabilities Act

ADP – African Disability Protocol

AIDS – Acquired Immune Deficiency Syndrome

ARV – Antiretroviral

AU – African Union

AUMDL – African Union Model Disability Law

CRPD – Convention on the Rights of Persons with Disabilities

DACT – Disabled Advocacy and Consultancy Trust

DDC – District Development Committee

DSD – Department of Social Development

GBV – Gender-Based Violence

GIS – Geographic Information System

HIV – Human Immunodeficiency Virus

ICPD – International Conference on Population and Development

IEC – Information, Education, and Communication

IPA – Interpretative Phenomenological Analysis

MOHCC – Ministry of Health and Child Care

NAC – National AIDS Council

NGO – Non-Governmental Organization

NHS – National Health Strategy

RHU – Reproductive Health Uganda

SHR – Sexual Health and Rights

SRH – Sexual and Reproductive Health

SRHR – Sexual and Reproductive Health and Rights

SRHS – Sexual and Reproductive Health Services

STI – Sexually Transmitted Infection

UN – United Nations

UNCRPD – United Nations Convention on the Rights of Persons with Disabilities

UNESCO – United Nations Educational, Scientific and Cultural Organization

UNFPA – United Nations Population Fund

UNICEF – United Nations International Children’s Emergency Fund

USAID – United States Agency for International Development

WCC – World Council of Churches

WHO – World Health Organization

WWD – Women with Disabilities

ZIMSTAT – Zimbabwe National Statistics Agency

ZNAD – Zimbabwe National Association of the Disabled

ZNASCH – Zimbabwe National Association of Societies for the Care of the Handicapped

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Sexual and reproductive health (SRH) is a fundamental human right, yet WWDs often encounter systemic and structural barriers that hinder their access to these vital services. In Zimbabwe, despite progressive policies such as the Constitution of Zimbabwe Amendment (No. 20) Act of 2013 and the National Disability Policy of 2021, women with disabilities continue to experience significant challenges, including physical inaccessibility, stigma, and limited awareness among healthcare providers regarding their specific needs. These issues are particularly pronounced in rural and peri-urban areas like Marondera District, where inadequate healthcare infrastructure and traditional cultural norms further exacerbate their vulnerability. This study explores the lived experiences of women with disabilities in accessing SRH services in Marondera District, examining the barriers they face, the quality of care available, and the inclusivity of healthcare systems. By highlighting these experiences, the study seeks to contribute to Zimbabwe's commitments to the Sustainable Development Goals, such as Goal number 3 (Good Health and Well-being) and Goal number 5 (Gender Equality), while advocating for evidence-based recommendations to improve healthcare delivery for women with disabilities as a critical step toward fostering inclusive and sustainable development.

1.2 BACKGROUND OF THE STUDY

Globally, the accessibility of sexual and reproductive health (SRH) services for women with disabilities remains a pressing concern despite strides in human rights and healthcare advancements (Johnson, et. al, 2021). Around one billion people worldwide are estimated to have some form of disability (World Health Organisation, 2023). According to Rugoho (2023), access to sexual and reproductive health services (SRHS) is a critical global issue to women with disabilities because they continue to be treated as second-class citizens. According to Johnson, (2021), the challenges encountered by women with disabilities in accessing SRHS are multifaceted because WWD are still viewed as people who cannot take part in many activities such as sexual and reproductive activities. These are physical obstacles, such as inaccessible healthcare facilities, hinder mobility and deter individuals from seeking care

(Ahumuza et al., 2024). Attitudinal barriers, including misconceptions about the sexuality of persons with disabilities, lead to inadequate or inappropriate service provision (Nguyen, 2020). Additionally, informational barriers, such as the lack of accessible formats for health information, further impede their ability to make informed decisions regarding their reproductive health (Ahumuza et al., 2024). These barriers are often perpetuated by physical barriers such as transportation issues and inaccessible facilities. Attitudinal barriers such as stigma and discrimination, health provider bias, inadequate health education, poor communication, poverty, health costs, limited social support, caregiver's dynamics, cultural beliefs, gender norms and the absence of policies explicitly addressing the SRH needs of this population, these are factors that perpetuate the barriers faced by WWD (Nguyen, 2020). The barriers encountered by WWDs violate their rights, leading to systemic inequalities. Inadequate access to SRH services result in dire health outcomes, including higher rates of untreated reproductive health issues, high risk of STIs, increased vulnerability to sexual violence and sexual abuse, unplanned pregnancies, and poor maternal health outcomes (Johnson, et. al, 2021)

In developed countries such as Australia, the United Kingdom, and Germany, initiatives to improve SRH services for women with disabilities are evident, yet significant gaps persist (Sinclair, et al., 2015). For instance, research in Australia highlights that women with disabilities often encounter attitudinal and systemic barriers, such as assumptions by healthcare providers that they are not sexually active or in need of reproductive healthcare (Goggin & Newell, 2020). In the United Kingdom, while the National Health Service (NHS) provides disability-inclusive services, studies indicate that women with disabilities face challenges in navigating physical environments and accessing specialized care (Department of Health and Social Care, 2021). Similarly, in Germany, despite the enactment of anti-discrimination laws, a report by the German Federal Ministry of Health, (2022), reveals that women with disabilities frequently experience limited autonomy in reproductive health decision-making due to societal stigmas and insufficient training among healthcare professionals. While the Americans with Disabilities Act of 2008 provides disability inclusion services in the United States, studies indicates that, WWDs have long been subjected to societal ableism, including belief that WWDs are not sexually active (Sinclair et al., 2015). Even now, reproductive age of WWDs in the United States are more likely to be sterilized and less likely to get family planning services than their counterparties without disabilities (Haynes et al., 2018)

In response to these challenges, various international and national initiatives have been undertaken such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD) emphasizes the right of individuals with disabilities to attain the highest standard of health without discrimination, explicitly including sexual and reproductive health (United Nations, 2006). Organizations like the World Health Organization (WHO) and the United Nations Population Fund (UNFPA) have developed guidelines to promote disability-inclusive SRH services, advocating for the removal of physical, attitudinal, and informational barriers (WHO/UNFPA, 2020). Despite these efforts, implementation at the national level varies, and significant gaps remain. To bridge these gaps, it is imperative to enforce existing policies, provide comprehensive training for healthcare providers, and actively involve persons with disabilities in the development and evaluation of SRH programs. Such measures are essential to ensure equitable access to SRHS for all WWDs, regardless of their disabilities.

In African context, across the African continent, women with disabilities encounter significant barriers in accessing SRH services, primarily because of inadequate healthcare systems, prevailing cultural norms, widespread poverty, poor communication and awareness, health costs, limited social support, caregiver’s dynamics, cultural beliefs, gender norms and inadequate legislation and lack of inclusive polices (Casebolt, 2020). According to Africa Renewal (2018), approximately ten percent of Africa's population is disabled, equating to 60-80 million individuals in developing countries on the continent and 35 -40 million people in Africa are believed to be women with disabilities who are facing challenges in accessing SRH services.

Many African countries face challenges in their healthcare systems due to inadequate resources, resulting in limited access to prenatal and maternal care for women with disabilities (Rugoho, 2021). This lack of access lead to complications during childbirth, increasing the likelihood of congenital disabilities or disabilities that arise during labour. Poor infrastructure is also another factor which drives challenges faced by women with disability in accessing SRH services in Africa (Casebolt, 2020). Studies by the Egyptian Family Health Association (2020) suggest that infrastructural barriers, coupled with misconceptions about the sexuality of WWDs, limit their access to SRH services. Women with disabilities in Africa have been subjected to coerced sterilizations, abortions and marriages, denying them their autonomy and rights (Kim, 2013). In African countries such as Kenya, Nigeria and Cameron women with disabilities are being prevented from forming relationships or forced into marriages where they are not treated as equals within the family (Kim, 2013). Additionally, women with disabilities are often exposed to the same risk factors for HIV/AIDS and other sexually transmitted infections as other marginalized groups (Wu et al., 2017). Some of the risks involved are poverty, restricted educational opportunities, inadequate healthcare services, and difficulties in promoting safer sexual behaviours. In Nigeria, similar issues exist, with additional barriers stemming from inadequate healthcare policies and the marginalization of disability-related concerns in national health strategies. According to Odu et al. (2019), healthcare providers in Nigeria often lack training in disability-sensitive approaches, leaving women with disabilities underserved.

African countries have legal frameworks and policies that were developed in order to address barriers that are being encountered by WWDs in accessing SRH services (Abbay, 2015). These include The African Disability Protocol of 2018, it is a legal framework that guides African Union member states in developing disability laws and policies. ADP acknowledges the compounded discrimination encountered by WWDs and also aim to ensure that WWD enjoy their human rights on an equal basis with others, fostering an environment where they can thrive without systemic barriers (Casebolt, 2020). The African Charter on Human and Peoples` Rights on the Rights of Persons with Disability it was agreed in 2018, and it includes the provision for WWDs in accessing SRH services. African Union Model Disability Law of 2019, serves as guide for AU member states to develop national legislation that align with the continental standards on disability rights. Article 39 of AUMDL specifically focuses on women with disability where it aim to achieve full participation and equal rights for WWDs by enhancing public awareness, developing programs to meet the needs of WWD and promote the inclusion of WWD in all mainstreams women’s organisation programmes (AUMDL, 2019). In trying to address issues of WWDs in accessing SRH services, African countries collaborating with international organisation and policies such as WHO, UNESCO, and The Convention on the Right of Persons with Disabilities (CRPD). These organisations play a vital role in funding money and materials for example, USAID funded protector plus and ARV in most African countries (Abbay, 2025). Collaborating with United Nations agencies, the World Bank, and governments enhance the involvement of women with disabilities in UNFPA and WHO initiatives. It is crucial for national and local partners collaborating with international organizations, as well as all locally and nationally funded organizations implementing their policies, to have clear policies and activities in place to include individuals with disabilities (Casebolt, 2020). This helps to reduce the challenges that are being faced by WWD in Africa.

In Zimbabwe, women with disabilities face compounded challenges in accessing SRH services. According to ZIMSTAT report (2022, *p 106*), about 1.6% of Zimbabwean population are people with disability. These challenges include, physical inaccessibility of healthcare facilities, poor healthcare facilities, discrimination by healthcare workers and lack of tailored information, poor infrastructure, and socioeconomic challenges. While the Constitution and the National Disability Policy provide a framework for inclusion, implementation remains inconsistent. Chireshe et al. (2021) note that healthcare facilities in Zimbabwe often lack the resources, infrastructure, and trained personnel required to meet the unique needs of WWDs. These challenges are driven by economic hardships in Zimbabwe, high costs of healthcare, poor infrastructure, poverty, weak legal frameworks and cultural norms and values, stigma within communities and healthcare institutions significantly limits their ability to access SRH services. These issues with women with disability is high in Zimbabwe because most people do not have knowledge on SRH services even the caregivers and others in community they treat everyone as equal.

Marondera, as a rural and peri-urban area in Zimbabwe, reflects these broader national trends but with added localized challenges. According to ZIMSTAT (2022, *p106*) they are 24 127, people with disability in Mashonaland East province. They are 14 021, women with disability in Marondera (ZIMSTAT, 2020). Marondera is characterized by limited healthcare infrastructure and high levels of poverty, which exacerbate barriers to SRH services for WWDs. A report by the Zimbabwe National Statistics Agency (ZIMSTAT, 2022) highlights that healthcare facilities in Marondera lack accessibility features such as ramps and disability-friendly consultation rooms, leaving women with disabilities underserved. Additionally, cultural attitudes Marondera often marginalize women with disabilities, further hindering their ability to seek reproductive healthcare.

In order to tackle this problem, it is crucial for the health sector, government, and organizations such as WHO, NAC, Zimbabwe National Disability Policy, collaborate with international organisations to recognize the significance of integrating women with disabilities in program planning. Upgrading of healthcare facilities, and services is paramount. Ensuring physical access to buildings, clinics, and various indoor and outdoor spaces is crucial for individuals with disabilities. It is essential to prioritize accessibility not just in healthcare facilities like hospitals and clinics, but also in settings where public health awareness is provided, places where condoms are distributed or sold, domestic violence shelters, drug and alcohol intervention programs, and all other establishments offering sexual and reproductive health services. Improving home-based care and community outreach is crucial, as many communities have health workers, social workers, and midwives who deliver sexual and reproductive health services directly to people in their homes. It is essential to provide proper training and supervision to all providers of home-based health, nutrition, and social services to ensure that women with disabilities is acknowledged and included in all home-based care and community outreach efforts.

It is important to do this research in Dombotombo ward 2, Marondera because no one carried it before in this areas. The research was done in Chitungwiza town in 2015 and it was ineffective to other town. By doing this research, will help to improve accessibility of healthcare infrastructure, improve home based care, provide education to women with disabilities and caregivers and to advocate for policy formulation that protect women with disability in accessing SRH services.

This study therefore seeks to explore on the difficulties encountered by WWDs in accessing SRH and finding out the actual causes or reasons for such challenges. It further looks on how health care systems work and myths held by the society with regard to WWDs access to SRH services. The results of this study are envisaged to come up with recommendations on how women with disabilities can have accessible SRH services without facing any setbacks or challenges. In addition, it will help in improving the current health systems through coming up with policies that promotes fair health care services as well as the general wellbeing of women with disabilities.

1.3 STATEMENT OF THE PROBLEM

Women with disability continue to access inadequate sexual and reproductive health (SRH) in Dombotombo area ward 2 in Marondera and this is associated with several challenges. Despite the existence of health policies aimed at promoting inclusivity, women with disabilities often experience significant barriers in utilizing SRH services. These barriers include physical inaccessibility of healthcare facilities, discrimination by health workers, lack of tailored information, and socioeconomic challenges. It is a problem because the barriers encountered by WWDs violate their rights, leading to systemic inequalities. Inadequate access to SRH services result in dire health outcomes, including higher rates of untreated reproductive health issues, increased vulnerability to sexual violence, unplanned pregnancies, and poor maternal health outcomes. Efforts to mitigate these challenges have been initiated at various levels. Internationally, the World Health Organization (WHO) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) set global standards that emphasize the right to accessible and inclusive healthcare for PWDs. Ideally, Zimbabwe should align with these standards by ensuring healthcare facilities are equipped to serve individuals with disabilities, training medical professionals to provide inclusive care, and implementing robust monitoring mechanisms to enforce compliance with disability-inclusive policies (Rugoho & Maphosa, 2017). However, on the ground, progress is slow, and many facilities in Marondera remain ill-equipped to meet these standards. There is an urgent need for policy reinforcement, increased funding, and greater community engagement to dismantle the structural and attitudinal barriers that hinder WWDs from accessing SRH services. Only through sustained efforts can the healthcare system in Marondera be transformed to include the needs of all women, ensuring their health, dignity, and reproductive rights are upheld.

1.4 AIM OF THE STUDY

The study seeks to explore women with disabilities' experiences in accessing sexual reproductive health services in Dombotombo area ward 2 of Marondera.

1.5 OBJECTIVES

i. To examine the SRHS available for women with disabilities in Dombotombo area ward 2 of Marondera.
ii. To examine the challenges faced by women with disabilities in accessing sexual reproductive health services in Dombotombo area ward 2 of Marondera.
iii. To scrutinise the coping mechanisms adopted by WWDs in relation to challenges of sexual reproductive health services in Dombotombo area ward 2 of Marondera.
iv. To proffer possible measures that can be adopted to improve women with disabilities' access to sexual and reproductive health services in Zimbabwe.

1.6 RESEARCH QUESTIONS

i. What are the SRHS available for women with disabilities in Dombotombo area ward 2 of Marondera.
ii. What are the challenges faced by women with disabilities in accessing sexual reproductive health services in Dombotombo area ward 2 of Marondera.
iii. What are the coping mechanisms adopted by WWDs in relation to challenges of sexual reproductive health services in Dombotombo area ward 2 of Marondera.
iv. What are possible measures that can be adopted to improve women with disabilities' access to sexual and reproductive health services in Zimbabwe?

1.7 JUSTIFICATION OF THE STUDY

The purpose of this study was to address the chronic marginalization of WWDs in their access to SRH services, particularly in low-resource settings like Dombotombo Ward 2, Marondera, Zimbabwe. Despite global and national policies emphasizing inclusive health services, WWDs continue to confront particular challenges, including stigma, inadequate infrastructure, and a lack of personalized information, which limit their SRH rights. By concentrating on their lived experiences, the study reveals vital insights that are frequently lacking from mainstream debate. It addresses the need for evidence-based interventions to guide policy, improve service delivery, and promote social inclusion. Finally, the project aims to empower WWDs and contribute to Zimbabwe's Education 5.0 agenda by providing information that promotes innovation, community participation, and sustainable development.

There is a considerable gap in local empirical work that addresses the lived reality of WWDs in Zimbabwe in terms of SRH access. Much of the available material either generalizes disability or focuses on larger health-care access issues without breaking down data by gender or disability. This study contributes to the existing body of literature by offering context-specific, qualitative insights into the hurdles, coping mechanisms, and perspectives of WWDs. It also adds to the greater regional and global discussion of disability-inclusive health services by documenting narratives from a rural Zimbabwean environment.

This study's findings provide clear, evidence-based suggestions for policy formation and program implementation in Zimbabwe. For example, the study may identify gaps in the implementation of the National Disability Policy (2021) and the SRHR Strategy (2022-2026), allowing policymakers to develop targeted actions to overcome these gaps. Furthermore, NGOs, healthcare providers, and government departments can use these findings to create inclusive, community-responsive SRH programs that prioritize the voices and needs of WWDs.

In line with Zimbabwe's Education 5.0 paradigm, which stresses teaching, research, community service, innovation, and industrialization, this study prioritizes knowledge that leads to transformation. Through community engagement throughout data collection and dissemination, the research empowers WWDs by amplifying their voices, promoting awareness, and encouraging inclusive dialogue. It also encourages local ownership of solutions, which may influence the design of community-based interventions, support groups, and peer-led education programs to improve SRH access for WWDs.

The study's findings can help shape curriculum for social work, disability studies, gender studies, and public health programs at Bindura University and elsewhere. It provides important case material for future social workers, public health professionals, and educators to learn about intersectional service delivery approaches. Furthermore, it promotes pedagogical approaches that stress decolonized, community-driven and inclusive research, which is critical for reforming higher education to align with national development goals.

1.8 DEFINITION OF KEY TERMS

Disability

Disability is characterised as a dynamic interplay between individual's health state and contextual variables, including both environmental and personal factors. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) views disability as a social construct that arises from barriers rather than impairments alone (UNCRPD, 2006; Mitra, 2018). In the SRH context, this view shifts responsibility from the individual to the system.

Women with Disabilities (WWDs)

Women with disabilities are females who experience long-term physical, sensory, intellectual, or psychosocial impairments which, in interaction with various attitudinal and environmental barriers, restrict their full participation in society, including in healthcare systems. According to Shakespeare et al. (2019), WWDs often experience compounded marginalisation due to both their gender and disability status, particularly in access to health services.

Sexual and Reproductive Health (SRH)

Sexual and reproductive health is defined as a condition of total physical, mental, and social well-being in all aspect of the reproductive system. It includes the right to a satisfying and safe sex life, reproductive autonomy, and access to services such as contraception, maternal care, STI prevention, and safe abortion (WHO, 2015). For WWDs, SRH includes the removal of disability-specific barriers in health provision.

Access to SRH services

Access is defined as the extent to which individuals are able to obtain, use, and benefit from SRH services. It incorporates dimensions such as availability, affordability, physical accessibility, acceptability, and information accessibility (Levesque et al., 2016). For WWDs, access is further influenced by provider attitudes, infrastructural barriers, and inclusive communication.

Barriers to Access

Barriers refer to systemic, structural, or interpersonal obstacles that limit the ability of WWDs to obtain SRH services. These include physical (e.g., inaccessible clinics), informational (e.g., lack of sign language interpreters), attitudinal (e.g., negative provider attitudes), economic (e.g., unaffordable costs), and institutional (e.g., non-inclusive policies) constraints (Schaaf et al., 2021).

Inclusion

Inclusion refers to the meaningful involvement and consideration of WWDs in the planning, implementation, and evaluation of SRH programs and policies. Inclusion implies the removal of discriminatory practices and ensuring equal access to opportunities and services (Ahumuza et al., 2017). Inclusive approaches are participatory and account for the unique needs of WWDs.

Experiences

Experiences refer to the subjective and lived realities of WWDs as they interact with SRH services and systems. These include perceptions of service quality, emotional responses, challenges, coping mechanisms, and satisfaction or dissatisfaction with care. Qualitative research emphasizes that experiences are shaped by social, cultural, and systemic factors (Braun and Clarke, 2021).

1.9 DESSERTATION OUTLINE

This research is divided into five chapters. The chapters are organised in the following manner.

Chapter One: Chapter on introduced the research and provide a background of the study on the experiences of women with disabilities in Dombotombo ward 2, Marondera, Zimbabwe. The chapter also presents the statement of the problem, the aim of the study, the objectives and the study questions, the assumption of the study and the significant of the study and also definition of key terms.

Chapter Two: This section examines literature from previous studies in accordance with the research questions. However, the chapter start with a theoretical framework that guided the study. In reviewing literature, the research start with covering the experiences of WWDs worldwide and narrows to Zimbabwe to support the relevance of the intersectional theory that served as the study’s compass.

Chapter Three: This chapter presents the study methodology, which the researcher used to find and choose subjects, collect data, evaluate the findings and report them.in this chapter, the researcher also described the challenges faced during data collection and the ethical guidelines that are adhered to throughout the study.

Chapter Four: This chapter provides, discusses and analyses the principal findings derived from the study, guided by its core objectives

Chapter Five: This chapter summarises the research methods and main results and also draws general inferences from the study. Crucial suggestions to enhance the welfare of WWDs in Zimbabwe are made, along with significant ramifications for social work practice and the proposed model.

1.10 LIMITATIONS OF THE STUDY

This study is subject to several limitations which includes the following

- Geographical limitation: The research is confined to Dombotombo Ward 2 in Marondera, which may not fully capture the diverse realities of women with disabilities in other wards, districts, or provinces of Zimbabwe. Findings may therefore not be generalizable to all settings.
- Population scope: The focus is exclusively on women with disabilities, excluding men with disabilities or other vulnerable groups who may also face similar barriers to SRH services.
- Policy-practice gap: Although the study considers Zimbabwe's policy frameworks, the assessment of their implementation is limited to participants' experiences rather than a full institutional or policy audit

1.11 DELIMITATIONS OF THE STUDY

The study also has delimitations that clearly define its scope

- Study focus: The research deliberately focuses on the experiences of women with disabilities (WWDs) in accessing sexual and reproductive health services, excluding other forms of healthcare access.

- Geographical boundary: The study is restricted to Dombotombo Ward 2 in Marondera, chosen because of its peri-urban and rural characteristics and the lack of previous similar studies in the area.
- Thematic scope: The study concentrates on four key aspects: (i) availability of SRHS, (ii) challenges faced by WWDs, (iii) coping mechanisms and (iv) possible measures to improve access. Other dimensions such as healthcare financing or service delivery for non-disabled populations are outside the study scope.
- Methodological boundary: The study emphasizes qualitative exploration of lived experiences rather than quantitative measurement, to capture deeper insights into barriers, perceptions, and coping strategies.

1.12 CHAPTER SUMMARY

Chapter one introduced the background and rationale for exploring the experiences of women with disabilities in accessing SRH services in Zimbabwe. It highlighted the global and national context of disability and SRH, emphasising the historical exclusion of WWDs from mainstreaming health intervention. The problem statement identified a knowledge and service gap regarding how WWDs experience and cope with barriers to SRH services. The chapter outlined the main aim, objectives and research questions guiding the study along with a brief overview of the theoretical framework. The chapter defined the key terms and introduced the study significance. Overall, this chapter laid the foundation for a deeper exploration of the lived experiences of WWDs in relation to SRH services.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The literature review provides a comprehensive analysis of existing studies, theories, and frameworks related to the SRHS for WWDs. This chapter analyse the SRH services available for woman with disabilities, examines the barriers that WWDs encountered in accessing SRHS, the coping mechanisms they adopt, and possible solutions that can be implemented to improve their access to these services. The review synthesizes information from global, regional and local contexts, focusing on the challenges within rural Zimbabwe, specifically Dombotombo in Marondera District.

2.2 THEORETICAL FRAMEWORK

This is a conceptual plan that provide a foundation for understanding and analysing a particular phenomenon. This framework guided the research and analysis of study findings. This study employed Intersectionality theory by Crenshaw.

2.2.1 Intersectionality Theory

Intersectionality is an analytical framework that is used for the purpose of equality and human rights monitoring to show the distinct forms of harm, abuse, discrimination and disadvantage experienced by people when multiple categories of social identity interact with each other (Crenshaw, 1989). It was developed by Kimberlé Crenshaw in the late 1980s, intersectionality emerged out of Black feminist thought and legal scholarship to better understand the ways in which systemic oppression affects individuals with multiple marginalised identities. This theory will be crucial in understanding what SRH services are available for women with disability, how women with disabilities in Zimbabwe navigate their unique challenges when seeking SRH services, as their experiences cannot be understood solely through the lens of gender or disability. Intersectionality will provide a framework for examining how varying factors such as socioeconomic status and cultural backgrounds contribute to the barriers faced by these women.

Intersectionality plays a significant role in informing this study by providing a framework for understanding how multiple social identities like gender, disability, and socio-economic status interact to create unique and compounded forms of marginalization for women with disabilities in Marondera District. Developed by Kimberlé Crenshaw (1989), the concept of intersectionality recognizes that individuals do not experience discrimination or oppression based on a single axis of identity; rather, these factors intersect and produce complex layers of inequality. In the context of this study, the intersection of gender and disability significantly shapes the experiences of women with disabilities in accessing sexual and reproductive health (SRH) services. Women with disabilities face both gender-based discrimination, which limits their reproductive autonomy, and disability-related barriers, such as physical inaccessibility of healthcare services and negative societal attitudes towards their sexual and reproductive rights (Chireshe et al., 2021). This intersectional approach is critical for understanding the multifaceted barriers such as physical and social hindrances to access to SRHS as it moves beyond a single focus on disability or gender alone, and instead emphasizes how these factors combine to produce unique challenges.

Intersectionality theory offers a fundamental framework for examining how overlapping social identities like gender, disability, and socioeconomic status contribute to distinct experiences of discrimination and marginalization. In the context of Dombotombo Ward 2, Marondera, WWDs encounter multifaceted barriers in accessing SRH services. These challenges are not merely additive but are compounded through the intersection of their identities, leading to distinct forms of disadvantage.

Analysing the SRHS available to WWDs in this area necessitates an appreciation of how societal perceptions of disability and gender intersect. Cultural norms often stigmatize disability and perpetuate misconceptions about the sexuality of WWDs, viewing them as either asexual or hypersexual. Such stereotypes can lead to their exclusion from SRHS or the provision of inadequate services that do not address their specific needs. For instance, healthcare providers may lack training on disability-inclusive practices, resulting in environments that are physically inaccessible or attitudinally unwelcoming.

The challenges faced by WWDs in accessing SRHS are further exacerbated by systemic issues such as poverty and limited educational opportunities. Economic constraints can impede their ability to afford healthcare services or transportation to facilities. Additionally, a lack of tailored sexual education leaves WWDs uninformed about their reproductive rights and health options, increasing their vulnerability to exploitation and abuse. These intersecting factors create a complex web of obstacles that uniquely affect WWDs, differing significantly from the experiences of non-disabled women or men with disabilities.

In response to these challenges, WWDs often develop coping mechanisms that reflect their resilience and agency. Some may seek support from disability advocacy groups or form peer networks to share information and resources. Others might rely on self-education through available media, despite the risk of encountering misinformation. While these strategies demonstrate adaptability, they also highlight the systemic gaps in support and the pressing need for inclusive policies.

To improve access to SRHS for WWDs in Zimbabwe, it is imperative to adopt measures that address these intersecting forms of discrimination. This includes implementing comprehensive training programs for healthcare providers on disability and gender sensitivity, ensuring that facilities are physically accessible, and developing educational materials that are inclusive of all women. Policymakers must engage with WWDs to understand their specific needs and challenges, fostering an environment where their rights are recognized and upheld.

By applying an intersectional lens, this study will explore not only the individual impacts of disability and gender but also how other factors, like cultural stigma, poverty, and lack of resources, intersect to further restrict access to SRH services for women with disabilities in Marondera. This approach ensures a more comprehensive understanding of the barriers to SRH access and supports the development of targeted, holistic interventions.

2.3 Overview of SRHS for PWDs

Sexual and reproductive health is a basic human right that must be accessible to everyone, including individuals with disabilities. The SRH services available includes STI treatment and education on prevention, cancer screening and counselling, family planning services, maternal care and HIV/AIDS testing. Nonetheless, worldwide WWDs particularly experience exclusion from sexual and reproductive health information, services, and policies, compromising their autonomy and well-being.

Worldwide, the World Health Organization (WHO, 2011) and the United Nations Population Fund (UNFPA, 2018) have highlighted the necessity of guaranteeing fair access to sexual and reproductive health services for everyone, including persons with disabilities (PWDs). Nevertheless, empirical evidence reveals enduring disparities. Groce et al. (2011) discovered that women with disabilities in more than 30 countries were consistently less likely to obtain antenatal care or contraceptive services than their non-disabled counterparts. The World Report on Disability (WHO, 2011) emphasizes that physical, communication, and institutional obstacles greatly restrict access to services. Additionally, the UNFPA Global Study (2018) emphasizes that societal misconceptions, like the idea that individuals with disabilities are asexual or incapable of parenting, result in policy oversight and denial of services. This is especially concerning since PWDs face a higher risk of sexual assault and STIs, yet are seldom included in health initiatives or reproductive policies.

In the African setting, challenges are intensified by poverty, fragile health systems, and insufficient disability advocacy. Research conducted in South Africa by Hanass-Hancock et al. (2017) showed that women with disabilities faced stigma, restricted autonomy, and insufficient access to information in healthcare settings. The facilities were deficient in tactile resources, interpreters for sign language, or personnel equipped to meet their specific requirements. In Uganda, Chireshe, Rutondoki, and Ojwang (2010) found that individuals with disabilities faced restricted access to HIV/AIDS education, with some being outright denied services. Similarly, Groce and Trasi (2004) addressed the susceptibility of disabled women to sexual assault and the related obstacles to obtaining post-violence sexual and reproductive health services.

In Zimbabwe, even with legal backing like the Constitution of Zimbabwe Amendment (No. 20) Act (2013) and initiatives like the National SRHR Strategy (2022–2026), the actual experiences of women with disabilities frequently show signs of exclusion. Mutswanga (2017), noted that numerous healthcare employees display condescending attitudes towards WWDs, and institutions lack ramps, Braille signs, or private service areas. In rural regions, these obstacles are exacerbated by transport challenges and poverty. The Leonard Cheshire Disability, (2020) report regarding inclusive SRH programming in rural Zimbabwe revealed that merely 12% of health facilities had implemented significant infrastructural changes for clients with disabilities. Moreover, women experienced unfavourable interactions with healthcare providers who presupposed they were not sexually active or did not need SRH information. Crenshaw’s (1991), intersectionality framework posits that disability by itself does not entirely account for exclusion. Gender, economic status, and location also interact to influence access. A deaf woman living in a rural area may encounter challenges in communication, societal stigma regarding her sexuality, and financial constraints that hinder her ability to visit clinics. Yeo and Moore (2003) contend that SRH programs in developing nations often leave PWDs out of the design and implementation stages, sustaining their marginalization.

Consequently, services despite being technically available, are functionally unreachable for many WWDs. The impact of restricted access to SRH services is significant. Women with disabilities frequently face unplanned pregnancies, hazardous abortions, untreated sexually transmitted infections, and negative maternal outcomes. Insufficient education regarding consent and safe sex heightens their susceptibility to sexual exploitation and abuse. Chakanyuka, et al. (2020) recorded instances in Zimbabwe where inclusive pilot initiatives like disability-specific SRH outreach led by local NGOs enhanced knowledge and increased service utilization. ZimAble (2021) discovered that after community health workers underwent disability inclusion training, a greater number of WWDs utilized contraceptives and STI treatments, indicating that focused interventions can lower obstacles.

2.4 The SRHS available for WWDs

Globally, the rights of women with disabilities (WWDs) to obtain sexual and reproductive health (SRH) services are recognized by global frameworks like the Convention on the Rights of Persons with Disabilities (CRPD) and the International Conference on Population and Development (ICPD). The services available to women with disabilities includes contraceptive and family planning, pregnancy and maternal care, STIs and HIV/AIDS prevention and treatment and cancer screening and counselling. Even with this acknowledgment, WWDs frequently face major obstacles, such as physical inaccessibility, stigma, insufficient provider training, and the lack of inclusive policies (World Health Organization, 2021). High-income countries have seen certain advancements for example, Sweden has incorporated SRH services into its main health systems, making substantial adjustments to improve accessibility for individuals with disabilities, including assistive technologies and transportation options (WHO, 2021). However, even in middle-income settings such as India, access continues to be irregular. Research conducted by Human Rights Watch (2021) indicated that numerous WWDs in India face service denial and coercive practices, especially concerning contraception and sterilization, resulting from prevalent provider bias and societal stigma. These instances emphasize that although legal structures exist, the actual implementation of SRH rights for WWDs remains inconsistent worldwide.

In Africa, the difficulties are even more evident because of the overlapping problems of poverty, gender disparities, and inadequate healthcare systems. Despite the ratification of the CRPD by numerous African nations, there is frequently a gap between policy and its implementation (Moodley and Graham, 2020). In Kenya, the National Gender and Equality Commission (2016) indicated that women with disabilities are often overlooked in sexual and reproductive health policymaking, and service providers frequently fail to grasp their unique needs. However, interventions at the community level have demonstrated potential. The NGO

Women Challenged to Challenge has initiated peer education and advocacy initiatives to enhance awareness of SRH among women with disabilities, resulting in a higher rate of service utilization. South Africa presents a more organized policy framework, with the Integrated National Disability Strategy (INDS) advancing inclusive health service.

In Zimbabwe, women with disabilities encounter considerable obstacles in obtaining SRH services available, even with established policy promises. The nation has ratified the Convention on the Rights of Persons with Disabilities (CRPD) and implemented national strategies like the National Sexual and Reproductive Health and Rights (SRHR) Strategy II (2016–2020) and the National Disability Policy (2021), which both highlight inclusion and non-discrimination (Government of Zimbabwe, 2021). In Dombotombo ward 2, Marondera, the general population can access SRH services that include STI education and treatment, cancer screening, family planning, HIV testing and treatment, maternal and child health services (UNICEF Zimbabwe, 2020). However, the degree to which these services are available to WWDs is still restricted. Cheshire (2019), discovered that many healthcare facilities are missing ramps, adjustable beds, and sign language interpreters. Moreover, negative perceptions among healthcare professionals and the lack of disability-specific sexual and reproductive health information contribute to additional levels of exclusion. A case study conducted by UNICEF (2020) in Mutasa District tested the incorporation of SRHR messages into community-oriented disability services. The intervention, involving trained community health workers, successfully provided customized SRHR information to WWDs, leading to a slight rise in knowledge and service usage. Likewise, Cheshire (2019), noted that peer support networks for WWDs in cities improved their understanding and self-assurance in utilizing services. These studies suggest that although national policies are forward-thinking, their execution presents a notable difficulty. Zimbabwe's health system is deficient in infrastructure, training, and inclusive communication strategies necessary for fair SRH service provision to WWDs.

2.5 The challenges faced by WWDs in accessing SRHS

Access to sexual and reproductive health services is a basic human right acknowledged in multiple international frameworks, like the Convention on the Rights of Persons with Disabilities (CRPD) and the Sustainable Development Goals (SDGs). Even with these worldwide commitments, women with disabilities still encounter systemic obstacles in obtaining SRH services. These difficulties are particularly evident in third world countries, where healthcare systems frequently lack the infrastructure, capacity, and inclusive policies required for guaranteeing fair access.

Globally, women with disabilities face many obstacles in obtaining SRH services. These difficulties encompass the physical unavailability of healthcare facilities, obstacles in communication, restricted access to information, economic barriers and prejudices from healthcare providers. The World Health Organization, (2021) highlights women with disabilities as a group significantly impacted by exclusion from sexual and reproductive health services due to structural and attitudinal obstacles. For example, in India, Human Rights Watch (2021), highlighted that healthcare professionals frequently hold baseless beliefs about the sexual orientation and reproductive wishes of women with disabilities. Numerous women have been refused access to SRH information and have undergone forced sterilizations, underscoring the seriousness of rights abuses. Likewise, in Canada, Ignagni et al. (2019) discovered that women with intellectual disabilities encountered difficulties in comprehending SRH information because of the absence of simplified communication strategies and inclusive health care systems. Despite advancements in certain high-income nations, prevalent negative perceptions and inadequate training for healthcare professionals continue worldwide, leading to the systemic disregard for the sexual and reproductive health requirements of women with disabilities.

In Africa, women with disabilities encounter multiple difficulties stemming from overlapping issues like poverty, gender disparity, and inadequate healthcare systems. Although numerous African countries have ratified the CRPD and created national disability strategies, the implementation is lacking, with limited incorporation of disability rights into mainstream SRH programs (Moodley and Graham, 2020). In Kenya, the National Gender and Equality Commission (2016) reported considerable exclusion of women with disabilities from sexual and reproductive health campaigns and services. Numerous individuals indicated that they depended on family for interpretation or physical support in healthcare appointments, which raised worries about privacy, dignity, and autonomy. Moreover, the stigma linked to disability makes women less likely to pursue these services. In Nigeria, Olawale et al. (2020) discovered that WWDs faced not only barriers to accessible infrastructure but also biased treatment from healthcare providers. Women who had physical and sensory disabilities were frequently viewed as asexual or unsuitable for parenting, leading to inadequate or denied healthcare. Although various community-driven efforts have sought to bridge the divide, such as peer education and outreach initiatives, the larger systemic obstacles persist within many African healthcare systems.

Zimbabwe has undertaken significant initiatives to enhance disability inclusion via policy. The National Disability Policy (2021) and National Sexual and Reproductive Health and Rights Strategy II (2016–2020) highlight the significance of fair access to health services, particularly for WWDs. Nonetheless, these pledges frequently fail during the execution phase. The majority of health facilities in Zimbabwe are not physically reachable for WWDs. Numerous healthcare facilities, including clinics and hospitals, are deficient in essential amenities like ramps, accessible restrooms, adjustable exam tables, and visual and hearing support tools (Cheshire, 2019).

Communication barriers also significantly affect the ability of women with disabilities to access sexual and reproductive health services. For those with hearing impairments, the unavailability of sign language interpreters or other communication aids in healthcare settings can hinder their understanding of health needs or prevent them from receiving necessary information (Chidzingwa, 2023). Similarly, women with visual impairments may lack access to written materials in accessible formats, like braille or large print, which limits their ability to obtain critical health information. This absence of accessible communication leaves many women with disabilities uninformed about their sexual and reproductive rights and available healthcare options. A study by McFadden et al. (2020) highlights that women with disabilities often report being unable to access information about contraception, maternal health, or sexual rights due to these communication barriers.

The economic barriers encountered by WWDs are widespread and deeply ingrained, presenting significant barriers to accessing essential sexual and reproductive health services. These women often experience a cycle of financial exclusion, primarily due to limited access to education and employment opportunities, which severely restricts their ability to participate fully in the economy. As Khabisi (2020), noted that the lack of job opportunities and educational access results in many women with disabilities being relegated to irregular or minimal income sources, leaving them financially vulnerable. This economic exclusion directly impacts their ability to afford necessary healthcare services, including SRHS, exacerbating their marginalization and poor health outcomes.

Negative provider attitudes further hinder access. Women with disabilities are frequently subjected to intimidation and discrimination in healthcare settings (UNICEF Zimbabwe, 2020).

These attitudes reflect deep-rooted societal beliefs that question the sexual agency and reproductive rights of WWDs. A pilot project by UNICEF in Mutasa District demonstrated that training community health workers to deliver SRHR messages to WWDs improved awareness and confidence among women (UNICEF Zimbabwe, 2020). However, the project also highlighted the need for broader systemic changes, such as accessible infrastructure, consistent provider training, and targeted outreach in both urban and rural areas.

2.6 The coping mechanisms adopted by WWDs in relation to challenges of SRHS

Even with considerable obstacles in obtaining sexual and reproductive health services, women with disabilities show resilience and empowerment through diverse coping methods. These mechanisms differ across geographic, social, and economic settings, frequently shaped by the presence (or absence) of supportive systems, cultural values, and the degree of marginalization faced.

Worldwide, WWDs have implemented various strategies to manage health systems that frequently lack the ability to meet their needs. In high-income nations, coping is often more structured, with increased dependence on advocacy, technology, and legal frameworks. A key coping strategy is self-advocacy, in which WWDs claim their entitlements to obtain health services in accordance with international agreements like the Convention on the Rights of Persons with Disabilities (CRPD). In Australia, women with intellectual disabilities frequently work alongside advocacy organizations and disability support professionals who help them get ready for and go to health appointments (Dowse et al., 2016). Additionally, Mitra et al. (2017) discovered that in the United States, women with physical disabilities engage in online health communities to obtain SRH information, exchange experiences, and look for suggestions for inclusive healthcare practitioners. These platforms provide confidentiality, minimize stigma exposure, and assist users in overcoming geographic and communication obstacles. In nations such as Canada and Sweden, some WWDs interact with healthcare systems by looking for care from recognized “disability-friendly” providers. This targeted involvement reduces bias and improves ease and privacy during consultations (Ignagni et al., 2019).

In sub-Saharan Africa, coping mechanisms tend to be more community-cantered and informal because of constrained health services and increased stigma. Among WWDs in Africa, peer education and informal knowledge exchange are commonly utilized approaches. In Kenya, groups like Women Challenged to Challenge promote peer-to-peer learning, educating WWDs to share SRH information and assist others in finding services (National Gender and Equality

Commission, 2016). These peer networks also offer emotional assistance and help alleviate feelings of loneliness. The use of Community Health Workers (CHWs) is crucial, as they act as important links between women with disabilities and established healthcare systems. In rural Nigeria and Uganda, community health workers educated in disability inclusion support women with disabilities by guiding them to clinics, interpreting information, or providing services at their homes (Olawale et al., 2020). This assistance has shown to be especially useful in regions where public transportation and healthcare facilities are insufficient. Engaging strategically with health systems is crucial, as women with disabilities frequently choose how they interact with healthcare, preferring certain providers or attending clinics during less busy times to minimize wait times and limit interactions with discriminatory personnel. In Nigeria, certain WWDs have established unofficial connections with reliable nurses and health practitioners who offer more dignified care (Olawale et al., 2020). Furthermore, depending on caregivers and family members is typical. Although this might affect privacy, certain WWDs rely on family or caregivers for help in obtaining sexual and reproductive health services, such as transportation, communication, and physical support. This dependence frequently leads to diminished autonomy and restricted confidentiality (WHO, 2021).

In Zimbabwe, the strategies for coping mirror the wider social and health system limitations impacting WWDs. These approaches emphasize both ingenuity and the constraints caused by systemic exclusion. One particular coping mechanism, although harmful, is avoidance. Concerns about discrimination, shame, or lack of physical access frequently cause certain women to skip necessary SRH services entirely, unless they are severely ill. This passive coping strategy highlights the degree of exclusion faced within the healthcare system (Chireshe, 2013). A key coping method for urban and rural WWDs is engaging in peer support groups and exchanging information. These casual groups create an environment for women to exchange experiences, find inclusive service providers, and motivate each other to pursue care. Cheshire (2019), indicated that these groups help establish networks linking WWDs with healthcare professionals educated in disability inclusion. Finally, employing traditional medicine serves as another method of coping. Worldwide, numerous women with disabilities seek alternative healthcare solutions because formal healthcare services are insufficient or hard to access. These options traditional healers, herbalists, and community health workers frequently become crucial care providers when formal systems do not satisfy the needs of women. The World Health Organization (2021) states that in certain developing nations, particularly in rural and underserved regions, traditional medicine constitutes the foundation of primary healthcare, representing as much as 80% of services. Women with disabilities in Zimbabwe are driving self-advocacy and assertiveness initiatives to promote policy reform and inclusion. Organizations such as the Zimbabwe National Association of the Deaf (ZNAD) and the Disability Amalgamation Community Trust (DACT) advocate for empowerment via rights-oriented education, confronting stigma and insisting on accountability.

2.7 Possible measures that can be adopted to improve access to SRH services

At global level, international organisations like WHO, UNFPA and UNCRPD must continue to advocate for inclusive SRH services through global frameworks, funding and technical assistance. International donor agencies should prioritise inclusive programming, requiring that all funded SRH projects demonstrate how they will address the needs of WWDs. Global partnership are also important such as Partnership for Maternal, Newborn and Child Health can promote best practices and facilitate knowledge sharing between countries. Educating and sensitizing healthcare professionals is another crucial strategy, as the training of providers is vital for diminishing stigma and improving proficiency. In the United Kingdom, the National Health Service (NHS) incorporates disability awareness into the training curriculum for sexual and reproductive health (SRH) providers. This has resulted in improved attitudes among providers and an increase in service uptake by women with disabilities (Mitra et al., 2017). In Sweden and Norway, there have been initiatives to make information and communication accessible, ensuring that WWDs can obtain SRH information in suitable formats. Materials are created in Braille, sign language, and easy-to-read formats for people with intellectual disabilities (UNFPA, 2018). Assistive technologies have become a solution in the United States, where digital health platforms provide accessible telehealth services for WWDs. These platforms typically feature compatibility with screen readers and offer live sign language interpretation (Mitra et al., 2017). Infrastructure enhancement is also another important measure as it allows women with different disabilities access. For example, in Sweden, healthcare services have been restructured to promote universal design, health facilities are physical accessible the offer sign language and others mentioned above.

In Africa, even though structural and social barriers are still widespread, certain countries have made strides in promoting disability-inclusive SRH services. Community health workers and mobile clinics are one option to improve access to SRH services for WWDs. In Uganda, the Reproductive Health Uganda (RHU) program equips community health workers to provide SRH services directly to WWDs living in rural regions. These workers utilize bicycles and contraceptive kits, and they also offer referrals to accessible health facilities (RHU, 2020). In

Nigeria, mobile clinics provide focused outreach services to remote communities for WWDs. These clinics frequently guarantee confidentiality, lessen travel challenges, and provide peer instruction (Olawale et al., 2020). In Kenya, efforts to promote disability-inclusive SRH education and advocacy are underway, with the organization Women Challenged to Challenge collaborating with the Ministry of Health to deliver peer-led SRH education for women with disabilities. Campaigns for advocacy that focus on communities and service providers seek to diminish stigma while augmenting the demand for services (National Gender and Equality Commission, 2016). The incorporation of disability into national policies is another important step in Africa. In South Africa, the White Paper on the Rights of Persons with Disabilities (2016) clearly states the need to incorporate WWDs in all healthcare strategies, including sexual and reproductive health. The incorporation of disability rights into national health strategies has established a basis for more inclusive practices (Moodley and Graham 2020).

Zimbabwe has made progress in policy, but the actual execution is still irregular. Nonetheless, new interventions indicate potential remedies. These actions encompass mobile health units, training of healthcare personnel, enhancement of infrastructure, and reform of national policies. The National Disability Policy (2021) and SRHR Strategy II (2016–2020) acknowledge the SRH rights for individuals with disabilities. These frameworks promote inclusive services, training for providers, and accessible infrastructure. However, financial and institutional limitations restrict enforcement and monitoring (Government of Zimbabwe, 2021). Non-profit organizations have led the way in providing inclusive sexual and reproductive health services. Plan International Zimbabwe and Leonard Cheshire have initiated pilot programs for disability-inclusive SRH services in areas like Mutasa and Epworth. Their actions involve training healthcare providers, creating accessible information, education, and communication (IEC) materials, and providing transport subsidies for women with disabilities (Cheshire, 2019). Peer educators, frequently women with disabilities, are engaged to provide SRH education in urban and rural areas. These teachers assist in decreasing stigma and raising awareness, especially among disabled adolescent girls. In Chitungwiza, a community-driven SRH peer education model effectively raised contraceptive use and clarified misconceptions regarding the sexuality of WWDs (UNICEF Zimbabwe, 2020).

Upgrades to infrastructure, like ramps, wider doorways, accessible restrooms, tactile signs, and adjustable exam tables, enable WWDs to visit clinics and hospitals with dignity and autonomy. In certain urban clinics located in Harare and Bulawayo, modifications like ramps, adjustable beds, and accessible restrooms have been implemented to serve women with physical disabilities. Although these initiatives are still small in scope, they showcase encouraging examples for wider adoption (Chireshe, 2013). Physical infrastructure plays a vital role in maintaining bodily integrity and enabling agency. A 2021 audit by the Zimbabwean National Association of Societies for the Care of the Handicapped (ZNASCH) revealed that fewer than 30% of public health institutions in Mashonaland East met basic accessibility standards. The lack of infrastructure, such as handrails, ramps, and wheelchairs, led many WWDs to avoid visiting clinics altogether. Inclusive infrastructure thus addresses not only mobility but also dignity and visibility. Therefore, improving infrastructure is essential as helps to accommodate everyone with different disabilities.

2.8 Legal and Policy Frameworks

Worldwide, the safeguarding and advancement of the rights of individuals with disabilities are established in various essential international legal frameworks and development initiatives. The most crucial is the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which was adopted in 2006 and ratified by Zimbabwe in 2013. The UNCRPD signifies a fundamental change from perceiving individuals with disabilities as recipients of charity to recognizing them as holders of rights. It requires state parties to guarantee equal access to healthcare (Article 25), covering SRH services, while fostering accessibility, participation, and autonomy. Notably, the convention highlights the importance of respecting the developing abilities of women with disabilities and their entitlement to make choices concerning their health and family matters. The World Health Organization (WHO) enhances this framework with actionable guidelines and worldwide monitoring instruments. The World Report on Disability (2011), created in partnership with the World Bank, offers policy suggestions to improve health service delivery, focusing on inclusive systems, universal design, and capacity building. The WHO's Ensuring Human Rights in the Provision of Contraceptive Information and Services, Guidance and Recommendations (2015), emphasizes the importance of providing non-discriminatory services for marginalized populations, such as women with disabilities.

Moreover, the 2030 Agenda for Sustainable Development offers a global framework that implicitly encompasses individuals with disabilities through the Sustainable Development Goals (SDGs). Goal 3 (Good Health and Well-being) and Goal 5 (Gender Equality) hold significant importance. The SDGs promote universal healthcare and access to SRH services, emphasizing the significance of inclusion and intersectionality in worldwide development.

In Africa, the African Union (AU) has made notable progress in integrating disability rights via legal and policy frameworks. The Protocol to the African Charter on Human and Peoples' Rights concerning the Rights of Persons with Disabilities in Africa, ratified in 2018, acknowledges the rights of individuals with disabilities to access education, healthcare, and safeguard against violence and discrimination. It draws on the African Charter on Human and Peoples' Rights and motivates member states to implement and uphold national laws that include disability provisions. Additionally, the African Decade of Persons with Disabilities (1999–2009, extended to 2019) and its associated Continental Plan of Action highlighted the importance of data gathering, awareness initiatives, policy alignment, and institutional changes to incorporate disability across all development sectors. Although these frameworks acknowledge women with disabilities as an especially vulnerable population, their implementation has varied by country. The Maputo Protocol (2003), officially referred to as the Protocol to the African Charter on Human and Peoples' Rights regarding Women's Rights in Africa, guarantees women's rights to autonomy, sexual and reproductive health, and protection from coercion. While it does not directly mention disability, it has been utilized to promote inclusive interpretations that consider the needs of women with disabilities.

Zimbabwe has achieved certain advancements in aligning its national regulations with global benchmarks. The 2013 Constitution of Zimbabwe is seen as progressive for acknowledging and safeguarding the rights of individuals with disabilities. Section 83 details the obligations of the State to offer support services, infrastructure, and legal safeguards essential for individuals with disabilities to live with dignity. Nonetheless, the Constitution currently lacks a definitive requirement or enforcement method to guarantee access to SRH services for women with disabilities.

The Disabled Persons Act (1992), continues to be the primary legislation overseeing disability rights in Zimbabwe. Although it was a ground breaking law when it was passed, it is currently often criticized for being obsolete and misaligned with the UNCRPD. There are no clear mentions of sexual and reproductive rights, gender-based violence, or assistance programs for women with disabilities. To address legislative shortcomings, Zimbabwe implemented the National Disability Policy (2021), which utilizes a human rights-oriented framework. It acknowledges various and overlapping types of discrimination and promotes the inclusion of individuals with disabilities in every sector. This policy clearly encourages access to SRH for individuals with disabilities and aims to remove stigma, systemic obstacles, and information deficits. Additionally, the National Sexual and Reproductive Health and Rights Strategy

(2022–2026) offers a broader perspective on SRHR, recognizing individuals with disabilities as a key priority group. It encompasses pledges for disability-aware service provision, training for health personnel, and accessible communication resources. The effectiveness of these frameworks relies on strong execution, financial support, and oversight. In reality, nonetheless, important gaps persist. Research, including work by Mutswanga (2017), and the Zimbabwe Human Rights NGO Forum (2020), shows that even with constitutional safeguards and national plans, women with disabilities persistently encounter significant discrimination, unattainable physical environments, and negative attitudes in healthcare settings. Healthcare personnel frequently receive insufficient training on including disabilities, and health information is seldom provided in accessible formats like Braille, sign language, or plain language. Even with robust international and national policy frameworks in place, achieving these rights poses difficulties due to multiple intersecting factors such as insufficient enforcement, constrained budgetary support, societal attitudes, lack of data, and geographic disparities.

2.9 Literature gap

Despite growing global recognition of SRH health rights of persons with disabilities, substantial knowledge gaps persist particularly in low and mid-income countries such as Zimbabwe. This section outlines critical gaps in the existing literature review.

Lack of localized, community-specific research, most of the existing literature on WWDs' access to SRH services in Zimbabwe is national-level or urban-focused. There is very limited research focused on semi-urban or rural wards such as Dombotombo Ward 2 in Marondera, despite evidence that geographic context significantly affects accessibility. This study fills this gap by providing place-specific insights into the barriers and lived realities of WWDs in this particular ward.

Minimal engagement with the lived experiences of WWDs, much of the literature is quantitative and lacks depth in understanding the subjective experiences of WWDs. There is a gap in qualitative, phenomenological research that explores how WWDs themselves perceive and navigate access to SRH services. This study, rooted in the interpretative paradigm and IPA methodology, contributes unique, experience-driven evidence to the discourse.

Inadequate representation of coping mechanisms, while some studies identify barriers, few investigate how WWDs cope with these barriers. For instance, the use of traditional medicine, peer support, or self-advocacy remains underexplored in Zimbabwean SRH literature. This study addresses this by explicitly examining the coping mechanisms adopted by WWDs.

Limited focus on attitudinal and institutional discrimination, although discrimination by healthcare workers is acknowledged, attitudinal barriers are often generalized. This study provides specific, contextual examples of health worker attitudes in Marondera, contributing to more actionable policy and training recommendations.

Absence of disability-inclusive policy evaluation, Zimbabwe is a signatory to the UN CRPD, yet there is limited evaluation of how national policies translate into practice at local health institutions. This study helps bridge this gap by assessing implementation realities of disability-inclusive policies at the ward level.

Insufficient data on SRH services utilization among WWDs, there is limited disaggregated data showing how many WWDs actually use SRH services and why utilization remains low. This study adds qualitative depth by examining enabling and deterring factors related to service usage.

Little attention to community and health system integration, few studies explore how health systems and community structures can jointly facilitate access to SRH for WWDs. This study, by considering possible measures such as mobile clinics and healthcare worker training, contributes to building a community-informed, system-level response.

2.10 CHAPTER SUMMARY

The literature indicates that WWDs in Zimbabwe, particularly in peri-urban areas like Dombotombo, face significant barriers in accessing sexual and SRH services. These barriers include physical, economic, communication, and informational challenges that limit their ability to obtain essential care. However, WWDs often develop coping mechanisms such as reliance on alternative healthcare providers or social support networks. To improve access to SRHS for women with disabilities, both local and national interventions are needed, including improved healthcare infrastructure, greater awareness and education, and policy enforcement. This literature review provides a foundation for addressing these challenges and offering recommendations that can enhance the sexual and reproductive health of women with disabilities in Dombotombo and other rural areas in Zimbabwe.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology refers to the systematic, theoretical analysis of the procedures functional to a field of study. Therefore, the objective of this section is to give the work plan of study. The chapter gives an outline of the research philosophy, research approach, research design, study setting, study population, sampling procedures, sample, data collection instruments, inclusion and exclusion criteria, trustworthy of the study, data analysis, ethical considerations, study limitations and chapter summary.

3.2 RESEARCH PHILOSOPHY

This study is based on an interpretative research theory, which holds that reality is socially produced rather than fixed, and that individuals' lived experiences and viewpoints provide the greatest understanding. In accordance with Creswell & Creswell (2018), who define research philosophies as "worldviews that guide the research process, from design to methods and interpretation," this study uses a worldview that acknowledges the subjective and contextual nature of knowledge. Given the emphasis on women with disabilities (WWDs) and their access to sexual and reproductive health (SRH) services in Zimbabwe, an interpretative approach seemed the best fit. It allows for a thorough examination of how these women make sense of their circumstances, which are influenced by both personal experiences and larger social and cultural systems.

The research is also influenced by constructivist and feminist epistemologies, which emphasize the need of prioritizing disadvantaged perspectives and co-creating knowledge between researchers and participants. Women with disabilities have a distinct social position at the confluence of gender and disability, and their interactions with SRH services are shaped by systemic exclusion, cultural norms, and unequal power dynamics. This research is based on the concept that truth is not singular or universal, but rather multifaceted and subtle, influenced by people's interactions with their surroundings and social settings.

In addition, the study uses intersectionality theory as a framework to investigate how overlapping identities, such as gender, disability, socioeconomic status, and rural residency, interact to form WWDs' SRH experiences. This viewpoint allowed the researchers to identify the multiple and interrelated kinds of prejudice that these women confront, rather than interpreting their issues in a one-dimensional manner.

In line with this philosophical attitude, the study used qualitative methodologies to deeply interact with participants' stories, viewpoints, and interpretations. The goal was not to obtain generalizable conclusions, but rather to gain a thorough, empathic understanding of how WWDs traverse the SRH terrain in their respective situations. Throughout the study process, ethical issues such as informed consent, respect for autonomy, and open communication were stressed to keep participants' rights, dignity, and lived experiences at the forefront of the investigation.

3.3 RESEARCH APPROACH

Creswell (2014), defined a research approach as the plans and procedures for a study, encompassing everything from broad assumptions to the detailed methods of data collection, analysis, and interpretation. In this study, the researcher used a qualitative research approach, which was particularly suitable for exploring the nuanced and complex experiences of WWDs in accessing SRH services in Marondera District. Qualitative research involves collecting and analysing non-numerical data such as texts, audios, or videos to understand concepts, opinions, and lived personal experiences (Saunders, 2021). It provides an in-depth exploration of a research problem, allowing for a detailed understanding of the experiences of women with disabilities in accessing SRHS (Bhandari, 2024). This approach is well-suited for the objectives of this study, as it enabled the researcher to gain rich insights into the lived experiences of women with disabilities, their perspectives on accessing SRH services, and the challenges they encountered in a context-specific manner (Saunders, 2021).

The qualitative approach was particularly valuable in this research because it allowed the researcher to explore the personal and subjective experiences of participants in ways that quantitative methods cannot (Creswell, 2021). By using techniques such as semi-structured interviews and focus groups, the researcher was able to capture the individual stories of women with disabilities, providing a deeper understanding of the barriers they face in seeking SRH services (Bhandari, 2024). This approach enabled participants to express their experiences in their own words, revealing the social, cultural, and institutional factors that shape their access to healthcare services (Creswell, 2014). Furthermore, qualitative research is particularly effective in exploring the intersectionality of gender, disability, and socio-economic status, as it helps uncover the complex, layered realities that influence the experiences of women with disabilities in Marondera. Through the use of qualitative methods, this study was able to generate new ideas and inform future policies and interventions aimed at improving SRH services for women with disabilities. The insights gained from this approach was able to provide a comprehensive, context-specific understanding that is essential for designing more inclusive and effective healthcare strategies (Bhandari, 2024).

3.4 RESEARCH DESIGN

According to Creswell (2014), a research design is a plan for collecting, analysing, and interpreting data, which guides the entire research process from formulating research questions to drawing conclusions. This study adopted an interpretative phenomenological research design, a qualitative approach aimed at exploring individuals’ lived experiences and understanding the meaning of those experiences. Interpretative phenomenological research design involves a systematic and detailed investigation of participants' subjective perspectives, allowing researchers to gain in-depth insights into a phenomenon from the participants’ own point of view (Patton, 2022). This design is particularly valuable for studying complex and multifaceted phenomena, such as the experiences of women with disabilities in Dombotombo ward 2, Marondera, who face barriers in accessing SRH services. An interpretative phenomenological approach was well-suited to this study because it focuses on the personal, lived experiences of women with disabilities, providing a deeper understanding of the challenges they face, which quantitative methods may overlooked. Interpretative phenomenology make use of open ended questions, detailed interviews to allow participants to freely express their experiences. It allows the researcher to suspend his own assumption and biases about the phenomena to allow the participant to be fully captured without distortion. By utilized this research design, the study uncovered the nuances and complexities of these women’s experiences, such as the intersection of gender, disability, and socio-economic factors, allowing for a comprehensive understanding of the barriers to SRH access. This approach provided an opportunity to explore the participants' perceptions in their own terms, offering insights that are crucial for designing more inclusive and effective healthcare strategies (Bhandari, 2024).

3.5 STUDY SETTING

The research setting refers to the location where data was collected (Creswell, 2021). In social science research, effectively contextualizing the research problem within its setting is essential, as it allows for a deeper understanding of the social, environmental, and cultural factors that influence participants' experiences (Creswell, 2020). For this study, was collected in the Dombotombo ward 2, situated in Marondera Urban District, Mashonaland East Province, approximately 85 kilometres from Harare, and the capital city of Zimbabwe. Dombotombo, as the first urban settlement in Marondera, is characterized by high population density and diverse housing structures, including high-rise flats. This setting is chosen because it houses a substantial number of women with disabilities (ZIMSTAT (2022, *.p106*). There are 14,021, women with disability in Mashonaland East province who face compounded barriers to accessing sexual and reproductive health (SRH) services due to both physical and socio-economic challenges (Chireshe et al., 2021).

This study is also the first to focus on the experiences of women with disabilities in accessing SRH services within Marondera, making it a crucial area of investigation in which inferences can be made to the nation at large. The combination of geographic distance, socio-economic factors, and limited access to healthcare services in this urban setting provides a unique opportunity to explore how these women navigate their sexual and reproductive health needs (Bhandari, 2024). The Dombotombo area, thus, offers an ideal context for this research, as it represents a marginalized community that is under-researched, despite its complex urban dynamics and significant challenges. By focusing on this site, the study was able to contribute valuable insights into the intersection of disability, gender, and access to healthcare, which informed future interventions and policies aimed at improving SRH services for women with disabilities in urban areas (Patel et al., 2023). This approach is consistent with the understanding that selecting an appropriate research setting is crucial for uncovering the specific challenges faced by marginalized groups, enabling a more comprehensive and context-specific exploration of social issues (Bhandari, 2024).

3.6 TARGET POPULATION

According to Creswell (2012), is a collection of people who share defining traits that the study can recognize and examine. The study targeted women with disabilities between the age of 18 and 49 years residing in Marondera Urban District, Dombotombo as they are the primary beneficiaries of SHR services. The target population for this study was consist of women with disabilities, caregivers who live with the WWDs and professionals who work with WWDs directly involved in or affected by the provision and access to SRH services for women with disabilities. Women with disabilities provided first-hand insights into the barriers and challenges they face in accessing such services. Caregivers who offer support to these women also formed a critical part of the target population, as they played a vital role in facilitating access to healthcare and shared their experiences and observations. Healthcare professionals including nurses, doctors, and other community health volunteers working in SRH services.

Additionally, professionals from the Department of Social Development and other related governmental or non-governmental organizations promoting access to healthcare services were able to help. These informants were able to offer valuable insights into policies, programs, and interventions aimed at supporting women with disabilities. Their input helped contextualize the findings within broader structural and institutional frameworks, providing a comprehensive understanding of the challenges and opportunities in addressing SRH access for women with disabilities.

3.7 SAMPLING TECHNIQUES

A sampling technique refers to the method used to select a subset of individuals or units from a larger population for inclusion in a research study (Creswell, 2014). For this study, purposive sampling technique was used.

3.7.1 Purposive sampling

Purposive sampling involves selecting participants based on specific criteria relevant to the research question (Creswell, 2021). It was used to select primary informants, caregivers and key informants who had direct experiences SRH services in Dombotombo ward 2, Marondera. As a researcher with prior field experience in the area through his work with the DSD, he managed to established familiarity with the households of many WWDs during previous community outreach and registration activities for the cash transfer programme where PWDs were identified as a key vulnerable group. The prior engagement facilitated rapport building and access allowing the researcher to conduct door to door visits to identify eligible participants. This type of purposive sampling is called opportunistic purposive sampling where the researcher leveraged his existing knowledge and relationship from the prior work. One key importance of purposive sampling is, it allows for a more targeted selection of participants, ensuring that the sample is relevant to the study’s goals, which can lead to deeper insights into the specific challenges faced by this group (Bhandari, 2024). Purposive sampling enabled the researcher to focus on individuals who possess the qualities needed to address the research questions, thereby facilitating more meaningful and context-specific findings. It allowed the researcher to gain detailed knowledge about a specific phenomenon rather than make statistical inferences, or where the population is very small and specific. This sampling technique was appropriate because it consider ethical considerations that is allowed for respect and sensitive engagement with participants, avoiding undue intrusion or stigma.

3.8 INCLUSION AND EXCLUSION CRITERIA

Inclusion and exclusion criteria are essential components of a well-designed study, serving to define the features of participants who are eligible to participate and those who are not. These criteria help to clinch the relevance, reliability, and validity of the study findings by focusing on participants who can provide meaningful insights into the research problem (Patino and Ferreira, 2018).

3.8.1 Inclusion criteria

Inclusive criteria are specific characteristics or attributes that participants must have to be eligible for the study. These criteria help to ensure that the study population reflects the research questions and is appropriate for the study’s objectives (Friedman et al., 2010). The researcher used age group, caregivers and gender to select the participants who were included in this study. The study focused on three key participant groups: women with disabilities aged 18-49 years residing in Dombotombo ward 2, Marondera, caregivers currently providing support to women with disabilities, and healthcare professionals involved in accessing SRH services.

Participants were selected based on specific inclusion criteria to ensure they can provide relevant and insightful information. Women with disabilities who have at one point in time have accessed SRH services. Caregivers were selected who have been involved with a woman with a disability concerning access to SRH services. Healthcare professionals were included who have been actively been involved in offering SRH services to WWDs in a healthcare setting, ensuring they possess the necessary knowledge about the barriers these women encounter in seeking SRH services. All participants were required to provide informed consent, ensuring they are fully aware of the study's purpose and their right to confidentiality.

The selection criteria are designed to ensure that participants can offer diverse perspectives and in-depth insights into the barriers women with disabilities face when accessing SRH services. By including women with disabilities, caregivers, and healthcare professionals, the study aims to capture a comprehensive understanding of the challenges and experiences from multiple viewpoints. This approach facilitated the identification of specific obstacles and inform the development of actionable recommendations to improve inclusivity and accessibility in SRH service provision.

Informed consent is a key ethical tenet in research that ensures participants willingly agree to participate after fully understanding the study's goal, procedures, and potential outcomes. It is essential that participants comprehend who is conducting the research, the goal of the research, what data was collected, how the results were used, and their rights, including the right to withdraw at any time without consequence. This process upholds the ethical standards of the study and protects the rights and well-being of all participants.

3.8.2 Exclusion criteria

It refers to specific characteristics or conditions that would disqualify a potential participant from being included in a study. In order to maintain the focus and relevance of the study, certain participant groups were excluded. Women under 18 years or over 49 years of age were excluded, as the research specifically aims to examine the experiences of women aged 18-49 who face barriers in accessing SRH services. Caregivers who do not have experience supporting a women with a disability in accessing SRH services were excluded, as their insights would not provide the necessary context for understanding the challenges women with disabilities face in this area. Healthcare professionals who do not work directly work with women with disabilities or do not have experience in SRH services were excluded, as their lack of relevant experience would limit their ability to provide valuable perspectives on this study. Additionally, participants who are unable or unwilling to communicate their experiences or opinions regarding SRH services were excluded, as their inability to express their views would hinder the data collection process. These exclusions are necessary to ensure that the study focuses on individuals who can provide relevant, informed, and meaningful contributions to understanding the barriers WWDs encounter in accessing SRH services.

3.9 SAMPLE SIZE

The sample is the group of individuals who will actually participate in the research (McCombes, 2023). The total sample size for the present study were 14 WWDs in Dombotombo ward 2. This sample was achieved once the researcher came to a point where no new topics were emerging from the data collection process (Saunders, 2018). The researcher recruited participants who were willing to participate in the current study and 4 key informants from Department of Social Development, National Aids Council and Nurses from Dombotombo clinic who worked with WWDs and also 4 Caregivers who cares and lives with WWDs. The overall number of research participants was determined by the sampling technique used. Thus, through the opportunistic sampling technique, only 14 WWDs indicated were comfortable to take part in the study.

3.10 DATA COLLECTION METHODS

Data collection methods are techniques used to gather data systematically and consistently during the research process. These techniques are designed to capture specific types of information, measure relevant variables, and align with the study's objectives to ensure the validity and reliability of findings (Bryman, 2021). Data was collected to women with disabilities experiencing challenges in accessing SRH services, also caregivers who live with women with disabilities and key informants who work with women with disabilities. In this study, semi-structured interview and focus group discussion was employed as primary data collection tools.

3.10.1 Semi-Structured Interviews

Semi-structured interview are data collection method that involves asking participants a set of open-ended questions and following them up with probe questions to explore further their response (Creswell, 2013). This was used to collect data from women with disabilities, their caregivers and healthcare professionals. Semi-structured interview allowed for a blend of structure and flexibility by providing a framework of open-ended questions tailored to explore themes central to the research objectives. These enabled researcher to probe deeper into participant responses, fostering a comprehensive understanding of individual experiences (Kallio et al., 2016). Open-ended questions also encouraged participants to share their perspectives freely, making them especially suitable for exploring complex and sensitive topics. This method was structured to stimulate interactive discussions among participants, creating an environment that encourages the sharing of diverse viewpoints and experiences (Morgan, 2020). The prompts in this method is designed to address the research themes while fostering dialogue, making focus groups a valuable method for understanding communal insights and social contexts (Braun and Clarke, 2021).

3.10.2 Focus Group Discussions

FGDs are a qualitative research method that involves guided discussions among a small group of participants who share common characteristics or experiences relevant to the research topic (Creswell, 2013). In this study, focus group discussions was employed to gain in-depth insights into the experiences of women with disabilities in accessing sexual and reproductive health services in Dombotombo ward 2, Marondera. This approach is particularly effective for exploring participants' attitudes, perceptions, and experiences in a social context, allowing researcher to observe group dynamics and the range of opinions within the group (Saunders, 2022).

The use of FGDs in this study enabled the researcher to facilitate interactive discussions, motivating participants to portion their thoughts and experiences openly. This method was advantageous for exploring complex issues, as it allowed for the collection of diverse perspectives in a relatively short period. Additionally, the group setting was stimulated memories and ideas that WWDs might not recall in one-on-one interviews, providing a richer understanding of the topic under investigation (Creswell, 2024).

To ensure the effectiveness of the FGDs, a skilled moderator guided the discussions, keeping them focused on the research questions while allowing for natural conversation. The moderator created a comfortable environment where participants feel valued and heard, which was crucial for obtaining honest and detailed responses (Hicks, 2020). The data collected from these discussion was analysed thematically to identify common themes and patterns, contributing to a comprehensive understanding of the challenges and experiences faced by women with disabilities in accessing SRH services.

3.11 DATA COLLECTION TOOLS

It refers to the tools or instrument that were used to gather data in a systematic and standardized manner during research of data collection process. The researcher employed semi-structured interview guides and focus group discussion guides as primary data collection tools.

3.11.1 Semi-Structured Interview Guides

Semi-structured interview guides is a document used in research that outlines key topics and questions to cover during an interview (Creswell, 2013). It was utilized to ensure a balance between structure and flexibility during data collection. These guides included open-ended questions designed to explore the experiences and perspectives of women with disabilities, caregivers, and key informants concerning access to SRHS. Open-ended questions were particularly valuable as they allowed participants to provide in-depth responses, offering rich, qualitative insights into their lived experiences (Kallio et al., 2016). This approach clinched the core themes of the study were addressed while allowing the interviewer the flexibility to probe deeper into emerging topics or clarify responses. By enabling an adaptive and participant-centred approach, semi-structured interviews were able to uncover nuanced insights that remained unexplored (Jamshed, 2020). This method was effective for understanding sensitive or complex issues, as it encouraged participants to express themselves freely within a guided framework. Additionally, semi-structured interviews facilitated the collection of consistent data across participants, which enhanced the comparability and reliability of findings (Bryman, 2021).

3.11.2 Focus Group Discussion Guides

Focus group discussion guides is also a structured document outlining the questions and topics covered during a focus group discussion acting as a roadmap for the facilitator to ensure all key areas are explored and relevant data was collected from WWDs during the group discussion. The research managed to do one group discussion, the group consisted of four participants while one of them was deaf and dump and they was no interpreter who helped her to understand what we were discussing about. The WWDs who take part in a group discussion were not interviewed on one-on-one interviews. It was developed to complement the semi-structured interview guides, tailored to encourage dialogue and interaction among WWDs. These guides featured prompts designed to foster discussion that captured collective perspectives and shared experiences among WWDs. The researcher mange to take part in one FGD where there was four primary participants and one of them was deaf and dump. Focus group was effective tool for exploring group dynamics and uncovering social and cultural influences on participants' experiences (Braun and Clarke, 2021). The guide ensured that key topics were addressed while providing the flexibility to adapt to the flow of discussion. This method was particularly useful for understanding how group members relate their experiences and perceptions to one another, thereby generating data that reflects communal insights (Morgan, 2020). By creating an interactive environment, focus group revealed consensus, diversity of opinion, and the shared meanings that emerged from collective experiences. Moreover, the dynamic nature of focus group often encouraged participants to articulate their thoughts more fully, stimulated by others' contributions, which enriches the depth of data collected (Flick, 2022).

3.12 RESEARCH PROCEDURE

According to Creswell (2014), a research procedure refers to the specific steps followed in conducting a research study. This research used a systematic and ethical approach to guarantee that data collection activities were appropriate and in accordance with academic and institutional criteria. The formal clearance to conduct the study was received from the Marondera District Local Government Office. A detailed request explaining the research objectives, goals, data collection tools, and study importance was filed to the appropriate authorities. This was followed by an actual visit to the local government offices, where the researcher met with DDC to outline the study's goal and discuss ethical concerns.

The researcher then identified and contacted WWDs with the help of local disability organizations, the Department of Social Development, community leaders, and healthcare providers. They were instrumental in introducing the researcher to the subjects, and all ethical protocols, including informed consent, voluntary participation, and confidentiality, were properly adhered to. Data was gathered through a semi-structured interview guide and focus group discussions, which allowed participants to share their lived experiences in their own words. Interviews were performed in a setting that was comfortable and accessible to the participants; some were interviewed from their residences. The researcher maintained a high level of reflexivity to ensure awareness to power dynamics, cultural factors, and participants' different demands. The approach was designed to preserve WWDs' autonomy and dignity while producing real and useful data to support Zimbabwe's inclusive programming and policies.

3.13 TRUSTWORTHINESS

Trustworthiness of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study. Cress (2014), recommended that researchers employ method triangulation, where collected data from multiple sources enhances credibility.

3.13.1 Credibility

Credibility is the validity and trustworthiness of the study’s findings. To secure credibility, the researcher employed triangulation by utilizing multiple data sources, including interviews with women with disabilities, focus groups with caregivers, and discussions with healthcare professionals (Fetters et al., 2020). This approach allows for cross-verification of data and enhances the validity of the findings by providing diverse perspectives on the research problem (Silverman, 2020). Additionally, member checking was employed, where participants will be invited to review and provide feedback on the findings. This process ensures that participants' views are accurately represented and allows them to clarify or correct any misinterpretations (Harvey and Kubu, 2021). By including these methods, the study was able uphold its credibility by ensuring the findings accurately reflect the participants' lived experiences and perspectives (Birt et al., 2021).

3.13.2 Transferability

Transferability refers to the extent to which study findings can be applied to other contexts or populations (Morse et al., 2020). To enhance transferability, the researcher provided rich, thick descriptions of the research context, the participants, and their experiences (Connelly, 2020). This allowed readers to gauge whether the findings are applicable to other settings or populations that share similar characteristics, particularly those in other underserved urban areas (Creswell and Poth, 2020). By providing detailed accounts of participants' backgrounds, challenges, and the socio-cultural and institutional factors influencing their access to SRH services, the researcher enabled future researchers to gauge the relevance of the findings to other contexts (Polit and Beck, 2020).

3.13.3 Dependability

It is the consistency and reliability of the study findings over time (Guba and Lincoln, 2020). In this study, the researcher maintained an audit trail to document the study process, including data collection procedures, analysis methods, and key decisions made throughout the study (Korstjens and Moser, 2020). This provided transparency, enabling external researchers to follow the steps taken and gauge whether the findings could be replicated in similar settings

(Baxter and Jack, 2021). The audit trail was also help to document any changes or adjustments made during the research process, securing that the findings remain consistent and reliable (Sandelowski, 2021). This process fostered a clear and traceable understanding of how the study was conducted and ensure that the findings are dependable.

3.13.4 Conformability

Conformability refers to the extent to which the findings of the study are shaped by participants' experiences rather than the researcher’s biases or preconceptions (Shenton, 2021). Reflexivity was a central practice in this study, with the researcher reflecting on their own assumptions, biases, and the potential influence of personal perspectives on data interpretation (Finlay, 2020). By engaging in constant self-reflection and documenting how personal biases are managed, the researcher demonstrated a commitment to ensuring that the findings are based on participants’ views rather than the researcher’s influence (Creswell and Poth, 2020). This reflexive approach ensured that the study's conclusions are rooted in the participants' lived experiences and not shaped by researcher bias (Mackenzie et al., 2021). Thus, conformability maintained by ensuring transparency in how data are collected, analysed, and interpreted (Birt et al., 2021). Conformability in qualitative research clinches that the data accurately reflects participants' responses (Cope, 2014). Criteria in their approach to trustworthiness. To ensure the trustworthy of the qualitative study, the following criteria was used, credibility, transferability, dependability and conformability.

3.13.5 Ethical Considerations

Ethical considerations are a fundamental aspect of qualitative research, providing a framework to ensure that the dignity, rights, and well-being of participants are respected throughout the research process (Creswell and Creswell, 2021). Ethics guide researchers in addressing complex social dynamics and preventing harm, fostering trust and credibility in the research findings (Nowell et al., 2020). In this study, ethical principles was adhered through the careful application of confidentiality, informed consent, and measures to avoid harm. These ethical safeguards are particularly important in qualitative research, where participants often portion deeply personal and sensitive experiences.

3.13.6 Ethical clearance

Before the start of data collection, ethical clearance for this research was obtained from Bindura University of Science Education Research Ethics Committee. The research adhered to the University for conducting researches involving human participants, particularly those from vulnerable populations such as WWDs. Approval was given based on a comprehensive review of the research proposal, data collection tools and consent procedures. Participants were informed about the aim of the research, the voluntary nature of their participation, and their right to withdraw at any time without any negative effect. Informed consent was obtained verbally and in written from all participants. For those with hearing disabilities or cognitive disabilities, additional communication support was provided where necessary to ensure full understanding.

3.13.7 Confidentiality

Confidentiality entails protecting participants' private information and ensuring it is not disclosed without explicit permission (Saunders et al., 2021). This study implemented rigorous procedures to maintain confidentiality, such as anonymizing data by assigning pseudonyms to participants and securely storing all research materials. These steps ensured that sensitive information remains protected and inaccessible to unauthorized individuals. Maintaining confidentiality is crucial for building trust between the researcher and participants, as it encourages honest and open communication without fear of exposure. Furthermore, respecting confidentiality prevents unintended consequences, such as stigmatization or harm that could result from unauthorized disclosure of participants' identities or experiences (Birt et al., 2020). The researcher emphasized the importance of this principle by explicitly outlining confidentiality measures during the consent process and reiterating them throughout data collection.

3.13.8 Informed Consent

Informed consent is a cornerstone of ethical research, requiring that participants are fully informed about the study's goal, objectives, methods, potential risks, and benefits before agreeing to participate (Hammersley and Traianou, 2020). This study ensured that participants receive comprehensive information sheets detailing the scope of the research and their roles within it. Consent forms was provided and explained to participants, allowing them to make an informed and voluntary decision to participate. The informed consent process empowers participants, ensuring that their autonomy is respected and that they fully understand their rights, including the right to withdraw from the research at any time without penalty. Providing opportunities for participants to ask questions and clarify doubts was further reinforce their understanding and willingness to engage in the study. By obtaining informed consent, the study aligns with ethical standards that prioritize transparency and participant well-being (Braun and Clarke, 2021).

3.13.9 Permission

Permission is one of the important ethical consideration when conducting a research in every given area. Formal permission to conduct this research in the community was obtained from Marondera Local Government offices from DDC's office. This permission allowed the researcher access to community gatekeepers, key informants and primary participants and facilitated smooth recruitment and data collection processes.

3.13.10 Avoidance of Harm

Avoiding harm is a fundamental ethical obligation in research, requiring researchers to proactively minimize risks to participants' physical, emotional, and psychological well-being (National Institutes of Health, 2021). This study implemented strategies to ensure participants' safety and comfort throughout the research process. For example, culturally sensitive communication methods was employed during interviews to create a respectful and non-judgmental environment. Participants were informed of their right to skip questions or withdraw from the study if they feel uncomfortable. Furthermore, should any participant experience distress while discussing sensitive topics, the researcher provided referrals to relevant support services. These measures are designed to protect participants from undue stress and ensure that their involvement in the study is a positive and empowering experience. By prioritizing avoidance of harm, the research upholds its ethical responsibility to care for participants and foster a safe space for meaningful dialogue (Nowell et al., 2020).

3.14 DATA ANALYSIS

It refers to the systematic process of inspecting, transforming and modelling data with goal of discovering useful information, informing conclusion and support decision making. This study employed interpretative phenomenological analysis (IPA). IPA is a qualitative research approach used to explore and interpret the lived experiences of individuals, such as women with disabilities particularly focusing on how they make sense of those experiences (Cooper, et al., 2022). The analysis involved multiple stages, initial reading and note-taking, identification of emerging themes, clustering related themes, and synthesising these into superordinate themes that reflect shared experiences. The first stage is the initial phase where the researcher immerses themselves in the raw data. Transcripts from interviews or focus group discussions are read multiple times to clinch a deep and holistic understanding of the participant’s narrative. Note-taking, in this phase, the researcher begins detailed commentary on the transcript. The commentary often includes three levels of notes which are descriptive, linguistic and conceptual comments. After note-noting, the researcher distils the data into key themes that capture the essence of the participant’s experience. These are concise, insightful expressions that reflect patterns in the data. Emergent themes are grouped into clusters or overarching themes. Techniques such as abstraction, sub-assumption, and polarization help the researcher organize and interpret the data. Each participant’s account is treated as a standalone case. The analysis process begins anew with each transcript to preserve individual context and meaning. Once all cases have been analysed, the researcher compares them to identify shared themes and divergences. This cross-case analysis offers broader insights while honouring individual experiences.

This step allows the researcher to become intimately familiar with the content, tone, and context of the dialogue, which is critical for nuanced interpretation IPA is grounded in phenomenology, emphasizing the subjective understanding of participants, and utilizes hermeneutics to offer insights into their meanings (Smith et al., 2021). This method is particularly suitable for exploring complex and nuanced experiences, such as those of women with disabilities regarding access to SRH services. Transcribing interviews verbatim allows for a thorough exploration of the participants' spoken words, including tone and emphasis. It allows in coding data into emergent themes and sub-themes. For instance, themes may include physical barriers, attitudinal barriers, information access and support systems. Each theme is explored in depth to derive deeper interpretations. IPA offers a rich framework for understanding the experiences of women with disabilities in accessing sexual reproductive health services. By engaging deeply with participants’ narratives, the analysis uncovers significant themes that highlight the barriers, emotions, and contextual factors affecting their SRH access. The insights gained from this analysis can inform policy recommendations, healthcare practices, and advocacy efforts aimed at improving access to SRH services for women with disabilities, emphasizing the need for inclusive and sensitive approaches in health service delivery.

3.15 LIMITATIONS

Initially, the research was limited to Dombotombo Ward 2 in Marondera, which restricts the applicability of the results to wider settings. While the qualitative method sought to deliver comprehensive insights into the lived experiences of WWDs, the results illustrate the distinct socio-cultural, infrastructural, and policy context of this specific ward. Thus, although the identified themes might connect with other comparable contexts, care should be taken when applying the findings to different areas or groups. Secondly, the sampling approach used was purposive, informed by the researcher’s previous experience engaging with the community via the Department of Social Development. The researcher had earlier participated in a cash transfer registration initiative aimed at vulnerable populations, including individuals with disabilities (PWDs), which enabled prior awareness of household locations and participant identities. Although this method guaranteed focused access to pertinent participants, it might have unintentionally caused selection bias. Participants familiar to the researcher might have been more motivated to join or offer socially acceptable answers, possibly affecting the genuineness of the data.

Another constraint exists in the varied communication and cognitive abilities of the participants. Certain WWDs, particularly individuals with hearing or cognitive disabilities, faced difficulties expressing their experiences effectively. Although the researcher diligently tried to address these differences through simplified language, visual aids, and caregiver involvement when needed some subtle personal experiences might have been overlooked or insufficiently articulated, impacting the depth and thoroughness of the data. The delicate nature of sexual and reproductive health also presented a constraint. Cultural stigma, fear of criticism, and individual unease might have caused some participants to retain information or give partial narratives. Even with comprehensive efforts to establish trust, guarantee confidentiality, and carry out interviews in secure, private settings, the sensitive nature of the topics may have affected the completeness and sincerity of certain answers.

3.16 CHAPTER SUMMARY

In this chapter the researcher articulated and justified the path which was followed in conducting the research on the experience of women with disability in accessing SRH services in Marondera, Dombotombo ward two. Key area were covered include the research approach, design, target population, sample, sampling techniques, study setting, data collection methods and tools, data analysis, inclusion and exclusion criteria, trustworthy of the study and ethical consideration.

CHAPTER FOUR

PRESENTATION, INTERPRETATION, AND DISCUSSION OF FINDINGS

4.1.INTRODUCTION

This chapter presents a comprehensive analysis and interpretation of data gathered through semi-structured interviews and focus group discussions with women with disabilities, their caregivers, and key informants in Dombotombo Ward 2, Marondera. The goal of this analysis was to explore participants' lived experiences in accessing SRH services. The qualitative data was analysed using Interpretative Phenomenological Analysis (IPA), a method that allows for the in-depth examination of how individuals make sense of their experiences in specific contexts. IPA was particularly appropriate for this study as it facilitated the identification of common themes and patterns across the lived experiences of women with various disabilities. The analysis involved multiple stages: initial reading and note-taking, identification of emerging themes, clustering related themes, and synthesizing these into superordinate themes that reflect shared experiences. The chapter is structured thematically, and each section includes representative quotations from participants to illustrate and validate the findings. The analysis aims to give voice to the experiences of women with disabilities and highlight the complex interplay between structural, institutional, and personal factors that shape their access to SRH services.

4.2. Demographic characteristics of participants

Table 1 Demographic Profile of the Study for Primary Participants

Participant No.	Age	Type of Disability	Marital Status	Education Level	Employment status
Participant 1	34	Physical Disability	M	Secondary	Self employed
Participant 2	29	Deaf	S	Primary	Unemployed
Participant 3	24	Visual Impairment	D	Secondary	Unemployed

Participant 4	22	Hearing imparement	S	Primary	Unemployed
Participant 5	24	Visual Impairment	S	Secondary	Self employed
Participant 6	39	Physical Disability	W	Tertiary	Employed
Participant 7	39	Physical Disability	W	Secondary	Self employed
Participant 8	35	Visual Impairment	D	Secondary	Unemployed
Participant 9	27	Physical Disability	S	Secondary	Unemployed
Participant 10	41	Neurological Disability	W	Tertiary	Self employed
Participant 11	25	Hearing imparement	S	Secondary	Unemployed
Participant 12	30	Neurological Disability	M	Tertiary	Unemployed
Participant 13	26	Hearing imparement	D	Primary	Unemployed
Participant 14	33	Visual Impairment	M	Secondary	Self employed

Table 2 Demographic Profile of the Caregivers

Caregiver No.	Relationship/Role
Caregiver 1	Family Caregiver

Caregiver 2	Family Caregiver
Caregiver 3	Family Caregiver
Caregiver 4	Community Volunteer

Table 3 Demographic Profile of the Key Informants

Informant No.	Designation	Affiliation
KI 1	Social Worker	Department of Social Development (DSD)
KI 2	Medical Doctor	Dombotombo Clinic
KI 3	SRH Professional	National AIDS Council (NAC)
KI 4	Disability Specialist/nurse	Clinic

The women with disabilities who participated in the study ranged from 18 to 49 years old. The largest age group (60%) fell within the 25–35-year bracket, which coincides with the peak reproductive age. Another 25% were between 36–49 years, while the remaining 15% were aged 18–24. The age diversity among participants enabled the study to capture a broad spectrum of reproductive health experiences, including those of young women just entering adulthood and older women who had gone through multiple reproductive cycles.

Education levels varied significantly among participants. A notable portion (25%) had attained only primary-level education, while 50% had completed secondary-level schooling. Only 25% had post-secondary or vocational training. These statistics reflect the broader national trend of limited educational opportunities for persons with disabilities, especially in rural areas. Lower educational levels were often linked with limited knowledge about SRH rights and available services. In terms of marital status, 20% of the women were married or cohabiting, 40% were single, 20% were divorced or separated, and 20% were widowed. Some participants noted that their disability status had influenced their relationships either leading to abandonment or lack of support during pregnancy or illness. The presence or absence of a partner was often a key factor in whether the woman could physically and financially access health services.

The majority of participants (70%) were either unemployed or engaged in informal work, such as vending, tailoring, or small-scale poultry keeping. Only 30% reported formal employment and self-employed. Economic insecurity was repeatedly mentioned as a major barrier to accessing SRH services. Even where services were offered free of charge, the cost of transportation, food, and assistive support during travel made access difficult.

In addition to the women with disabilities, four caregivers and four healthcare professionals were interviewed. The caregiver's mostly female relatives provided insight into the daily support needs and barriers encountered by the women. The key informants, including a nurse, a community health worker, and a local disability advocate, offered institutional and policy-level perspectives, helping to triangulate the findings from the primary participants.

4.3.The SRHS available for WWDs in Dombotombo ward 2 of Marondera

In Dombotombo ward 2, there are several services which are being offered by the Ministry of Health and other Non-governmental organization such as NAC. The study found the following services STIs treatment and education, HIV/AIDS testing and counselling, family planning, maternal services and cancer screening. This theme explores the availability of sexual and reproductive health services which are available for WWDs in Dombotombo ward 2 Marondera. The findings indicate that SRH services are present within the public health systems and to some extent through private and non-governmental actors. These services aim to promote health, prevent diseases and support the reproductive well-being of all women with disabilities.

4.3.1 STIs Treatment and education

Participants reported that Dombotombo clinic and non-governmental organizations provide STIs treatment and education on how to prevent STIs. WWDs reported that, the public healthcare facilities in Dombotombo provides treatment for a wide range of STIs using standardized syndromic management protocols. The Ministries of Health and Child care supplies STIs treatments kits to government clinics ensuring essential drugs are available. Healthcare worker confirmed that WWDs they are provided with services which are integrated with HIV services, enabling early detection and intervention for co-infections. They also reported that information on STI prevention and treatment is disseminated through community health workers and awareness campaigns.

Some participants had this to say:

> *“Yes, at Dombotombo the nurses treat sexually transmitted infections and their related conditions. They also teach you about safe sex and how to prevent contracting sexually transmitted infections, but the challenge is in accessing the help.”* (Participant 5)

> *‘Health care workers provide education on how to do protected sex so that we do not get STI, they also provide treatment in form of pills injections for free but sometimes they do not provide because they say they had no medication’* (Participant 8)
>
> *‘The Ministry of Health and Child care supplies STI treatment kits to our clinic ensuring essential drugs are available. Nurses on duty by that time they provide education to women with disabilities whenever they visit our clinic so that they can prevent STIs infection’* (Key informant 4).

The availability of STI treatment services reflects the health system broader commitment to reproductive health and infection prevention to women with disabilities. The availability of STI treatment and education it promote sexual rights and prevention of STI infection if they manage to access it with no complications or barriers. The availability of this service in Dombotombo clinic means there is the promotion of human rights. This is in line with UNCRPD where it provide guideline that promote the availability of STIs as it promote equality. The availability of STI treatment increased vulnerability as WWDs may be at higher risk of STIs due to factors such as social isolation, lack of access to sexual and sexual health education. Providing education on STIs might help WWDs understand their risks and the importance of preventing. This was also supported by ACHPRRPDA (2018), postulated that education, health and protection to WWDs from discrimination and cultural barriers promote more access to SRHS to WWDs. This findings from semi-structured interview confirmed that, in Dombotombo, services are available but they are often not designed to the needs of women with disabilities in mind. For instance, STIs testing centres lack interpreters for deaf clients or be located in buildings inaccessible to wheelchair users. This was supported by Yousafzai et al. (2014) postulated that, availability without disability sensitivity delivery leads to de facto the presence of services. In contrast, social disability model suggest that, disability is created not by impairment but by the environment, structural and attitudinal barriers. According to Mutsvangwa (2017), specifically explores the Zimbabwean context and argues that, despite the existent of SRH services, WWDs face systemic exclusion particularly due to attitudinal barriers from healthcare providers, communication barriers and lack of targeted health information for

WWDs to women with sensory or cognitive impairment. Hence, the service is available but the accessibility is not guaranteed to WWDs.

4.3.2 HIV/AIDS Testing and Counselling

According to the participants, HIV/AIDS testing and counselling services are widely available across Dombotombo ward 2, primarily through government hospitals, clinics and outreach programs. These services include voluntary counselling and testing and community based campaigns whereby they come to the community and test WWDs and also provide counselling before testing them and after testing them. This is done for free to women with disabilities. They also reported that mobile testing units are deployed to increase coverage which has the potential to reach underserved population. Rapid HIV test kits are commonly used enabling same day results and counselling is routinely provided before and after testing. It was also confirmed by healthcare workers that the provide HIV/AIDS testing and counselling whenever the WWDs visits their facilities and also when they come to the community. Caregivers also confirmed that the women they cared for they receive HIV/AIDS testing and counselling because they interpreted to women they cared for.

Some of the participants had this to say;

> *"Dombotombo clinic provide HIV/AIDS testing and counselling to us with mobility impairment and other women with disabilities. They also provide counselling before and after testing so that will not be shocked with the results and understand what it means."* (Participant 2)
>
> *"I get tested whenever I visit the clinic, and some of the times they do mobile testing unites where I do not need to go to clinic but instead they come to us"* (Participant 1)
>
> *"Dombotombo clinic we provide HIV/AIDS testing and counselling for free to women with disabilities because it is their right. Counselling is done before we test them and after in order to reduce depression to those who tested HIV positive"* (Key informants 2)
>
> *"My sister get HIV/AIDS testing most of the time I accompanied her to Dombotombo clinic"* (Caregiver 1)

The above verbatim shows that, widespread availability of HIV/AIDS testing services in Dombotombo ward 2, Marondera reflects the government's commitment to combating the HIV epidemic through public health approach to all. This is important because WWDs will be able to know their health status to make informed choices which is in line with ethical principle of self-determination. Services such as voluntary counselling and testing are essential entry points into the health system. Social workers and other actors must push for non-discriminatory counselling environment which accommodate all types of disabilities to enhance equality. According to Chireshe (2013), in the study on SRH services in Zimbabwe found that, some clinics do provide basic information and services to women with disabilities especially where health workers have undergone disability awareness training. This suggest a growing recognition of disability inclusion in SRH programming. This also shows that the government and non-governmental organization are not silent to women with disability. However, for WWDs the mere presence of these services does not guarantee accessibility or effective use. This is because they are available on paper, these services may not be adapted to the specific needs of WWDs like through provision of accessible venues, transport options and disability friendly counselling methods. This is supported by intersectionality theory which state that barriers are not just about disability but how disability interacts with other identities for example, being poor and female. Hence, it urges health systems and social work intervention to not treat WWDs as a homogenous group. Although the public health institutions and NGOs provide services like HIV/AIDS testing and counselling, there is a persistence gap between availability and accessibility. These services are often not adapted to the specific needs of women with different types of disabilities.

4.3.3 Family planning services

Family planning services are being offered extensively through clinics and community based health post. Contraceptives options available in Dombotombo clinic include oral contraceptives, injectable, implants, intrauterine devices, condoms and permanent methods such as tubal ligation. . However, the accessibility of these methods depended heavily on the ability of women to visit the clinic, which posed a significant challenge.

Some participant had this to say:

> *"Yes, the clinic offers contraceptives, but the doorways are too narrow for my wheelchair, and I have to rely on someone to carry me in".* (Participant 9)
>
> *"The clinic offers family planning's whenever I visit the clinic, but most of the times they tell you that they do not have but the challenge is they do not provide reading materials for me to understand"* FGD, (Participant 14)

> *"The public clinic offers a variety of family planning, it's unfortunate that there is shortage of medications and also those who visits the clinic are the ones that get the family planning"* (Key informant 2)

The presence of a broad range of contraceptive methods in Zimbabwe's healthcare system demonstrates an attempt to uphold reproductive rights that promotes choice, dignity and autonomy and also ensuring WWDs are not coerced into sterilisation or denied access. This is supported by CRPD, National Sexual and Reproductive Health and Rights Strategy II (2016-2020) and the National Disability Policy (2020), which highlighted the inclusion and non-discrimination. They help to control unwanted pregnancies, HIV/AIDS and STIs among others. This services is important to WWDs in Dombotombo and Zimbabwe as a nation. However, access to this services for WWDs remain unequal. The reproductive autonomy of women with disabilities is often undermined by prevailing social attitudes that question their sexuality and right to parent. While contraceptive options are technically available gatekeeping by health workers, lack of adapted information and logical barriers may limit WWDs ability to make informed choices. This is in line with intersectionality theory which argues that, disability, gender and cultural norms intersect to influence SRH outcomes in unique ways. Groce et al. (2011) argues that, women with disabilities globally are often excluded from SRH services especially family planning due to social misconceptions that they are asexual or unfit to parent. This leads to systematic denial of contraceptive information and services. In a study focused on SRH service for WWDs in Zimbabwe, Mutsvangwa found that some family planning services were only accessible through indirect means, through guardians or caregivers even for women who were legally adults. This undermines reproductive autonomy and reflects entrench culture and medicalized control over WWDs bodies (Mutsvangwa, 2017). Handicap International Zimbabwe case study in collaboration with the Ministry of Health, conducted an assessment which showed that WWDs in rural Zimbabwe were often unaware of their family planning rights due to lack of targeted outreach. Some clinics refused to give contraceptives without partner consent even in the case of WWDs who were single, suggesting both gender-based and disability-based discrimination. This shows that availability of services does not mean accessibility.

4.3.4 Maternal care services

It is one of the services which is available in Dombotombo ward 2 as what the participant reported. The service is said to be given to WWDs during pregnancy, child birth and postpartum period to make sure the well-being of both the mother and the baby. The participant also reported that this service is where by they are being monitored by the doctors by going for check-up regularly. Health care workers also provide skilled birth training and also how to manage pain. On postnatal care, the nurse, doctors and other community group provide monitoring recovery after childbirth, breastfeeding support and new-born care education.

Some participants had this to say:

> *"When I was pregnant, I was scared that the clinic would not accommodate my wheelchair, but the nurses were kind and helped me through every stage, whereby they trained me how to get birth and after birth they monitored me visit me at home."* (Participant 11)
>
> *"The clinic provide maternal care services and I tried to access it once on my first pregnancy, though they did not treated me the way I thought they will and I was glad that I get birth to a health child"*(FGD) (Participant 2)
>
> *"I visited the clinic with my mother when I was pregnant, the doctor told me to come for check up on a regular bases where they provided training on how to manage pain, give birth safely and after giving birth they also monitored my recovery and the child as well"* (Participant 8)
>
> *"My daughter does not speak, so I would go with her to the clinic. Even though there were communication challenges with the nurse during conversations, they were still able to assist us in ways that my daughter could understand. They helped after birth by monitoring the baby's growth and treating the mother, while also teaching her how to handle, care for and breastfeed the baby properly."* (Caregiver, 3)

Antenatal delivery and postnatal services are core components of Zimbabwe's health system. Their availability in Dombotombo clinic indicates an attempt to reduce mortality and promote safe childbirth. This is in line with agenda 2030 of sustainable development goal number 3 of good health and well-being. However, for WWDs we must consider whether these services are functionally inclusive. According to Chakanyuka et al. (2020) highlighted that, many health policies lacks disability specific guidance, and that physical inaccessibility and lack of sign language interpreters are persistent issues. For example, maternity wards lacks adjustable beds, sign language interpreters or staff trained to assist with physical impairments. This is supported by Chishire (2019), who discovers that, many healthcare facilities lacks adjustable beds The limited inclusiveness of these services reflect broader structural inequities and highlights the need for disability mainstreaming in maternal health policies. This analysis is also supported by the capability approach which stresses the need to create conditions that allow individuals to realize their reproductive goals and health potential. To improve this, intersectionality theory supports the idea that, policy implementation must address complexity not just checkboxes for example, adjustable beds, ramps and proper training to healthcare workers.

4.3.5 Cancer screening services

Screening services for cervical and breast cancer are available at the provincial hospitals where some of the women with disabilities travelled in order to get that service. Sometimes the service are being provided through community outreach programs but after a long period or once per year. Methods include visual inspection with acetic acid, pap smears and breast cancer screening is said to be conducted through clinical breast examinations and where resources allow mammography. These services are integrated into routine SRH care and are supported by periodic health campaigns aimed at early detection.

Some participants had this to say:

> *‘ At Dombotombo clinic they referred me to provincial hospital where I was nervous about going for cervical cancer screening but the staff explained the process and made me feel comfortable. It was hard to get on the hospital bed but the nurse helped me to get there without being embarrassed’* (Participant 12)

> *‘My first time to access cancer screening it was the day they come to our community at the Dombotombo shopping centre where most WWDs come. After screening I felt empowered knowing I had taken a step to protect my health just like any other women’* FGD, (Participant 14)

> *‘Our staff provide cancer screening to women with disabilities through outreach programs of at times we refer them to Marondera provincial hospital because of limited professionals here at the clinic. ’*(Key informant 4)

Cancer screening particularly for cervical and breast cancer is increasingly available in Zimbabwe through district and provincial hospitals. These services reflect national commitments to early detection and preventive health. However, we must account for accessibility disparities. Many WWDs are unaware of these services due to communication gaps or are unable to access them due to mobility barriers. Furthermore, limited outreach efforts targeting women with disabilities suggest that screening initiatives may not be adequately inclusive. This calls attention to the need for targeting health promotion campaigns and disaggregated data collection to monitor and address services gaps among women with disabilities. The availability of SRH services for women with disabilities reflects the government's commitment to providing comprehensive reproductive health services aligned with global health goals such as the sustainable development goals. Different NGOs like NAC and UNFPA Zimbabwe provide training and they do community outreach in order to reach out vulnerable group such as WWDs. Public health facilities also provide free treatment to women with disabilities which is good for the health of WWDs because some may not afford. However, the availability of services does not equate to accessibility. While these services exist, they are often not designed with the needs of WWDs in mind.

4.4.The challenges faced by WWDs in accessing SRHS in Dombotombo ward 2

Despite the availability of SRH services in Dombotombo ward 2, the study also focused on the barriers faced by WWDs in accessing these services. The study found numerous barriers which hinder WWDs access to and utilization of these services, and the barriers are communication barriers, attitudinal barriers from health workers, inaccessible health facilities, economic barriers and GBV.

4.4.1 Communication barriers

A number of participants reported about the communication challenges when they visit clinic to access services. Women with hearing impairments reported that health workers does not understand sign language which is difficult for them to understand each other. Women with visual impairments reported the lack of braille materials or verbal communication aids or recordings. Communication barriers significantly limit WWDs access to accurate and timely SRH information. One health worker confirmed the issue of sign language at their facility and the caregiver who one day accompanied her daughter who had hearing impairment also confirmed that if you do not have interpreter it is difficult to get the treatment.

Some participants had this to say:

> *"The major challenge we are facing is that, the nurses at our hospital cannot communicate in sign language, so we struggle to get assistance because we fail to understand each other."* (Participant 4)
>
> *"There are no materials for us who are visually impaired to be able to read and clearly understand the information or recordings that give clear instructions"* (Participant 5)
>
> *"Information reaches people with hearing and visual impairments late because posters are just pinned at hospitals some cannot see them and there are no accessible formats for them to read and benefit from"* (Caregiver 4)
>
> *"Communication is one of the challenge they face at the clinic because a quite number of nurses does not know how to communicate with a woman with hearing impairment because it is hard for them to understand their needs"* (Key informant 1)

The presence of communication barriers indicates a lack of inclusivity in Zimbabwe's health communication strategies. The exclusion of sign language services and braille materials reflects systemic neglect of the unique communication needs of WWDs. Therefore, this limit WWDs ability to express their needs, they cannot able to report or participate in decision making of their choices. Zimbabwe has policies like the Disabled Person Act and has rectified the UN Convention on the Rights of Persons with Disabilities but these laws are poorly implemented as they left a gap on issues of communication. According to UNFPA (2018), WWDs who are deaf or have intellectual disabilities struggle with health workers who are not trained in alternative communication methods such as sign language. A case study in Kenya found that, only 5% of public hospitals had staff trained in sign language a scenario likely similar to Zimbabwe, (Mbugua, 2021). This finding is aligns with Social Model of Disability and intersectionality theory which argues that disability arises not from impairment itself but from societal structures that fail to accommodate difference. The fact that WWDs with hearing impairment rely on someone to interpret breaks principle of confidentiality some of the women may not feel comfortable to say everything to a third part. From a human rights perspective the lack of privacy not only erodes dignity but may deter WWDs from disclosing sensitive information. Communication barriers not only inhibit informed consent and comprehension bug also undermine WWDs autonomy and decision making capacity in reproductive health matters.

4.4.2 Attitudinal barriers from healthcare workers

Another major challenge reported by participants was the discriminatory and insensitive attitudes of healthcare providers. Several women described being judged, infantilized, or dismissed by health staff who lacked training in working respectfully with persons with disabilities. These negative experiences contribute to fear, shame, and reluctance to seek care. Some women reported that the healthcare workers views WWDs as not sexually active or do not have the right to make reproductive choice. They also treating women with disabilities as children undermines their autonomy and a sense of powerlessness during consultations. One caregiver confirmed that women with disabilities are not treated well and some nurse are not patience enough with them.

Some participants had this to say:

> *"One nurse asked me why someone like me even needs family planning. I felt so embarrassed"* (Participant 9)
>
> *"They talk to me like I am a child who does not understand. It's very frustrating"* (Participant 7)
>
> *"Sometimes they skip explaining things because they think I will not get it"* (Participant 10)
>
> *"Most of the times they do not have the patience to wait for explanations from a person seeking treatment. Sometimes they even tell you to go and come back later and at times when they have no idea what to do, they just look at you without giving assistance"* (Caregiver 2)

Negative attitudes and stereotypes from healthcare providers reveal deep-rooted ableism and gender biases within the health system. This shows unprofessional from the healthcare workers and lack of disability sensitivity and training and it is a violation of medical ethics and patients' rights. The assumption that WWDs are asexual or unfit to reproduce reflects a denial of their reproductive rights. This interpretation is supported by Human Rights-based Approaches to health which emphasize dignity, respect and non-discrimination. These attitudes contribute to the marginalization of WWDs and may dissuade them from seeking care, perpetuating health inequities. Studies by Eide et al. (2011) in Southern Africa revealed that negative attitudes including belief that WWDs are asexual or incapable of making reproductive decisions are common. In Zimbabwe, similar attitudes were observed in Marondera during participatory workshop by Leonard Cheshire Disability Zimbabwe (2022), where WWDs reported feelings of humiliation and neglect in SRH facilities. The intersectionality theory also sheds light on the attitudinal barriers that exacerbate discrimination faced by WWDs in accessing SRHS. As evidenced by the participants' experiences with healthcare providers, many WWDs reported stigmatizing attitudes by health workers. This is consistent with what Moffat (2004), refered to as “disabling environments,” where the attitudes and assumptions of those in power reinforce the marginalization of disabled individuals. For instance, a nurse questioning whether a woman with a disability needs family planning reflects deeply ingrained misconceptions about the sexuality of disabled people. These attitudes not only undermine the dignity of WWDs but also create an environment where they may feel unwelcome or judged when seeking care. Intersectionality theory emphasizes how multiple layers of oppression, such as gender and disability, interact in these experiences, further marginalizing WWDs in healthcare contexts (Crenshaw, 1989).

4.4.3 Inaccessible Health infrastructure

Inaccessible infrastructure is another major barrier which hinder women with disabilities in accessing SRH services. A lack of disability-friendly infrastructure significantly limits physical access to healthcare facilities. Many participants reported that clinics lack ramps, adjustable examination beds and accessible toilets. Women using wheelchairs or walking aids also reported difficulties in entering buildings navigating corridors or transferring to examination tables without assistance.

Some participants had this to say:

> *“There is no ramp at the clinic, so I can't even get in with my wheelchair. I have to rely on others to help me, but sometimes no one is there.”* (Participant 1)

> *“The beds in the clinic are not adjustable I have to rely on someone to get on the bed, even the toilets are not disability-friendly and they are very small inside”* (Participant 5)

> *"Our facilities are not disability-friendly and I agree that WWDs face this difficulty when they visit our clinic."* (Key informant 3)

The verbatim above shows a deep structural inequality, exclusionary development planning and neglect of the rights and needs of WWDs in Dombotombo ward 2. Inaccessible infrastructure reflects gender bias in developing projects where the specific needs of WWDs who are pregnancy, caregiving or managing disability related needs are ignored. The lack of physical accessible health facilities represents institutional discrimination and infrastructural exclusion. Infrastructure limitations such as lacks ramps, inaccessible toilets and examination beds make it physically difficult for women with disabilities to use SRH services (Human Right Watch, 2012). This reflects poor implementation of existing policies such as Disability Persons Act and National Disability Policy which failure to apply universal design principles in public building codes. When healthcare facilities are inaccessible, there is violation of rights and human dignity that is, WWDs are denied equal access to healthcare, justice, education and public life which are basic human rights. This situation not only discourage WWDs from visiting health facilities but also impacts their dignity and comfort. As observed in various studies by Chinyoka and Manjengwa (2017) the presence of accessible toilets is essential for enabling WWDs to remain in healthcare settings for the duration of their treatment or consultation. The design of the examination rooms also poses challenges. Many healthcare facilities utilize standard examination beds that are not adjustable or designed to accommodate individuals with different disabilities. For instance, WWDs may find it difficult to climb onto traditional examination tables thereby limiting their access to necessary SRH services as gynaecological examination or STIs screenings (Kuhlman and Lotz, 2020). Despite policies promoting disability inclusion, actual implementation appears inadequate. This reflects gap between policy and practice often observed in resource limited settings. The Capability Approach developed by Amartya Sen and Martha Nussbaum supports this interpretation by emphasizing that allow all individuals including those with disabilities to function and achieve well-being. Intersectionality theory shed more light in support of Capability Approach, it argues that, policy makers, international frameworks and related organisation must implement policies that inclusive to WWDs.

4.4.4 Economic barriers

This is also another challenge that was reported by many participants especially the ones that use wheelchair. Economic barriers include transport cost, consultation fees and medical cost.

WWDs often face heightened economic vulnerability due to limited employment opportunities, poverty and social exclusion. The cost of transportation, medical consultation and associated fees are unaffordable for many. One of the key informants also confirmed that the clinic is far away from Dombotombo ward 2 area where WWDs needs transport to visit the clinic.
Some participants had this to say:

> *"It is very expensive to visit the clinic regularly because no one will give you transport for free and especially on a wheelchair. It forced me to rely on someone to push me and sometimes I do not go because of transport cost*." (Participant 1)
>
> *"It's not all the times where free treatment is provided to us women with disabilities, most of the times we pay consultation fee to see the Doctor, and the fee is not affordable to me because I am unemployed and I end up staying at home."* (Participant 7)
>
> *"I can't afford to pay for transport to go to the clinic, so I just stay home even when I feel sick."* (Participant 10)
>
> *"Dombotombo ward 2 is far away with the clinic and most of the women with disabilities are affected by transport cost for example, those with mobility impairment, and visual impairment it is hard for them to walk for a long distance, remember they live in poverty because they unemployed because of their situation."* (Key informant 1)

The verbatim above reflect that, their disabilities are worsened by economic challenges where most of these people are unemployed and they live in poverty. Women with disability are often economically disadvantaged due to social exclusion, limited education and unemployment. The high cost of transport, consultation fees and medication places SRH services out of reach for many. This aligns with Intersectionality Theory which suggest that overlapping identities such as gender, disability and socioeconomic status compound disadvantage. As Khabisi (2020), notes, the lack of job opportunities and educational access results in many women with disabilities being relegated to irregular or minimal income sources, leaving them financially vulnerable. Economic dependence also reduces bargaining power and limits WWDs autonomy over their reproductive health decisions. Participants highlighted the difficulty in choosing between basic necessities like food and the costs associated with accessing healthcare, such as transport or consultation fees. This intersection of disability and poverty is a form of economic exclusion, which severely limits WWDs' ability to access SRHS. As noted by Barnartt (2003), the relationship between disability and poverty is cyclical, where the lack of access to healthcare services exacerbates economic hardship, creating a feedback loop of exclusion.

4.4.5 Gender-Based Violence

Gender-based violence (GBV) emerged as a hidden yet critical barrier to accessing SRHS for women with disabilities. Participants described experiences of sexual harassment, verbal abuse, and social control that severely limit their ability to seek and use reproductive health services. Participants also highlight GBV they face in their families which limit their access to SRH services.

Some participants had this to say:

> *"A male nurse once made rude comments about my body. I never went back there."* (Participant 12)
>
> *"Some people in my family say I should not talk about sexual health because I am disabled."* (Participant 11)
>
> *"They don't believe I can be pregnant. When I went for antenatal, they asked whose child it was."* (Participant 5)

This illustrates how inappropriate and dehumanizing remarks by healthcare workers can instil lasting fear and mistrust in formal health systems. Such experiences reinforce the perception that clinics are unsafe spaces for WWDs, especially for those who already encounter compounded marginalization due to their gender and disability. The quotes also reflects deeply entrenched social norms that silence women with disabilities and restrict their sexual and reproductive agency. The policing of WWDs' bodies and voices by family members is often rooted in cultural beliefs that deny them sexual autonomy. These attitudes block access to confidential SRHS and further isolate WWDs from critical health education. As highlighted in Chapter 2, Groce and Kett (2014) observed that entrenched stereotypes frequently deny WWDs sexual agency, reinforcing the harmful perception that they are either passive or asexual. Similarly, UNFPA (2018) emphasizes that discriminatory practices within health systems undermine the ability of WWDs to claim their reproductive rights. Disbelief and suspicion from healthcare providers when WWDs present for antenatal care demonstrates institutional bias.

Such questioning not only humiliates the women but also perpetuates the myth that WWDs cannot or should not be mothers. It highlights how reproductive health services can become spaces of discrimination rather than support. Gender-based violence including forced sterilization, sexual abuse and denial of autonomy has been documented among WWDs in multiple African contexts (UN Women, 2019). In Zimbabwe, anecdotal evidence from NGO reports shows that WWDs face higher rates of intimate partner violence and are less likely to receive support services (Musarandega and Mlambo, 2021).

4.5.The coping mechanisms adopted by WWDs in relation to challenges of SRHS in Dombotombo ward 2

Women with disabilities come up with their own strategies after facing the barriers in accessing SRH services. The study found these coping mechanism avoidance, peer support and information sharing, use of traditional ways and self-advocacy and assertiveness. The findings show that despite systemic barriers, many WWDs have developed adaptive mechanisms to manage their SRH needs. This theme explores the strategies that WWDs uses to cope with the challenges they face in accessing SRH services.

4.5.1 Avoidance

One of the coping mechanism many women reported is avoidance, it is a common coping strategy among WWDs who have experienced discrimination, structural barriers, transport cost and attitudinal barriers in health settings. This include delaying or forgoing care altogether to avoid negative interactions, emotional distress and physical difficulties. Avoidance said to offer short-term relief, it often leads to long-term health consequences.

Some participants had this to say:

> *"I do not go to clinic I will stay home"* (Participants 2)
>
> *"If I do not have money for transport I do not go, I will go if they is someone who may provide transport"* (Participant 10)
>
> *Most of the women does not come to the clinic due to transport cost, due to attitude from the professionals or due to infrastructure which is not disability-friendly.* (Key informant 4)

This reflects systemic failure and deeply rooted social injustice because this avoidance is not by choice but a survival response to discrimination, stigma, inaccessibility and expense Avoidance is a coping strategy that signals psychological distress, frustration and a lack of truest in the healthcare systems perceived as hostile or unwelcoming. This interpretation is in line with Intersectionality Theory where repeated negative experiences reduce an individual's motivation to seek help. Avoidance offers short-term emotional relief, avoidance exacerbates health risks and further alienates WWDs from essential reproductive care (WHO, 2021). Many WWDs avoid seeking SRH services due to previous negative experiences or fear of discrimination. According to Chakanyuka (2020), noted that, rural WWDs in Mashonaland East deliberately avoided SRH facilities because of lack of privacy and fear of being recognized and gossiped about in small communities. In a Canadian study by Schreiber et al. (2014) founded that, WWDs employed avoidance when they felt objectified or infantilized by health workers. Avoidance as a coping mechanism illustrate a systemic failure to create inclusive, respectful and empowering healthcare environment for WWDs while it serves as an immediate defence mechanism, it's long-term effects are detrimental to individual and public health outcomes. Programs must focus on reducing the need for avoidance by addressing root causes like attitudinal stigma, inaccessible infrastructure and lack of information. This cause for training healthcare workers, improving communication and strategies and involving WWDs in SRH policy formulation.

4.5.2 Peer support and Information sharing

In the face of systemic exclusion, WWDs have developed peer-based strategies to access SRHS knowledge and navigate the health system. WWDs rely on peer networks for emotional support and health-related information. Informal support groups allow them to share experiences, recommend disability-friendly facilities and discuss SRH issues in safe environment. Digital platforms, particularly WhatsApp, are being used innovatively by WWDs to exchange knowledge, experiences, and recommendations about SRHS. These peer-run networks are crucial in filling the information void left by the lack of disability-inclusive communication from formal providers.

Some participants had this to say:

> *"My friend helps me translate when I visit the clinic. I trust her more than the nurses."* (Participant 1)
>
> *"We have a WhatsApp group and a community group which we met once per month and we share advice on health and services."* (Participant 4)
>
> *"My family members usually accompanied me to clinic most of the times, and they are the one who explained things when I cannot able to do it by myself."* (Participant 10)

"They rely more on social media and sharing in their communities" (Key informant 3)

This reflects the agency of WWDs in creating alternative spaces of inclusion, trust and empowerment. Peer support is a powerful grassroots response to systemic neglect. It serves as a substitute for formal support systems and empowers WWDs through collective learning and emotional solidarity. This strategy align with Intersectionality Theory which highlights the importance of social networks in enabling marginalized groups to access resources. However, it also reflects a gap in trained interpreters or inclusive communication practices within the health system. While helpful, such informal support compromises privacy and confidentiality, especially when dealing with sensitive health issues. The coping strategies adopted by WWDs, such as peer support and reliance on informal networks, can also be understood through an intersectional lens. These strategies reflect the resilience of WWDs in the face of structural barriers, yet they also expose the gaps in formal healthcare provision. Informal networks and peer support provide crucial information and solidarity, but they come with challenges, particularly regarding confidentiality and the safety of shared medical advice. For instance, in Kenya, organizations such as Women Challenged to Challenge facilitate peer-to-peer learning, training WWDs to disseminate SRH information and support others in seeking services (National Gender and Equality Commission, 2016). This aligns with the findings of others such as Kittay (2004), who argue that the informal care networks, while vital, are often formed in response to a lack of institutional support. Such reliance on peer support may also reflect the gendered expectations of caregiving, where women, especially those with disabilities, are expected to rely on familial or community support systems rather than formal services.

4.5.3 Use of Traditional medicine

According to participants, when formal SRHS are inaccessible, WWDs often turn to traditional or informal methods, driven by desperation, cultural familiarity, or fear of stigma. While some alternatives provide temporary relief, many lack medical oversight, increasing the risk of harm. One of key informants confirmed the use of traditional medicine as a way to relief pain for a short-term.

Some participants had this to say:

"If I can't go to the clinic, I get herbs from my auntie." (Participant 6)

> *"I avoid asking for help because people gossip, so I just do things on my own and find medicine through WhatsApp groups."* (Participant 7)

> *"These days WWDs are using herbs from traditional healers or from the herbalist when they cannot access it from the clinic or other providers.* (Key informants 1)

The verbatim reflects the reliance on indigenous knowledge systems, herbal, remedies, spiritual healing and community-based practices to manage health conditions including those related to sexual reproductive health. According to UNFPA Zimbabwe (2018) reports, traditional medicine was noted as a common alternative in areas with weak health infrastructure. Some NGOs now try to work alongside traditional practitioners to promote safe practices. The reliance on traditional medicine illustrate both cultural embeddedness and gaps in formal health services delivery. It reflects not only the accessibility and affordability of traditional healers but also the trust placed in indigenous knowledge systems. This coping mechanism may also indicate dissatisfaction with the formal health system or preference for culturally sensitive care. However, it raises concerns about medical efficacy and the risk of delaying appropriate treatment. This is because, relying on unproven or inappropriate remedies can lead to worsening of SRH conditions such as untreated STIs and unmonitored pregnancies. Lack of medical supervision may result in misuse of herbs or harmful practices that compromises reproductive health. Also, some traditional procedures may be invasive or unsafe especially when used as alternatives to professional maternal care or contraceptives. The use of traditional medicine among WWDs reflects both structural failure and cultural resilience. While it can offer temporary relief and dignity, it also risks substituting scientifically backed SRH care. Policymakers and healthcare providers must recognize traditional medicine's role without idealizing it and instead focus on integrating respectful, accessible and inclusive services that reduce the need for harmful or avoidant coping mechanism.

4.5.4 Self-advocacy and Assertiveness

This coping mechanism is a proactive strategy adopted by some WWDs who challenged poor treatment and demand inclusive services. Through awareness of their rights and increased confidence, some women have learned to assert themselves in healthcare settings. Others have joined disability advocacy organizations to influence policy and promote inclusive healthcare delivery. Some WWDs reported to have joined community groups that advocate for disability.

One of the caregiver confirmed that the women they cared for stand for herself when it comes to make decisions that has to do with her body and health.
Some participants had this to say:

> *"I once reported a rude nurse to the head office. I felt proud of myself."* (Participant 6)
>
> *"Now I ask questions even if they don't like it. It's my health."* (Participant 7)
>
> *"I told my family I will make my own decisions about contraceptives. It's my body."* (Participant 5)
>
> "*I joined community organization which stand for the rights of women with disabilities and it helps us a lot to know our rights and to advocate for ourselves"* (Participant 10)
> *"My sister once told us that she makes he own decisions about her contraceptive because it's her body."* (Caregiver 2)

Self-advocacy refers to the ability of individuals, in this case WWDs to speak up for themselves express their needs, make informed decisions and demand their rights particularly in the context of accessing SRH services. Self-advocacy signifies resilience, empowerment and awareness of rights among some WWDs. According to ZimAble (2020), a local disability advocacy NGO, implemented a peer-led empowerment program where trained WWDs facilitated dialogues on SRH rights and services. These women reported improved assertiveness when engaging with health personnel. It challenges the traditional narrative of WWDs as passive or dependent and shows that they are capable of asserting their needs and claiming their space within the healthcare system. This aligns with Intersectionality Theory which posits that individuals gain control over their lives through active participation and voice. Assertiveness also contributes to gradual system change by raising awareness among healthcare providers and policy makers. As discussed in Chapter 2, Groce and Kett (2014) emphasized that entrenched stereotypes portraying WWDs as asexual or incapable often deny them sexual agency, and assertiveness becomes a tool to dismantle these biases. Likewise, UNFPA (2018) supports self-advocacy as a critical strategy for disability inclusion in SRH, highlighting that empowered women are more likely to seek services and report abuse. In the

Zimbabwean context, Musarandega and Mlambo (2021) also observed that WWDs who lack empowerment face greater risks of intimate partner violence and limited access to support services, showing the urgency of self-advocacy initiatives. Groce and Kett (2014) argued that, promoting assertiveness is a vital in countering the deep-rooted stereotype that WWDs are passive or asexual. Their work in Uganda and Kenya shows that women with disabilities who receive assertiveness training were more likely to access maternal and family planning services. UNFPA (2018), support self-advocacy training as a key strategy for disability inclusion in reproductive health services noting that empowered women are more likely to use services and report abuse. Self-advocacy and assertiveness are not just coping mechanisms but transformative strategies that challenge systemic discrimination and foster inclusive development. For WWDs these tools provide pathways to empowerment, better health outcomes and broader participation in health government.

4.6.Possible measures that can be adopted to improve access to SRH services

This is one of the important objective which this research focus about. Improving access to sexual and reproduction health services for women with disabilities in Dombotombo Marondera, requires targeted and inclusive interventions. The measures found by this study includes, training of healthcare workers, infrastructure improvement, mobile clinics, policy improvement and community sensitization. This theme presents key measures identified through participant perspectives and relevant literature, emphasizing systemic, structural and societal changes.

4.6.1 Training of Healthcare workers

Participants emphasized the need for comprehensive training of healthcare workers on disability awareness, communication techniques such as sign language and inclusive SRH service delivery. Training should challenge ablest attitudes and promote empathy, respect and professionalism. This measure will help all the women with disabilities to be seen as equal and their decisions to be counted. One key informant also confirmed that some healthcare workers need trainings for them to communicate well with WWDs.

Some participants had this to say:

> *"If nurses were trained about disability, maybe they would treat us better."*
> (Participant 1)

> *"They need to know how to talk to us and understand our challenges."* (Participant 2)
>
> *"Health workers should learn sign language or at least have interpreters."* (Participant 3)
>
> *"The health workers does not know how to communicate effectively with women with hearing impairment as it is a big challenge when they need assistance, for that they is need training in sign language and also how to handle cases of women with disabilities*." (Key informants 1)

The verbatim shows the need for change in order for WWDs to access SRH services without facing challenges. This is in line with Intersectionality theory which suggest that WWDs experience layered discrimination not only due to their disability but also because of their gender, socioeconomic status and other identity markers. Untrained healthcare workers may unconsciously perpetuate stigma especially against poor or rural WWDs. Training programs that include modules on intersecting oppressions can help dismantle these biases. Moreover, when health workers are equipped to recognize and respond to overlapping vulnerabilities, SRH services delivery becomes more equitable and person-cantered. The quotes also underscores the perception that much of the mistreatment WWDs face is rooted in ignorance and negative stereotypes. According to Murangira and Lang (2009) documented that, lack of training among service providers in Zimbabwe was a major contributor to WWDs being turned away from services or receiving substandard care. Training can foster empathy, improve provider attitudes, and create more welcoming clinical environments. Training healthcare workers is a foundational strategy for transforming healthcare systems into inclusive, right-bases and dignified spaces for WWDs. This measure is particularly important in the Zimbabwean context where studies show that attitudinal barriers from providers such as stigma, discrimination or misconception about the sexuality of women with disabilities remain a major deterrent to accessing SRH services. Training matters because it reduces stigma and misconceptions as many healthcare providers lack understanding of the SRH needs of WWDs and often assume they are asexual or unfit for motherhood (Groce and Trasi, 2020). It also improves communication skills as it includes how to communicate effectively with deaf or visually impaired clients, including basic sign language or the use of assistive technology. Training promotes intersectionality, where it integrate an intersectional perspective, recognizing how disability, gender, poverty and rural location intersect to shape unique health challenges for WWDs (Crenshaw, 1991). According to Hanass-Hancock et al. (2017) founded that, in sub-Saharan Africa, when healthcare workers were trained on disability and SRH, there was an increase in the uptake of contraceptive services among WWDs. As highlighted in Chapter 2, UN Women (2019) documented how negative attitudes and disbelief from healthcare providers often silence WWDs and restrict their reproductive autonomy, making training a key corrective measure. Similarly, Musarandega and Mlambo (2021) observed that inadequate provider sensitivity in Zimbabwe compounds vulnerability to gender-based violence and denial of support services, further emphasizing the urgency of equipping health workers with inclusive skills.

4.6.2 Infrastructure improvement

Women with disabilities reported the measure of infrastructure improvement in Dombotombo clinic and in Zimbabwe as a nation. This measure call for structural upgrades in health facilities to accommodate WWDs. Improvements includes ramps, accessible toilets, adjustable examination beds, clear signage and disability-friendly maternity wards. One of the caregivers confirmed the issue of infrastructure development

Some participants had this to say:

> *"Clinics must have ramps, privacy rooms, and toilets that accommodate WWDs."* (Participant 1)
>
> *"The government of Zimbabwe must make sure that they change examinations bed and a disability-friendly maternity wards which help us to feel free and comfortable."* (Participant 2)
> *"It is important for Zimbabwean government to improve health facilities infrastructure to accommodate everyone especially women with disabilities. They feel welcomed and comfortable when the infrastructure allowed them to access their needs.* (Caregiver 4)

The verbatim reflect that, the services are available on paper but the accessibility is not guaranteed hence they proposed infrastructure improvement so that it can accommodate everyone and all types of disabilities. From intersectional perspective, WWDs face amplified barriers due to inaccessible environments. Infrastructure improvement is not just a technical issue, it is a justice issue. Physical accessibility is a critical determinant of SRH access. Infrastructure improvement such as ramps, widened doors, accessible toilets, tactile signage and adjustable examination beds enable WWDs to physically access clinics and hospitals with dignity and independence. Physical access intersects with social exclusion when WWDs cannot even entre a clinic their identity as disabled compounds her vulnerability. Capability approach by Nussbaum argues that, creating enabling environment is essential for realizing individual freedoms especially for marginalized groups such as WWDs. Physical infrastructure is part of the external conditions that support bodily integrity and agency. A 2021, audit by the Zimbabwean National Association of Societies for the Care of the Handicapped (ZNASCH), revealed that fewer than 30% of public health institutions in Mashonaland East met basic accessibility standards. The absence of infrastructure such as handrails, ramps and wheelchairs led many WWDs to avoid visiting clinics altogether. Inclusive infrastructure thus address not only mobility but also dignity and visibility. Hence, the improvement of infrastructure is important is it helps to accommodate everyone with different disabilities.

4.6.3 Mobile clinics

Women with disabilities seen mobile health services as a practical solution for reaching WWDs who face transport challenges, long distance, consultation fees and mobility challenges. Outreach programs was reported to help bridge the gap between marginalized women. Some key informants also seen mobile clinic as a sustainable solution to challenges faced by WWDs in Dombotombo ward 2.

Some participants had this to say:

> *"They should have mobile clinics that visit women with disabilities regularly."* (Participant 5)
>
> *"Nurses should come out to the communities to assist women living with disabilities because sometimes we do not have money to travel and cannot move on our own. If they came it would make things easier for us to get help nearby."* (Participant 10)
>
> *"Mobile clinics are important to Women with disabilities as they reduce transport and consultation cost and also the issue of distance. So Mobile clinics is one of the important solution to some of the challenges faced by women with disabilities*." (Key informant 2)

The verbatim shows the need for service accessibility for WWDs as the face challenges like long distance and transport cost. Mobile clinics are vehicles or portable units that's deliver SRH services directly to remote or underserved communities. This is in line with

Intersectionality Theory that postulate that mobile clinic help to mitigate the effects of geographical isolation, economic limitations and inadequate transportation challenges that intersect to disproportionately exclude peri-urban WWDs. WHO (2015) recognizes mobile clinics as a best practice in ensuring SRH equity for vulnerable population. Their flexibility allows for outreach to people with multiple disadvantages including disabilities. WWDs in Zimbabwe often sit at the intersection of geographic exclusion, poverty and disability. Mobile clinics directly targets these layers of disadvantage by reducing distance and cost barriers. Chireshe et al. (2010) asserted that women with disabilities in Zimbabwe often live far from health facilities and rely on others for transportation. Mobile clinics reduces this dependency by bringing services closer to homes. Groce et al. (2020) highlighted how mobile outreach in Sierra Leon and Ethiopia significantly increases contraceptive uptake among women with disabilities when the services were tailored to be inclusive. A case study in Zimbabwe by the Zimbabwe Red Cross Society piloted a mobile SRH unit in Manicaland Province 2022, which included disability-focused interventions such as sign language interpreters and staff trained in inclusive care. WWDs reported that this was the first time they had accessed such services without the stress and cost of long-distance travel. This study shows that, mobile clinics are rarely active in Zimbabwe, and it is important for the Zimbabwean government to do these mobile clinics in order to accommodate WWDs who cannot manage to visit clinics and transport challenges. As discussed in Chapter 2, many WWDs perceive clinics as unsafe or inaccessible due to both physical and attitudinal barriers (UN Women, 2019), making mobile units an essential strategy to bridge this gap. Likewise, Musarandega and Mlambo (2021) observed that Zimbabwean WWDs already face higher risks of exclusion and violence, which mobile SRH services could help reduce by bringing care closer to their communities.

4.6.4 Policy improvement

Participants, caregivers and professionals called for more inclusive national SRH and disability policies, better enforcement of disability rights laws and the incorporation of disability-inclusive indicators in health planning and budgeting. This was supported by key informants that thought the ministry of health and child care must improve their policy in order to include WWDs effectively.

Some participants had this to say:

> "*The government of Zimbabwe should strengthen laws that addresses people living with disabilities and also make follow ups to ensure that these laws are being implemented.*" (Participant 12)

> *"The government of Zimbabwe must include disability fund in the national budget and make sure that the money is funded to Disability Department."* (Participant 11)

> *"The government must strengthen disability policies and to introduce new laws that include SRH for women with disabilities and to make sure are effective"* (Key informant 1)

The verbatim show that, in Zimbabwe policies exist but they only exist on paper because they are not effective on ground. Although Zimbabwe has progressive legal framework such as the Disability Policy (2021) and National Sexual and Reproductive Health Strategy, implementation remains weak. Policies often treat WWDs as a monolithic group and fails to account for the intersecting realities of disability, gender, poverty and locations. This was supported by Hankivsky (2014), and Intersectionality Theory which emphasises the importance of intersectional policy-making, arguing that policies must be designed with an understanding of how multiple factors such as gender, race and disability interact to shape disadvantaged. This also shows that Zimbabwe SRH policies lacked enforceable inclusion clauses leaving room for institutional neglect of WWDs. UNFPA (2018), also calls for SRH policies to specifically target marginalized subgroups of women with disabilities and recommends disability-disaggregated data to inform policy decisions. An evaluation by UNICEF Zimbabwe (2020), of the National Adolescent Sexual and Reproductive Health Strategy found limited reference to disability and zero budget lines for disability-specific inclusion. Key informants reported that, monitoring framework lacked indicators related to disability making it difficult to assess progress or accountability. Intersectionality theory therefore demands nuanced policy that acknowledges the unique realities of WWDs especially those from marginalized ethnicities, economic backgrounds or rural areas. Inclusive policies must therefore, go beyond disability-specific clauses and integrate gender-responsive, poverty-aware and culturally sensitive provisions to effective address the multi-layered nature of exclusion faced by WWDs.

4.7.CHAPTER SUMMARY

This chapter described, evaluated and analysed the study's findings. The study was discussed in accordance with the literature review from chapter 2 of the research, which focused on the intersectional theory. The findings shows that the most WWDs in Dombotombo ward 2 are aware of the SRH services available at public clinic but some of them are not able to access them because of the challenges they face such as attitudinal barriers, communication barriers, economic barriers, and infrastructural barriers. The research then manage to find coping mechanism which are adapted by WWDs such as avoidance, use of traditional medicine and self-advocacy and assertiveness. The study also found the possible measures to improve SRH access to women with disability which include mobile clinics, policy improvement, infrastructure improvement and training for healthcare workers in order to address all the barriers.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the concluding sections of this study focusing on the synthesis of key findings, conclusions drawn and actionable recommendations. This chapter builds upon the data presented and discussed in the preceding chapter by summarising the major themes, interpreting their implications for policy and practice and suggesting future areas for research. Informed by intersectional framework, the chapter reflects on how gender, disability and socio-economic factors intersect to shape WWDs access to SRH services. The findings also highlight systemic gaps and opportunities for innovation in inclusive health delivery. The chapter concludes with a proposed innovative model to address the identified barriers and enhance access to SRH services for WWDs in Zimbabwe.

5.2 SUMMARY OF FINDINGS

This section provides summary of findings from the previous chapter. The summary of findings are given according to the order of objectives of this study.

5.2.1 Available SRH services for WWDs in Dombotombo ward 2, Marondera

The study found that a range of SRH services, including HIV/AIDS testing, STI treatment, family planning, maternal care, and cancer screening, are formally available within Zimbabwe's public health system. These services align with national health priorities and demonstrate Zimbabwe's commitment to universal health coverage. However, the availability of these services does not ensure their accessibility or inclusivity for WWDs. While these services are technically present in hospitals and clinics, their design, communication methods, and physical environments have not been adapted to meet the specific needs of women with physical, sensory, or intellectual disabilities.

The findings highlighted the disconnection between service availability and functional access. Many WWDs are unaware of the full range of services due to ineffective health communication strategies, while others are discouraged by inaccessible infrastructure and provider attitudes. Consequently, the promise of comprehensive SRH services remains unfulfilled for a significant portion of the population. The study emphasizes the need to conceptualize "availability" through an inclusive lens that takes into account not just the presence of services, but also their usability, safety, and relevance to marginalized groups.

5.2.2 The challenges faced by WWDs in accessing SRHS in Dombotombo ward 2, Marondera

The study revealed that women with disabilities face a complex array of barriers, including communication limitations, negative provider attitudes, physical inaccessibility, financial hardship, and lack of privacy, which significantly hinder their access to sexual and reproductive health services. These barriers do not exist in isolation, they are intersectional and compounded by other social factors such as poverty, gender, and rural location, reinforcing systemic marginalization.

The challenges encountered by WWDs in accessing SRH services have deep and wide ranging effects on their health, dignity autonomy and overall well-being. Due to poor access to SRH services, WWDs face unintended pregnancies, high risk of STIs and HIV/AIDS infection and psychological problems like post-trauma stress, depression and social isolation.

5.2.3 The coping mechanisms adopted by WWDs in relation to challenges of SRHS in Dombotombo ward 2, Marondera

In response to these challenges, WWDs have developed various coping strategies to navigate Zimbabwe’s health system. Some women avoid health services altogether, especially if their previous experiences were traumatic or dehumanizing. Others turn to traditional medicine and self-treatment, driven by concerns of accessibility, affordability, and cultural familiarity. While these practices may offer short-term relief, they often lead to delays in care or inadequate SRH services, potentially worsening health outcomes.

Conversely, some positive coping mechanisms have also emerged. Peer support networks have become vital sources of emotional strength, shared information, and practical advice for navigating the health system. A few WWDs demonstrated strong self-advocacy and assertiveness, actively challenging discriminatory treatment and demanding better care. These coping strategies highlight both the resilience and agency of WWDs, even in contexts of systemic neglect.

5.2.4 Possible measures that can be adopted to improve access to SRH services in Zimbabwe

Participants identified several measures that could significantly improve women with disabilities' (WWDs) access to sexual and reproductive health (SRH) services. Chief among these was training healthcare workers to address discriminatory attitudes and improve communication with women with various types of disabilities. Infrastructure development, such as ramps, disability-friendly toilets, and accessible maternity beds, was also highlighted as a foundational requirement for inclusive healthcare. Participants deemed policy-level interventions essential as well, calling for the revision and enforcement of disability-inclusive health policies that are responsive to gender, location, and socioeconomic status. Furthermore, community sensitization was identified as a long-term solution to combat stigma and challenge cultural norms that marginalize WWDs.

5.3 CONCLUSIONS

Although sexual and reproductive health services such as HIV testing, STI treatment, family planning, maternal care, and cancer screening are technically available in Zimbabwe, their design and delivery often exclude women with disabilities, undermining the principle of universal access. The concept of "availability" in the health sector must be redefined to go beyond the mere physical presence of services, incorporating accessibility, acceptability, and quality, particularly for marginalized populations like WWDs. Service availability without inclusion strategies leads to de facto exclusion, suggesting that health systems in Zimbabwe are not yet fully responsive to the specific and diverse needs of women with disabilities.

WWDs face a complex set of barriers, including communication limitations, negative provider attitudes, physical inaccessibility, financial hardship, and a lack of privacy, which significantly hinder their access to SRH services. These barriers do not exist in isolation; they are intersectional and compounded by other social factors such as poverty, gender, and rural location, reinforcing systemic marginalization. The existing healthcare infrastructure and service delivery models in Zimbabwe fail to uphold the rights of WWDs to equitable SRH services, indicating a gap between policy intentions and lived realities.

Women with disabilities exhibit both resilience and vulnerability when facing barriers to sexual and reproductive health services. They adopt various coping mechanisms, ranging from avoidance and the use of traditional remedies to seeking peer support and asserting their needs. Negative coping strategies, such as avoidance, reflect a healthcare system that fails to inspire trust or safety among WWDs, which could worsen health disparities. On the other hand, positive strategies like peer support and self-advocacy showcase the agency of WWDs and emphasize the need for interventions that promote empowerment, leadership, and a collective voice among women with disabilities.

To effectively improve access to SRH services for WWDs, multifaceted strategies are essential, including training healthcare workers, ensuring accessible infrastructure, providing mobile service delivery, implementing inclusive policies, and fostering community-level awareness initiatives. It is equally important to address both attitudinal and structural barriers, as physical access alone is insufficient; both require intentional, sustained efforts grounded in disability rights frameworks and intersectional approaches. Sustainable improvements to SRH access for WWDs can only be realized through systemic change that prioritizes the voices and experiences of WWDs in health planning, service delivery, and policy formulation.

5.4 IMPLICATIONS TO SOCIAL WORK

The findings of this study have significant implications for social work practice in Zimbabwe and similar contexts. They highlight the need for a reorientation of methods, settings, training, and ethical frameworks to ensure that health and social service delivery is disability-inclusive, intersectional, and rights-based.

- **Practice Methods**

Social workers must adopt intersectional and participatory approaches when working with women with disabilities (WWDs), acknowledging the interlocking influences of gender, disability, poverty, and social norms on health outcomes. Practice models should focus on empowerment, advocacy, and capacity-building for WWDs. Home-based interventions, community health forums, and one-on-one case management strategies can help bridge the gap between formal health systems and marginalized women.

- **Settings**

The findings indicate that community-based and decentralized service settings are essential. Social work practice should expand beyond institutional environments to include community clinics, disability centres, and homes. The proposed COMMIT model aligns with the shift toward community-led, accessible service delivery models that incorporate sexual and reproductive health (SRH) services within existing local support structures.

- **Training and Capacity Building**

The study uncovers a pressing need for disability-specific and gender-sensitive training for social workers and allied health professionals. Both pre-service and in-service training curricula should integrate modules on working with persons with disabilities, intersectionality, and sexual rights. This includes training in sign language, braille communication, cultural competence, and advocacy techniques.

- **Ethics and Human Rights**

Ethical social work practice must be rooted in human rights principles such as dignity, autonomy, confidentiality, and informed consent. The findings emphasize that WWDs frequently experience systemic violations of these principles, making it crucial for social workers to act as watchdogs and advocates for the rights of marginalized women. Codes of ethics should be updated to reflect the unique vulnerabilities of WWDs in SRH contexts.

- **Policy and Advocacy**

Social workers are uniquely positioned to influence policy reform by utilizing evidence from frontline practice to advocate for inclusive health policies, budget allocations, and accessible infrastructure. The findings suggest that current policies inadequately protect the SRH rights of WWDs, and social workers should collaborate with government and NGOs to address this issue.

- **Collaboration and Multidisciplinary Work**

Effective social work practice in SRH for WWDs requires collaboration with medical personnel, educators, traditional leaders, and disability organizations. An integrated service approach ensures holistic care. Social workers should facilitate and lead cross-sector dialogues to dismantle attitudinal and systemic barriers.

5.5 RECOMMENDATIONS

This section presents recommendations based on the study’s findings on access to SRH services for WWDs in Dombotombo ward 2, Marondera. The recommendations are aimed to addressing the identified barriers, improving service delivery and promoting the inclusion of WWDs in SRH programs. These suggestions target policymakers, healthcare providers, community stakeholders and disability rights organisations to ensure more equitable and accessible SRH services for all.

Recommendations to Policy and Programmatic

- Review and Enforce Disability-Inclusive Health Policies: Policymakers should review national health and disability policies to ensure explicit inclusion of SRH rights for WWDs, with measurable indicators. Monitoring mechanisms should be strengthened to track inclusive policy implementation.
- Development of Inclusive SRHR Implementation Guidelines: The Ministry of Health and Child Care, in partnership with the Department of Disability Affairs, should develop ward-level SRHR service guidelines tailored to the needs of WWDs. These guidelines should include communication adaptations (e.g., pictorial charts, braille, and

sign language) and minimum accessibility standards. This should be completed within 12 months, with periodic reviews every 2 years.

- Integration of Disability Inclusion into Health Worker Training: The Health Services Board, working with nursing colleges and universities, must incorporate compulsory disability-inclusive SRHR modules into pre-service and in-service health training curricula by the start of the 2026 academic year.
- Monitoring and Evaluation Framework for Disability-Sensitive SRH: The Zimbabwe National Statistics Agency (ZIMSTAT) and Ministry of Women Affairs should develop measurable indicators to track SRHR service access and satisfaction among WWDs at ward level by end of 2025.

Recommendations to Stakeholder and Partner

- Expand Outreach Through Mobile SRH Clinics: Deploy well-equipped mobile clinics staffed with disability-trained personnel to serve remote and underserved communities. Mobile clinics should offer comprehensive SRH services and be scheduled in consultation with disability organizations.
- Upgrade Health Infrastructure to Ensure Accessibility: The government and development partners should prioritize funding for structural improvements in public health facilities, ensuring all SRH service points are accessible to women with physical, sensory, and intellectual disabilities. This includes ramps, accessible toilets, adjustable examination beds, and inclusive signage.
- Stakeholder Capacity Building Forums: Stakeholders including traditional leaders and advocacy groups should engage in bi-annual district-level forums.

Recommendations to Community and Research Participants

- Promote Peer-Led Support and Empowerment Programs: Encourage and fund community-based peer support groups and self-advocacy training for WWDs to empower them to engage with healthcare systems and assert their rights.
- Increase Community Sensitization and Awareness Campaigns: Develop culturally appropriate, disability-aware public education campaigns to challenge misconceptions and promote SRH rights for WWDs. Involve traditional leaders, community health workers, and caregivers.
- Family Involvement in SRH Education: Families of WWDs should be trained by health workers on respectful SRH support.

Recommendations to Social Work

- Mainstreaming Disability in Social Work Training: The Council of Social Workers in Zimbabwe should incorporate disability-sensitive SRH training in all curricula.
- Deployment of Ward-Based Social Workers: Social workers trained in SRH and disability should be deployed as liaison officers.
- Case Management System for SRH Violations: A confidential reporting system for violations against WWDs.

Innovative model

Community Operated Mobile and Modular Inclusive Treatment Model (COMMIT)

Women with Disabilities are still frequently excluded from fair access to sexual and reproductive health services. This is due to a variety of structural, cultural, economic, and institutional impediments. To address these deficiencies, this study presents the COMMIT strategy an innovative, context-responsive, and scalable strategy for promoting access, dignity and inclusivity in the delivery of SRH services to WWDs.

The COMMIT Model based on intersectionality theory, which recognises the WWDs various and overlapping identities and disadvantages such as, disability, gender, poverty, rural location, and sociocultural attitudes. It combines inclusive health delivery with community participation, mobile health technology, and decentralization of services to meet WWDs where they are, both literally and figuratively.

Figure 1 COMMIT MODEL

Community Engagement

Community ownership is a crucial basis. The strategy begins by identifying and educating local disability-inclusive health champions, which includes WWDs, caregivers, peer educators, and traditional leaders. This builds trust, foster engagement, and reduces stigma. These champions will co-design health campaigns, assist with service delivery, and provide localized SRH education in user-friendly formats.

Operated by Trained Local Teams

The COMMIT Model delivers services through teams of nurses, social workers, SRH officers, and trained disability advocates preferably from the communities being served. Intersectionality, gender sensitivity, sign language, and ethical communication with WWDs are among the subjects covered throughout training. This strategy not only bridges the communication gap but it also strengthens the provider-client relationship.

Mobile Modular Clinics

The strategy includes adaptable mobile health units that are equipped with, ramps and wheelchair-accessible structures, adjustable examination beds, confidential counselling pods, inclusive toilets. Modules within the unit offer SRH education, testing (HIV, STIs, cancer screening), contraception, maternal services, and referrals. Clinics move on a fixed schedule and can be dispatched for emergencies or special campaigns.

Multi-sectoral Collaboration

- The COMMIT Model emphasizes partnerships between:
- Ministry of Health and Child Care (MOHCC)
- Local government (e.g., Marondera Municipality)
- NGOs and Disabled Persons Organizations (DPOs)
- Traditional and religious leaders
- Community-Based Organizations (CBOs)

Such collaboration ensures shared responsibility, sustainability, policy support, and community legitimacy.

Inclusive Technologies

Inclusive communication tools such as tablets with sign language videos, audio messages in Shona and English, braille pamphlets, and visual aids are used to deliver SRH education. The tools are updated regularly to reflect new health information and ensure accessibility for all categories of disabilities.

Tailored Outreach & Tracking

Using participatory GIS mapping, WWDs within a community are identified (with consent) and mapped for targeted outreach and follow-up. This ensures continuity of care and allows service providers to maintain a personalized approach. Tracking also assists in monitoring health outcomes, referrals, and revisits.

This model is rooted in;

- Intersectionality Theory (Crenshaw, 1991; Hankivsky, 2014), addressing the overlapping barriers of gender, disability, socio-economic status, and location.
- Capability Approach (Nussbaum, 2006), promoting functioning's and freedoms by ensuring that WWDs have the opportunity and means to achieve health and reproductive wellbeing.
- Social Model of Disability, shifting the burden of accessibility from individuals to systems and structures.
- Human Rights-Based Approach to Health (UNFPA, 2018): Centering dignity, agency, and participation.

Expected Impact

- Increased access to SRH services among WWDs in remote and urban-poor areas.
- Improved SRH knowledge through targeted, inclusive education.
- Reduced stigma via inclusive community engagement.
- Enhanced data collection and policy responsiveness through community mapping and follow-up.
- Promotion of autonomy and dignity for WWDs in making reproductive choices.

The COMMIT Model is not just a service delivery innovation, it is a rights-based, community-driven solution that centers the needs, voices, and capacities of WWDs. By leveraging mobility, technology, and participatory approaches, it seeks to bridge the persistent gap in SRH access for WWDs in Zimbabwe. With appropriate policy alignment, funding, and partnership, COMMIT has the potential to transform how inclusive healthcare is delivered in resource-constrained contexts.

5.6 AREA OF FUTURE STUDY

- Men with Disabilities and SRHR: There is a need to explore the SRH experiences and needs of men with disabilities to promote inclusive gender equity.
- Post-Service Evaluation: Research on the quality and outcomes of SRH services received by WWDs would help evaluate service effectiveness and areas for improvement.
- Role of Religion and Culture: Further research on the influence of religious and traditional beliefs on WWDs' access and experiences with SRH services in Zimbabwe.

5.7 CHAPTER SUMMARY

This chapter presented summary of findings from chapter four, conclusions drawn from study findings and literature review, practical recommendations to address the gaps identified in accessing SRH services for WWDs, drawing on intersectionality theory and grounded insights from fieldwork. It emphasized the critical role of social workers as advocates, educators, and change agents in the fight for inclusive SRH services. Additionally, the proposed COMMIT innovation serves as a strategic model to institutionalize inclusion within the healthcare system. Future research was recommended in areas that are currently underexplored but vital for comprehensive SRH access for all persons with disabilities in Zimbabwe.

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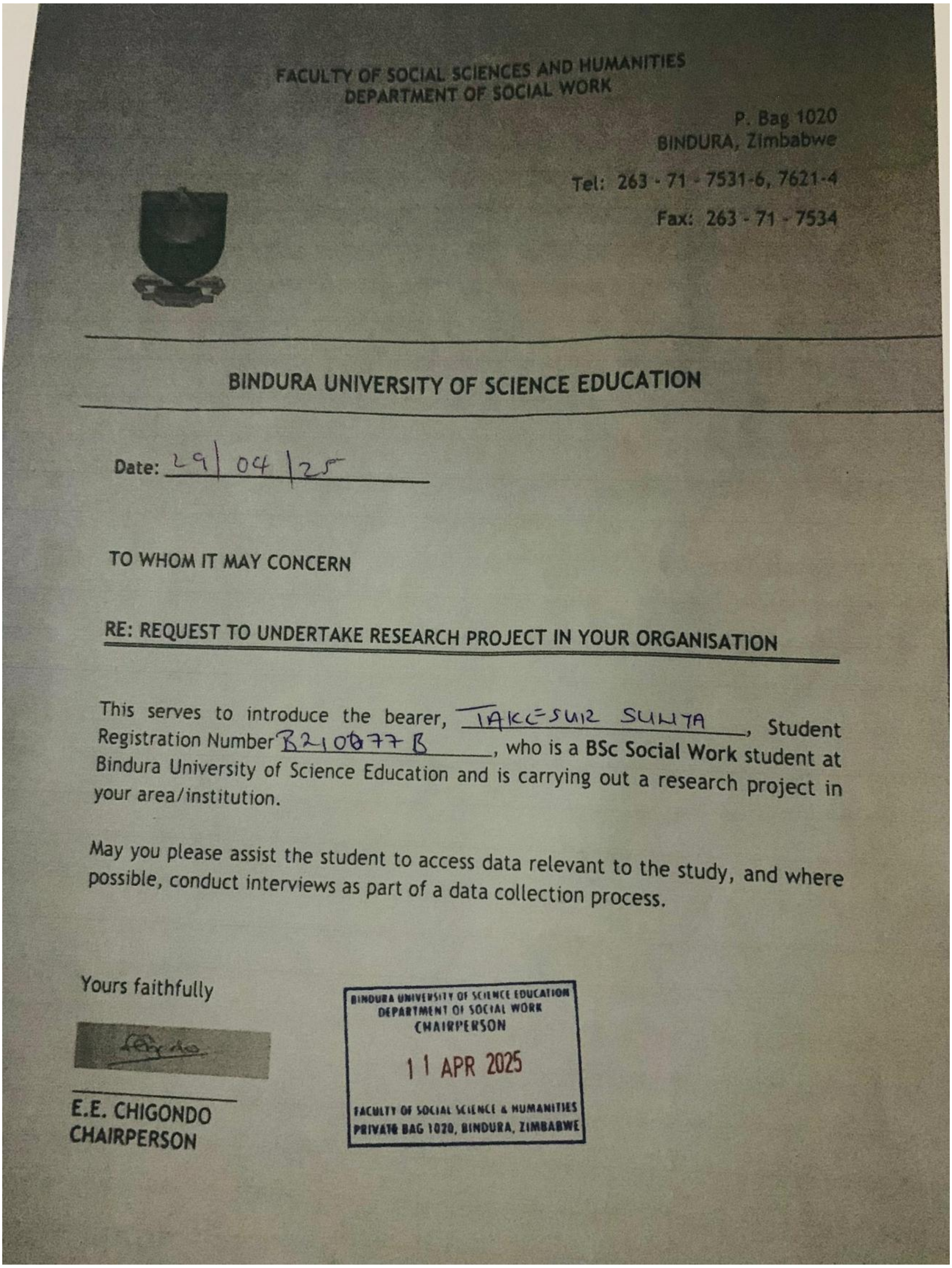
APPENDICE 1



FACULTY OF SOCIAL SCIENCES AND HUMANITIES
DEPARTMENT OF SOCIAL WORK

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BINDURA, Zimbabwe

Tel: 263 - 71 - 7531-6, 7621-4

Fax: 263 - 71 - 7534

BINDURA UNIVERSITY OF SCIENCE EDUCATION

Date: 29/04/25

TO WHOM IT MAY CONCERN

RE: REQUEST TO UNDERTAKE RESEARCH PROJECT IN YOUR ORGANISATION

This serves to introduce the bearer, TAKESUR SUNYA, Student Registration Number B210877B, who is a **BSc Social Work** student at Bindura University of Science Education and is carrying out a research project in your area/institution.

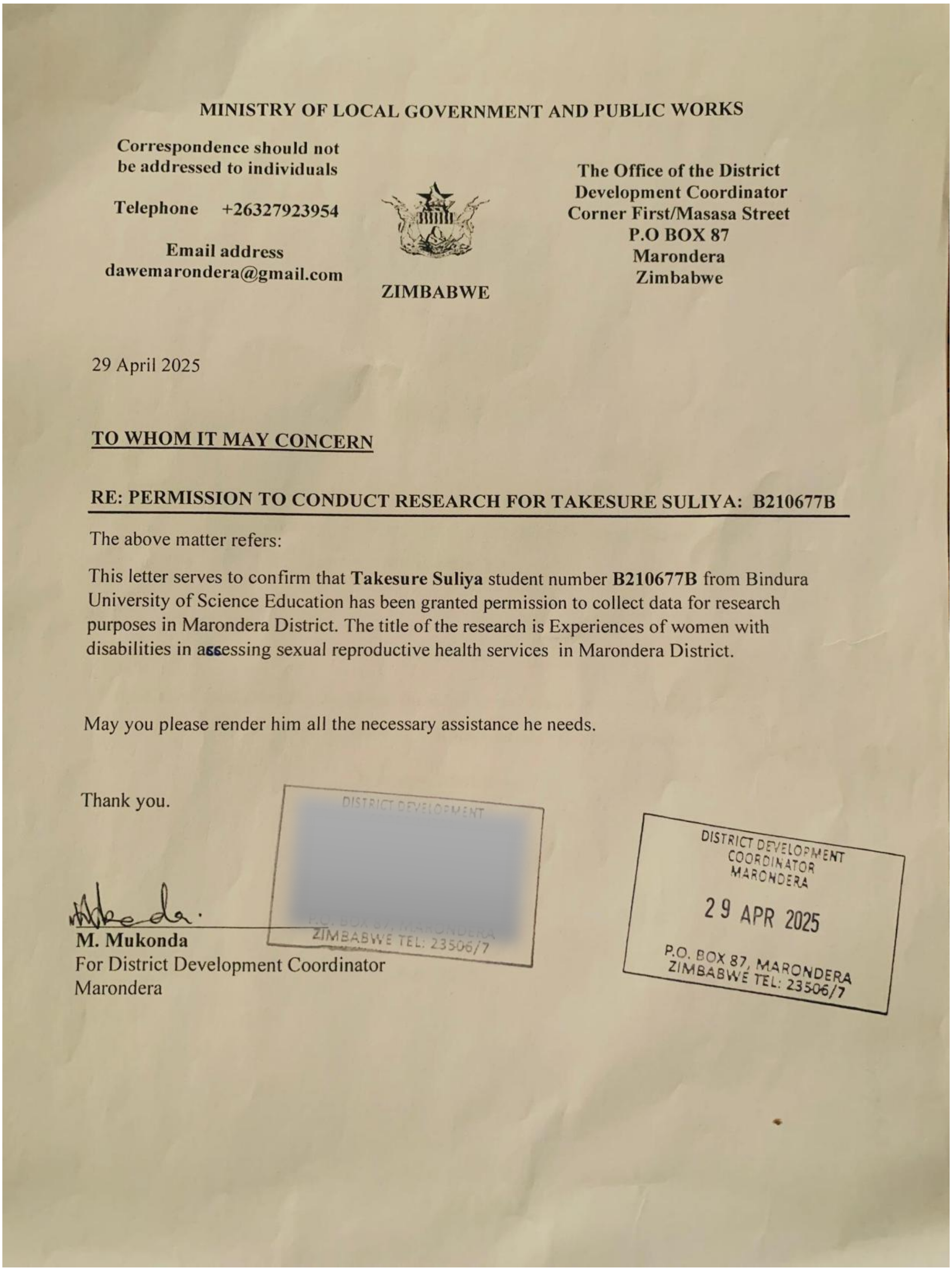
May you please assist the student to access data relevant to the study, and where possible, conduct interviews as part of a data collection process.

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

APPENDICE 2



MINISTRY OF LOCAL GOVERNMENT AND PUBLIC WORKS

Correspondence should not
be addressed to individuals

Telephone +26327923954

Email address
dawemarondera@gmail.com

ZIMBABWE

The Office of the District
Development Coordinator
Corner First/Masasa Street
P.O BOX 87
Marondera
Zimbabwe

29 April 2025

TO WHOM IT MAY CONCERN

RE: PERMISSION TO CONDUCT RESEARCH FOR TAKESURE SULIYA: B210677B

The above matter refers:

This letter serves to confirm that **Takesure Suliya** student number **B210677B** from Bindura University of Science Education has been granted permission to collect data for research purposes in Marondera District. The title of the research is Experiences of women with disabilities in assessing sexual reproductive health services in Marondera District.

May you please render him all the necessary assistance he needs.

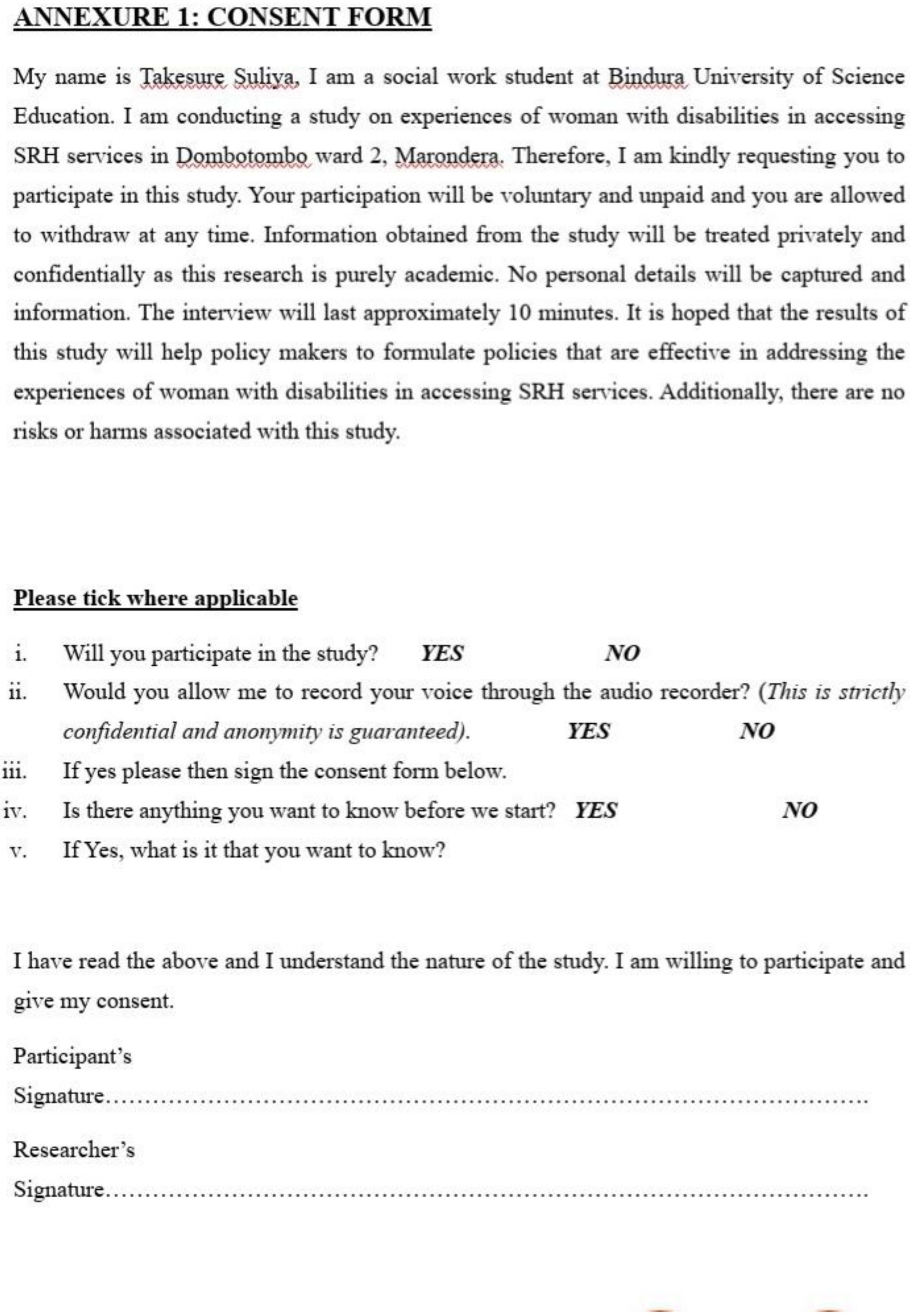
Thank you.

[redacted]

M. Mukonda
For District Development Coordinator
Marondera

DISTRICT DEVELOPMENT
COORDINATOR
MARONDERA
29 APR 2025
P.O. BOX 87, MARONDERA
ZIMBABWE TEL: 23506/7

APPENDICE 3



ANNEXURE 1: CONSENT FORM

My name is Takesure Suliya, I am a social work student at Bindura University of Science Education. I am conducting a study on experiences of woman with disabilities in accessing SRH services in Dombotombo ward 2, Marondera. Therefore, I am kindly requesting you to participate in this study. Your participation will be voluntary and unpaid and you are allowed to withdraw at any time. Information obtained from the study will be treated privately and confidentially as this research is purely academic. No personal details will be captured and information. The interview will last approximately 10 minutes. It is hoped that the results of this study will help policy makers to formulate policies that are effective in addressing the experiences of woman with disabilities in accessing SRH services. Additionally, there are no risks or harms associated with this study.

Please tick where applicable

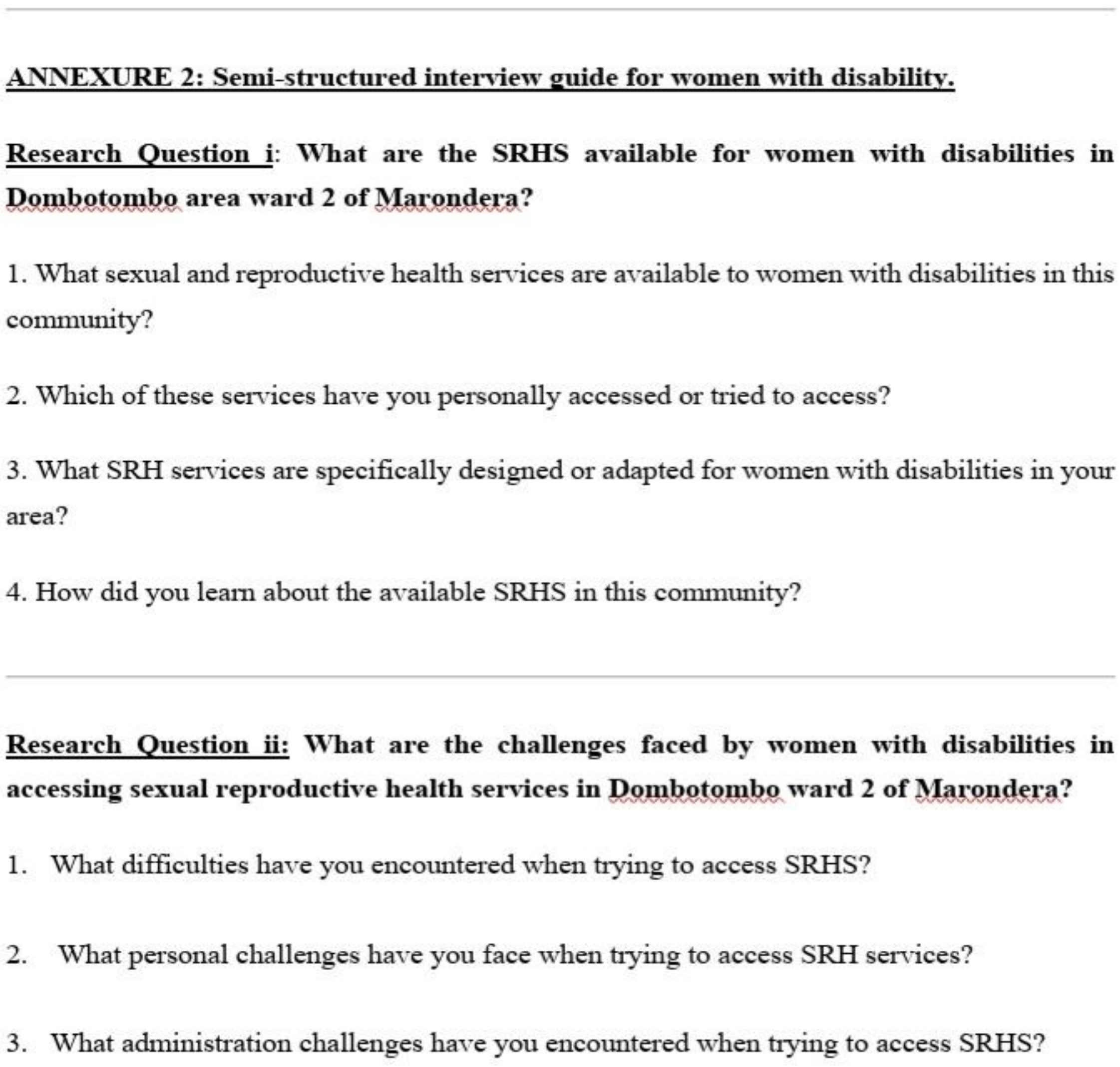
i. Will you participate in the study? ***YES*** ***NO***
ii. Would you allow me to record your voice through the audio recorder? (*This is strictly confidential and anonymity is guaranteed).* ***YES*** ***NO***
iii. If yes please then sign the consent form below.
iv. Is there anything you want to know before we start? ***YES*** ***NO***
v. If Yes, what is it that you want to know?

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………………………………………………………………………………….

APPENDICE 4



ANNEXURE 2: Semi-structured interview guide for women with disability.

Research Question i: What are the SRHS available for women with disabilities in Dombotombo area ward 2 of Marondera?

1. What sexual and reproductive health services are available to women with disabilities in this community?

2. Which of these services have you personally accessed or tried to access?

3. What SRH services are specifically designed or adapted for women with disabilities in your area?

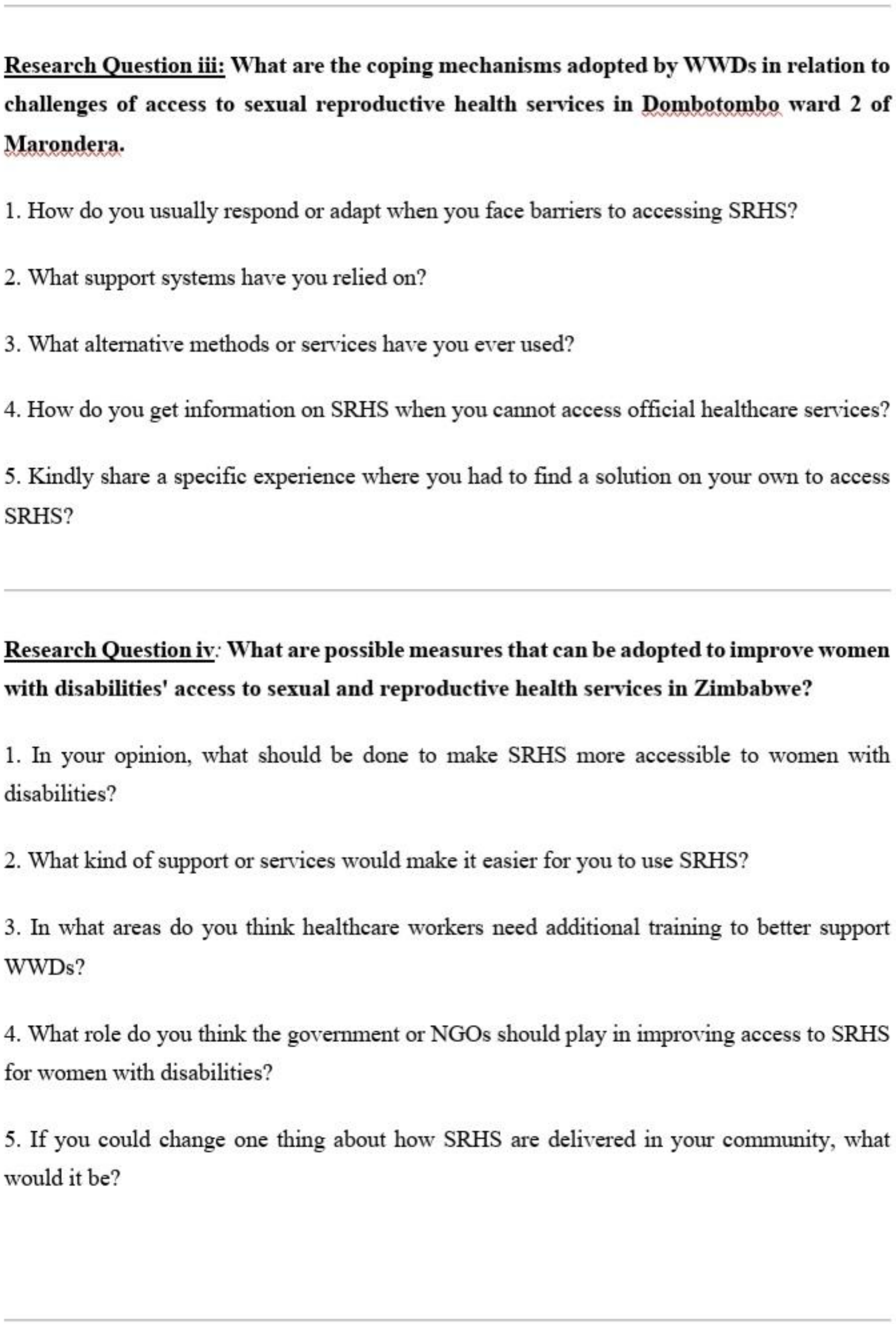
4. How did you learn about the available SRHS in this community?

Research Question ii: What are the challenges faced by women with disabilities in accessing sexual reproductive health services in Dombotombo ward 2 of Marondera?

1. What difficulties have you encountered when trying to access SRHS?

2. What personal challenges have you face when trying to access SRH services?

3. What administration challenges have you encountered when trying to access SRHS?



Research Question iii: What are the coping mechanisms adopted by WWDs in relation to challenges of access to sexual reproductive health services in Dombotombo ward 2 of Marondera.

1. How do you usually respond or adapt when you face barriers to accessing SRHS?

2. What support systems have you relied on?

3. What alternative methods or services have you ever used?

4. How do you get information on SRHS when you cannot access official healthcare services?

5. Kindly share a specific experience where you had to find a solution on your own to access SRHS?

Research Question iv: What are possible measures that can be adopted to improve women with disabilities' access to sexual and reproductive health services in Zimbabwe?

1. In your opinion, what should be done to make SRHS more accessible to women with disabilities?

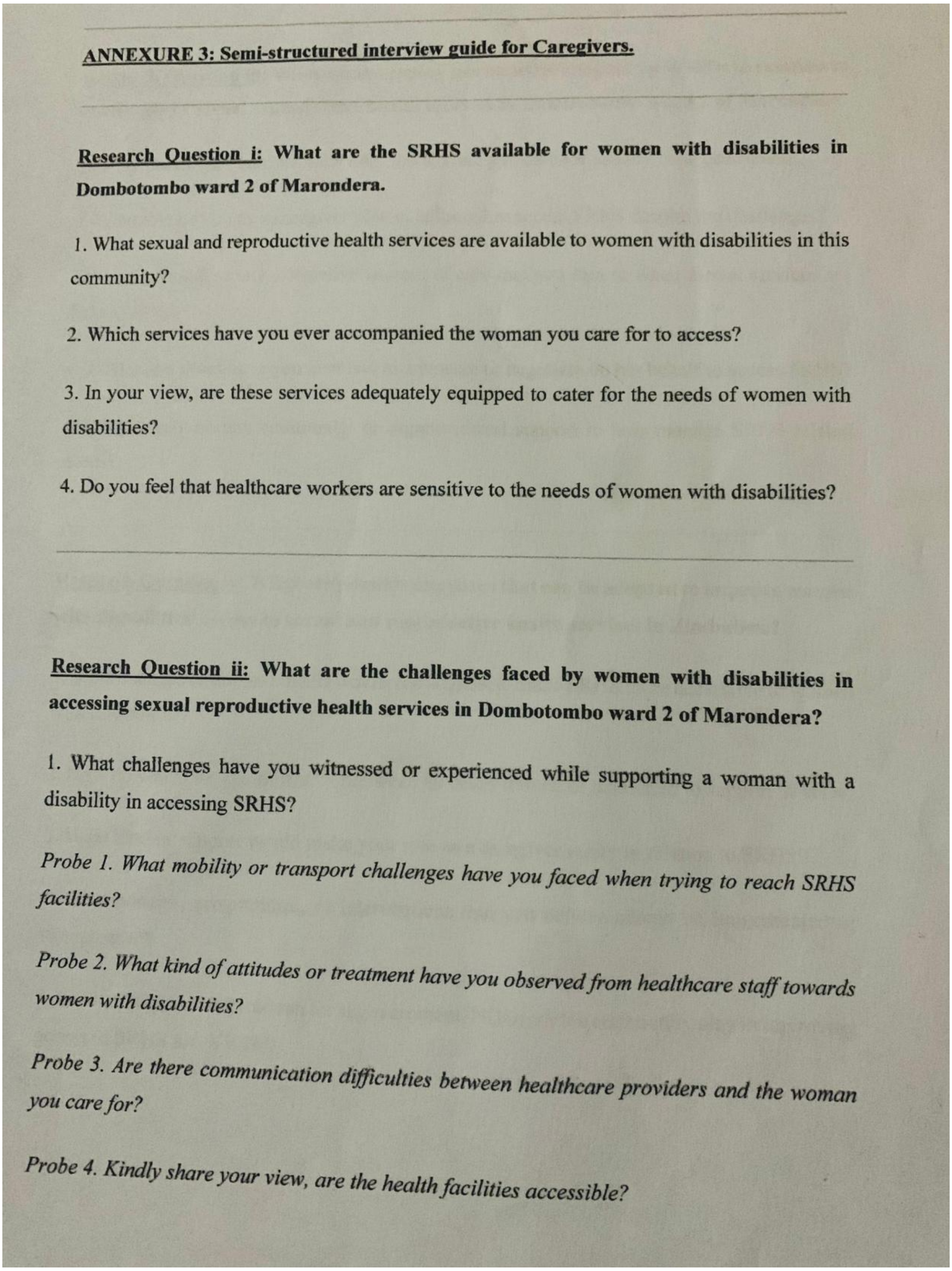
2. What kind of support or services would make it easier for you to use SRHS?

3. In what areas do you think healthcare workers need additional training to better support WWDs?

4. What role do you think the government or NGOs should play in improving access to SRHS for women with disabilities?

5. If you could change one thing about how SRHS are delivered in your community, what would it be?

APPENDICE 5



ANNEXURE 3: Semi-structured interview guide for Caregivers.

Research Question i: What are the SRHS available for women with disabilities in Dombotombo ward 2 of Marondera.

1. What sexual and reproductive health services are available to women with disabilities in this community?

2. Which services have you ever accompanied the woman you care for to access?

3. In your view, are these services adequately equipped to cater for the needs of women with disabilities?

4. Do you feel that healthcare workers are sensitive to the needs of women with disabilities?

Research Question ii: What are the challenges faced by women with disabilities in accessing sexual reproductive health services in Dombotombo ward 2 of Marondera?

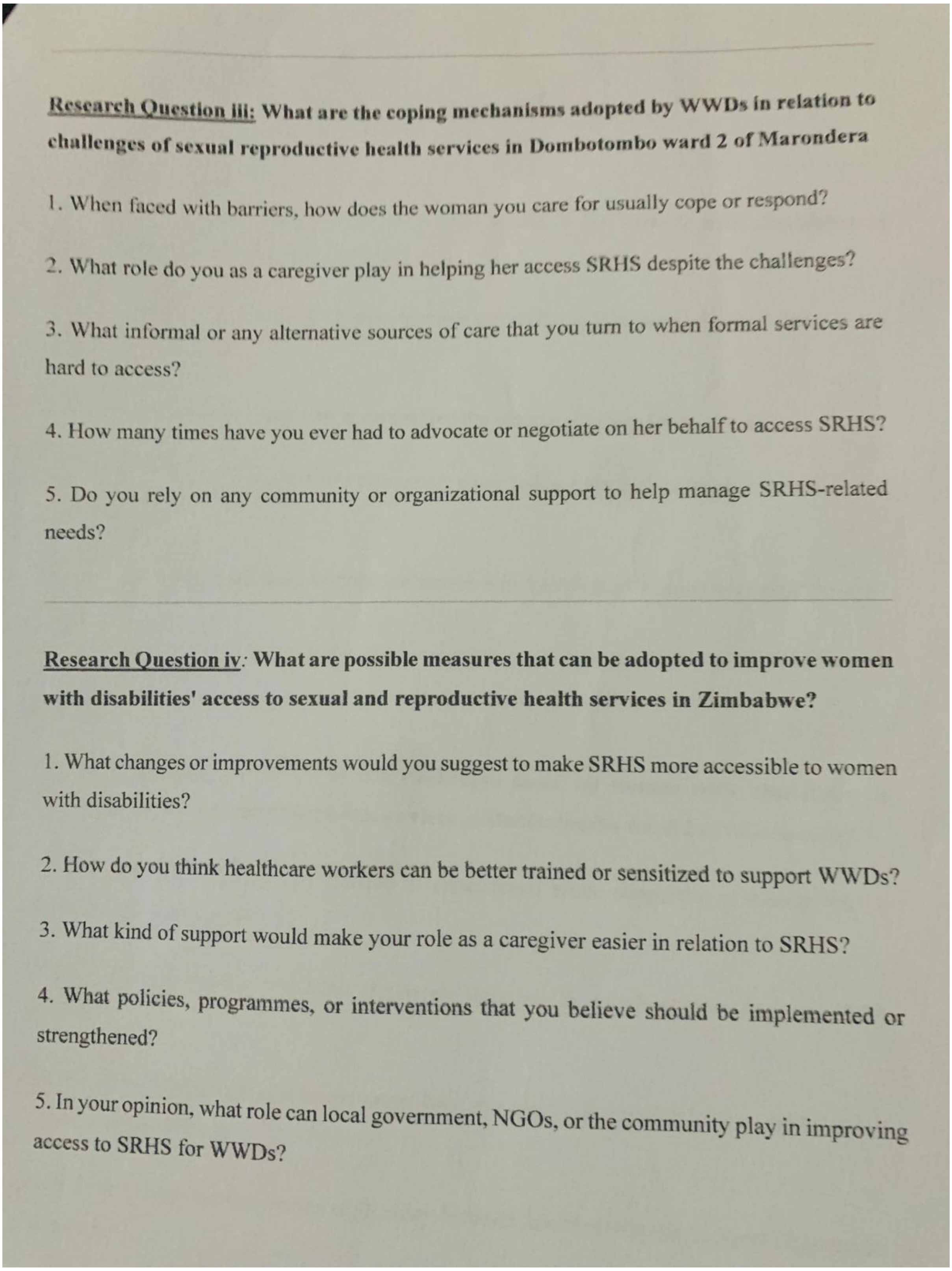
1. What challenges have you witnessed or experienced while supporting a woman with a disability in accessing SRHS?

Probe 1. What mobility or transport challenges have you faced when trying to reach SRHS facilities?

Probe 2. What kind of attitudes or treatment have you observed from healthcare staff towards women with disabilities?

Probe 3. Are there communication difficulties between healthcare providers and the woman you care for?

Probe 4. Kindly share your view, are the health facilities accessible?



Research Question iii: What are the coping mechanisms adopted by WWDs in relation to challenges of sexual reproductive health services in Dombotombo ward 2 of Marondera

1. When faced with barriers, how does the woman you care for usually cope or respond?

2. What role do you as a caregiver play in helping her access SRHS despite the challenges?

3. What informal or any alternative sources of care that you turn to when formal services are hard to access?

4. How many times have you ever had to advocate or negotiate on her behalf to access SRHS?

5. Do you rely on any community or organizational support to help manage SRHS-related needs?

Research Question iv: What are possible measures that can be adopted to improve women with disabilities' access to sexual and reproductive health services in Zimbabwe?

1. What changes or improvements would you suggest to make SRHS more accessible to women with disabilities?

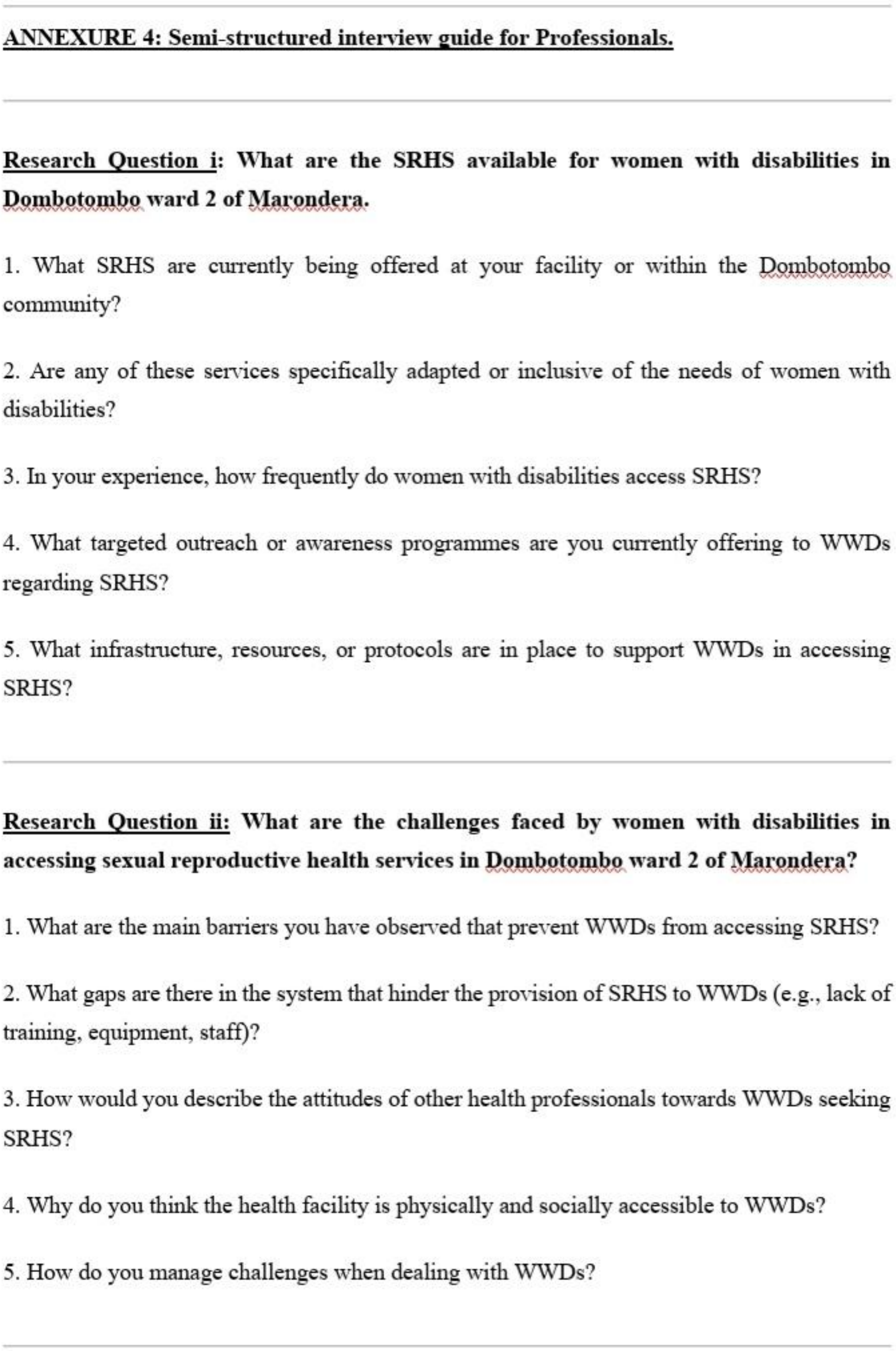
2. How do you think healthcare workers can be better trained or sensitized to support WWDs?

3. What kind of support would make your role as a caregiver easier in relation to SRHS?

4. What policies, programmes, or interventions that you believe should be implemented or strengthened?

5. In your opinion, what role can local government, NGOs, or the community play in improving access to SRHS for WWDs?

APPENDICE 6



ANNEXURE 4: Semi-structured interview guide for Professionals.

Research Question i: What are the SRHS available for women with disabilities in Dombotombo ward 2 of Marondera.

1. What SRHS are currently being offered at your facility or within the Dombotombo community?

2. Are any of these services specifically adapted or inclusive of the needs of women with disabilities?

3. In your experience, how frequently do women with disabilities access SRHS?

4. What targeted outreach or awareness programmes are you currently offering to WWDs regarding SRHS?

5. What infrastructure, resources, or protocols are in place to support WWDs in accessing SRHS?

Research Question ii: What are the challenges faced by women with disabilities in accessing sexual reproductive health services in Dombotombo ward 2 of Marondera?

1. What are the main barriers you have observed that prevent WWDs from accessing SRHS?

2. What gaps are there in the system that hinder the provision of SRHS to WWDs (e.g., lack of training, equipment, staff)?

3. How would you describe the attitudes of other health professionals towards WWDs seeking SRHS?

4. Why do you think the health facility is physically and socially accessible to WWDs?

5. How do you manage challenges when dealing with WWDs?

<u>Research Question iii:</u> What are the coping mechanisms adopted by WWDs in relation to challenges of sexual reproductive health services in Dombotombo ward 2 of Marondera?

1. How do women with disabilities tend to respond when faced with difficulties in accessing SRHS?

2. What specific strategies or alternatives that WWDs use to overcome barriers to service access issues?

3. What role do caregivers or family members typically play in supporting access to SRHS?

4. Which community-based solutions or support networks that WWDs rely on?

5. In your professional opinion, do these coping mechanisms address the health needs of WWDs adequately?

<u>Research Question iv</u>: What are possible measures that can be adopted to improve women with disabilities' access to sexual and reproductive health services in Zimbabwe?

1. What practical steps could be taken to make SRHS more inclusive for women with disabilities?

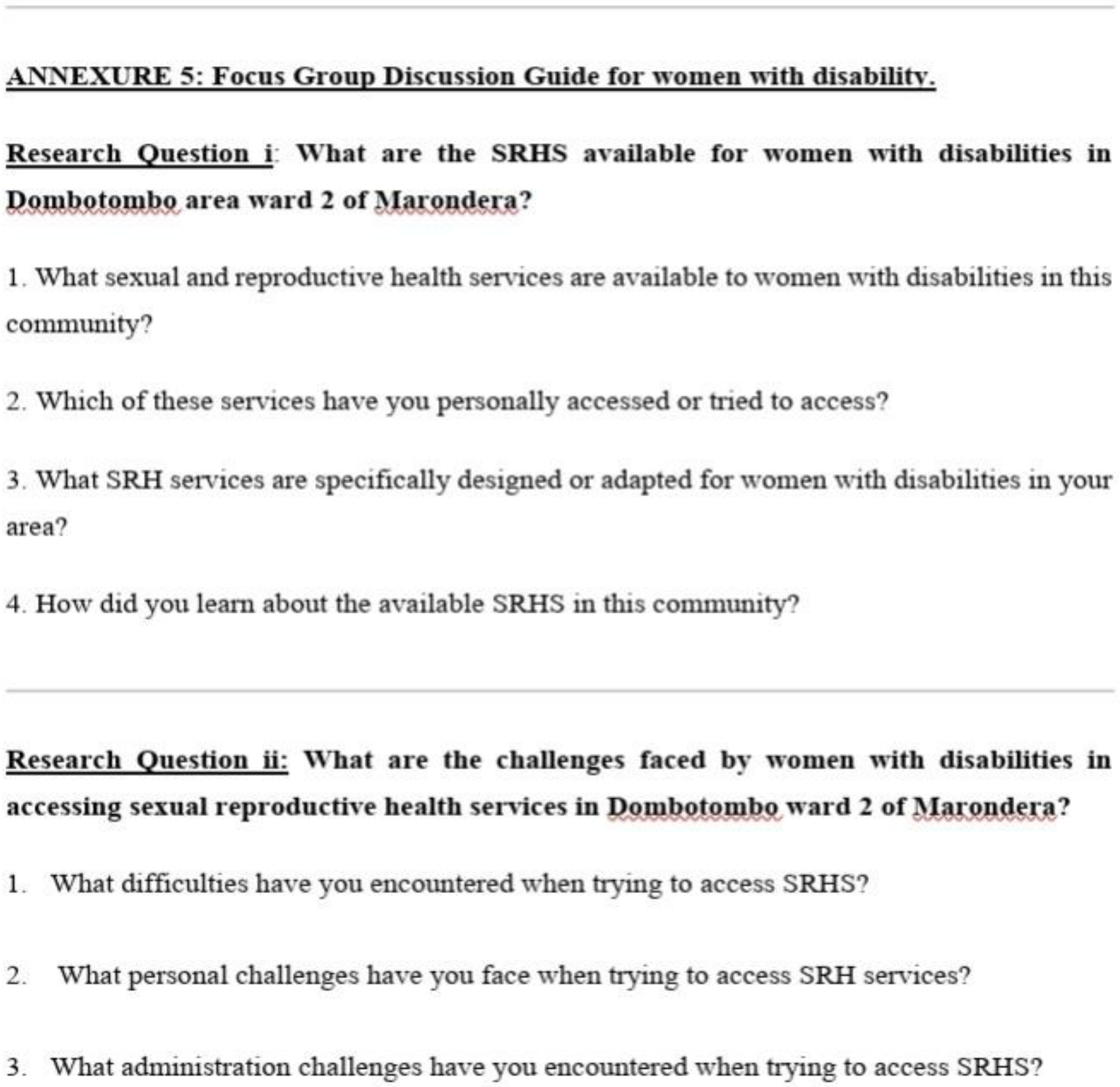
2. What kind of training or support do you and your colleagues need to better serve WWDs?

3. What policy or systematic changes would you recommend to improve service delivery for WWDs?

4. Which partnerships are there (with NGOs, local government, etc.) that could be strengthened to support better SRHS access?

5. From your experience, what is the most urgent need to address when it comes to SRHS for WWDs?

APPENDICE 7



ANNEXURE 5: Focus Group Discussion Guide for women with disability.

Research Question i: What are the SRHS available for women with disabilities in Dombotombo area ward 2 of Marondera?

1. What sexual and reproductive health services are available to women with disabilities in this community?

2. Which of these services have you personally accessed or tried to access?

3. What SRH services are specifically designed or adapted for women with disabilities in your area?

4. How did you learn about the available SRHS in this community?

Research Question ii: What are the challenges faced by women with disabilities in accessing sexual reproductive health services in Dombotombo ward 2 of Marondera?

1. What difficulties have you encountered when trying to access SRHS?

2. What personal challenges have you face when trying to access SRH services?

3. What administration challenges have you encountered when trying to access SRHS?

Research Question iii: What are the coping mechanisms adopted by WWDs in relation to challenges of access to sexual reproductive health services in Dombotombo ward 2 of Marondera.

1. How do you usually respond or adapt when you face barriers to accessing SRHS?

2. What support systems have you relied on?

3. What alternative methods or services have you ever used?

4. How do you get information on SRHS when you cannot access official healthcare services?

5. Kindly share a specific experience where you had to find a solution on your own to access SRHS?

Research Question iv: What are possible measures that can be adopted to improve women with disabilities' access to sexual and reproductive health services in Zimbabwe?

1. In your opinion, what should be done to make SRHS more accessible to women with disabilities?

2. What kind of support or services would make it easier for you to use SRHS?

3. In what areas do you think healthcare workers need additional training to better support WWDs?

4. What role do you think the government or NGOs should play in improving access to SRHS for women with disabilities?

5. If you could change one thing about how SRHS are delivered in your community, what would it be?