Ensuring sexual and reproductive health rights of women with disabilities: A study of policies, actions and commitments in Uganda and Zimbabwe

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Dedication

I dedicate this work to my parents, Obadiah T. and Liyana S. Moyo who both live with disability. They have truly shown me and my siblings that “disability is not inability” through the role they play as loving parents. Thank you for the love, inspiration, wise words, comfort and support you have always offered me. You have truly shaped my life.
Acknowledgements

The writing of this dissertation has been a captivating moment filled with moments of excitement, joy, hesitation, intrigue, fatigue and a whole lot of other feelings. These moments have been a learning curve which has shaped my experiences in academic life. This work would have not been possible without the unwavering support of a number of individuals. Firstly, I would like to acknowledge the support of my supervisor Dr Sarah Cardey who has supervised and guided me during this process and during my stay at the University of Reading as well. Your unending input through the discussions and comments you made are greatly valued. I am greatly indebted to the Joint Japan/World Bank Graduate Scholarship Programme (JJ/WBGSP) 2009/10 who believed in my aspirations to further my academic studies and sponsored my graduate studies. Without the financial support this dream could have not been realised, I will forever value this opportunity and will use the numerous skills gained to help other fellow human beings realise their full potential and dreams.

The support of my parents and my siblings, Rejoice, Thembalethu and Thubelihle has been awesome and got me through each day, thank you guys for the love, concern and contributions. A special thank you goes to Moreblessing Mbire a friend who pitched up in time of great need, thank you for your assistance with the key informant interviews. To Monich Mbiba thank you for the times we spent assisting each other through the comments, thought provoking discussions and encouragement.

Acknowledgements also go to the following people who all contributed immensely in various ways to this dissertation. To Tawanda Mhene, Blessing Dube, Batsirai Majuru, Myroslavo Tataryn, Ruth Karimatsenga, Jenny Docto and Farai Katiro, thank you all for your time and support.
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADD</td>
<td>Action on Disability and Development</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Virus</td>
</tr>
<tr>
<td>CBR</td>
<td>Community Based Rehabilitation</td>
</tr>
<tr>
<td>DFID</td>
<td>United Kingdom Department for International Development</td>
</tr>
<tr>
<td>DPA</td>
<td>Disabled People’s Act</td>
</tr>
<tr>
<td>DPI</td>
<td>Disabled People's International</td>
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<tr>
<td>DPOs</td>
<td>Disabled people’s Organisations</td>
</tr>
<tr>
<td>DWSO</td>
<td>Disabled Women’s Support Organisation</td>
</tr>
<tr>
<td>ECOSOC</td>
<td>United Nations Economic and Social Council</td>
</tr>
<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Convention on Population and Development</td>
</tr>
<tr>
<td>INGOs</td>
<td>International Non-governmental Organisations</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOHCW</td>
<td>Ministry of Health and Child Welfare</td>
</tr>
<tr>
<td>NUWODU</td>
<td>National Union of Women with Disabilities in Uganda</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-governmental Organisations</td>
</tr>
<tr>
<td>POA</td>
<td>Plan of Action</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Papers</td>
</tr>
<tr>
<td>PWDs</td>
<td>People/persons with disabilities</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strengths, weaknesses, opportunities and threats</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>------------------------------------------</td>
</tr>
<tr>
<td>UN CRPD</td>
<td>United Nations Convection on the Rights of Persons with Disabilities</td>
</tr>
<tr>
<td>UNECA</td>
<td>United Nations Economic Commission for Africa</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WWDs</td>
<td>Women with disabilities</td>
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<tr>
<td>ZNFPC</td>
<td>Zimbabwe National Family Planning Council</td>
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Summary

Very little research has been done on the importance of including women with disabilities into sexual and reproductive health programmes in developing countries. While other developed countries have been progressing well in sexual and reproductive health issues, most countries in Sub-Saharan African are performing dismally due to an array of socio-economic, political and cultural factors hindering progress. This has seen women of various diversities suffer and amongst these women with disabilities. The purpose of this study is to assess the implications of disability among women on accessing sexual and reproductive health information and services in Uganda and Zimbabwe. Both Uganda and Zimbabwe have been influential in shaping disability and development debates on the continent.

This dissertation reviewed literature on gender, disability, HIV/AIDS and sexual and reproductive health, analysed policy documents on reproductive health and interviewed key informants who were well versed in disability and development issues. The literature review was done through drawing upon substantive findings of researches on the relevant topics. The study analysed the Maputo Plan of Action on the Operationalisation of the Continental policy framework for sexual and reproductive health rights and the national reproductive health policies of Uganda and Zimbabwe to assess how women with disabilities are mainstreamed in these frameworks. The key informant interviews shed light on the challenges faced by disabled women in accessing sexual and reproductive health information and services.

The study revealed that women with disabilities face a multiplicity of challenges in accessing services and information for their sexual and reproductive rights concerns. The existence of various negative barriers within society has rendered women with disabilities to be marginalised or completely excluded from claiming and receiving these rights in
extreme cases. Findings confirmed that policies on reproductive health are disability blind. In other areas and sectors minimal positive strides are being taken to mainstream disability in Uganda and Zimbabwe.

The study concluded that ensuring universal access to sexual and reproductive health will not be achieved in Uganda and Zimbabwe including other Africa countries without the meaningful involvement of women with disabilities. This involvement can be achieved through rights based approaches which promote participation of women with disabilities and mainstreaming of disability into key policies. Also made imperative in the conclusion is the notion that policies that reflect disability rights are essential but are not the solution as societal attitudes and behaviours towards disability requires to be altered in a direction that promotes inclusiveness.

The main body of the dissertation has 14 027 words excluding tables, figures, boxes, annexes and references.
Chapter 1 Introduction

“Sexuality is often the source of our deepest oppression; it is also often the source of our deepest pain. It’s easier for us to talk about - and formulate strategies for changing - discrimination in employment, education, and housing than to talk about our exclusion from sexuality and reproduction.” (Anne Finger 1992)

1.1 Introduction
An estimated world population of about 650 million people have physical, cognitive and sensory disabilities which limit their participation in mainstream activities and the majority of this population lives in middle-income and low-income countries (Kangere 2003, World Health Organisation 2008). This makes a significant ten percent of the world population people living with various forms of disabilities. This significant group of people should not be excluded in any social, political and economic margins of their lives so that they can live a fully functional life. The Convention on the Rights of Persons with Disabilities, Article 1 (CRPD) states that “persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”. While the definition of disability various among different countries and contexts (Mont 2007), this dissertation will use the above definition stated by the CRDP in reference to people with disabilities (PWDs).

The number of PWDs is increasing globally. There are estimates which highlight this rise, particularly in developing countries, due to conflicts, malnutrition, accidents, violence, communicable and non-communicable diseases including HIV/AIDS, ageing
and natural disasters (Elwan 1999, Chaudhry 2005). Given this it is critical for any development interventions to involve and work with PWDs. In addition, developing countries are a habitat to about 8% of PWDs living without social systems to support them, such as inadequate health services and limited access to education (UNFPA 2006). The situation of health systems is a major cause of concern in most developing countries as healthcare has stagnated and worsened in some instances (Bhatia and Mossialos 2004).

While a wide range of factors that exclude PWDs exist, sexual and reproductive health (SRH) rights are amongst the major social factors that have seen PWDs being worse marginalised. Box 1 on Definition of reproductive health and sexual rights provides a definition for these two concepts. SRH rights are an important element of development policies and processes which have been advanced within the development arena by the International Convention on Population and Development (ICPD) 1994 in Cairo (Shaw 2006). Hardee et al (1998:1), highlight that “many countries have worked to adopt the recommendations from the ICPD plan of action and to shift their population policies and programmes from an emphasis on achieving demographic targets for reduced population growth to a focus on improving the reproductive health of their populations”. Prior to the ICPD relatively little work expounded the issues of SRH rights in most countries and within the development agenda.
Box 1: Definitions of reproductive health and sexual rights

<table>
<thead>
<tr>
<th>Definition of reproductive health and sexual rights</th>
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<tr>
<td>Reproductive Health (RH) is a “state of complete physical, mental and social well being and not merely the absence of disease and infirmity in all matters related to the reproductive system and its functions and processes” (ICPD 1994).</td>
</tr>
<tr>
<td>Sexual rights include “the rights to privacy, non-discrimination, bodily integrity, freedom of information, access to healthcare, protection from epidemic disease and equality within the family, as well as rights to marry and found a family and the highest attainable standard of mental and physical health (ICPD 1994 cited by Miller 2000:76).</td>
</tr>
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</table>

However, despite the lack of work around SRH rights as mentioned above, debates within feminism did to some extent address SRH rights as they voiced concerns on the need to go beyond regarding women and men’s bodies as “biological essence” due to their different biological and maternal functions (Harcourt 2009:16). This view illustrates that SRH rights issues are embroiled in different power structures which have in the past undermined their recognition. Miller (2000) postulates that in the past some norms within society functioned to regulate sexuality and reproduction by gender, race, age and other forms of power that axes. This view indicates that within society powerful groups are likely to undermine the rights of other groups deemed as less powerful, as for instance patriarchy has endeavoured to marginalism women and consequently ableism undermines those with limited abilities (Razavi and Miller 1995, Wolbring 2008). Thus, from this understanding this thesis will seek to argue for the realisation and attainment of the SRH rights of women with disabilities (WWDs) from a gender and development as well as a gender and disability perspective.
In recent years a number of reasons have continued to emerge aiming at strengthening the obligation to attain SRH rights by many governments and development agencies (DFID 2004, Shanner 2005). Firstly, the Millennium Development Goals (MDGs) reaffirmed this commitment. Shaw (2006:207) states that “the MDGs incorporated many of the previously stated ICPD goals and targets” and the comprehensive universal access to SRH is one of these goals. MDG five aimed at improving maternal health states one of its targets, as to achievement of universal access to reproductive by 2015. Secondly, as the rates of HIV infection continue to rise, women's and men's sexual and reproductive ill-health threatens international development targets, as such there has never been a more pressing need to make positive connections between sexuality, health and human rights (Eldis 2008). Sub-Saharan Africa struggles with the highest rate of HIV infection with over 25 million people infected (WHO 2008), some of the means to prevent and mitigate infect lay within addressing sexual health and behaviours. Box 2 on Why SRH is needed urgently in Africa summaries key reasons to why SRH rights should be made a priority issues so that it contributes towards human development.

Box 2: Why SRH information and services is needed urgently in Africa

<table>
<thead>
<tr>
<th>Box 2 Why universal access to SRH services and information is needed urgently in Africa</th>
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<tbody>
<tr>
<td>• A million deaths experienced each year due to maternal deaths</td>
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<tr>
<td>• 1 in 16 African women have a chance of dying or having disabling complication during childbirth</td>
</tr>
<tr>
<td>• About 25 million people on the continent are infected with HIV</td>
</tr>
<tr>
<td>• 25.7% of the 340 million cases of curable STIs were recorded in sub-Saharan Africa</td>
</tr>
<tr>
<td>• High lack of access to comprehensive reproductive health services such as contraception, voluntary testing and counselling due to unmet needs and poverty. Glasier and Gülmezoglu (2006), Griffin (2008)</td>
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</table>
On the other hand, conversations on disability and development have been taking shape and making gains within development think. It is important to emphasise that previously the needs of PWDs were being considered through rehabilitation efforts offered by charities and religious institutions as part of moral obligation by society to care for those who were unable to do so for themselves (Coleridge 1993). However at the World Congress of Rehabilitation International (1981) Winnipeg, Canada, PWDs protested against the fact that professionals were always speaking on their behalf, they demanded their own voice to be heard thus disabled people’s organisations (DPOs) such as Disabled People’s International (DPI) were formed (Coleridge 2003). DPOs have been influential in representing, involving and advocating for PWDs. The fact that the idea that disability must be approached as a fundamental human rights issue has begun to make a significant impression on governments and international development agencies (Metts 2000). This resulted in the formulation of the United Nations CRPD in 2006 which makes provisions for women in Article 6 and Article 23 states the need for SRH rights for PWDs to be met (CRPD 2006). Such mention is critical as it sets the agenda and framework for development practitioners, in determining that the health and well being of women with disabilities (Groce and Trani 2009).

1.2 Problem Statement
This study hypothesises that universal access to SRH rights will not be a realistic goal to achieve in Africa despite the recent positive strides due to marginalisation of PWDs specifically women. A number of conversations have been brought to the fore arguing why WWDs are more likely to be marginalised from SRH healthcare as
compared to their male counterparts. It has been shown that WWDs are multiply discriminated against and they have less access to essential services such as healthcare, education and vocational rehabilitation (Thomas 2005, Barron and Amerena 2007). Women with disabilities are at a higher risk of various forms of abuse especially sexual abuse and they are more likely to live in poverty than men with disabilities (Fritzson and Kabue 2004). Furthermore, it has been estimated that about 10 million women per year are disabled as a result of pregnancy or child birth and an alarming 100 million women and girls experience disabling effects of female genital mutilation (FGM) (WHO 2008, DFID 2000).

The facts stated above depict a dim picture for WWDs and this is due to various socio-cultural, political and economic reasons, even though this is generally across Sub-Saharan there will be differences across countries, such as Uganda and Zimbabwe which are the countries under study in this dissertation. This study does acknowledge that different types of impairments or disability will affects how women access and use SRH services and information but this will not be taken into account due to a general lack of information on disability in Africa, and in this case Uganda and Zimbabwe (Lang 2009). As such, various impairments and disabilities will not be classified in this study.

1.3 Goal
The goal of this study is to discuss the implications of disability towards access to information and services on disability by WWDs in Uganda and Zimbabwe. The study will seek to clarify how access to information and services on SRH rights is crucial for social development particularly in Sub-Saharan Africa. Uganda has been selected for
this study due to its robust researches and efforts around disability and development issues. Zimbabwe has also been selected for its efforts around disability issues although it has been argued that little achievements have been gained due to economic and political turmoil (Lang and Charowa 2007). The goal of this study will be met through achievements of the aims and objectives outlined below.

1.4 Aims and objectives
This research has been influenced and inspired by the need to see women being fully integrated into all development policies and initiatives, particularly in SRH issues. The opening quotation to this chapter by Finger (1992) reflects that a number of positive efforts have been done to fully include PWDs in employment and education but little is changing on matters of sexuality and reproduction and the implications of this are drastic to development. This will be met through the following objectives outlined below:

- To identify if key policies on sexual and reproductive health address the specific needs of women with disabilities
- To identify how discourses on Gender, Sexuality, HIV/AIDS are incorporating women with disabilities
- To investigate the scope to which the Maputo Plan of Action for the Operationalisation of the Continental policy framework for sexual and reproductive health rights (2007 – 2010) is being used to advance the sexual and reproductive health rights of women with disabilities in the Africa countries under study
- To highlight the challenges being faced by women with disabilities in Uganda and Zimbabwe with regards to accessing services and information on sexual and reproductive health rights.
This study will endeavour to answer questions such as how do different policies on SRH include and represent WWDs. Questions pertaining to the impact of addressing WWDs’ SRH right on development will be investigated. Lastly the question around assessing which challenges are being faced by WWDs in Uganda and Zimbabwe in seeking SRH information and services will be discussed in this dissertation.

1.5 Dissertation Outline
This study will start by reviewing different material on gender, sexuality, reproductive health and disability. The purpose of this narrative will be to review researches and articles done by other scholars which explore these issues and link them to the objectives of the dissertation. After the review an analysis chapter of the results will be carried out. This chapter will mainly focus on an analysis of policy documents to identify the challenges being face by WWDs in accessing SRH information and services. A discuss will be drawn from the analysis and results of the study, leading to discussions on recommendations and questions for further study. A conclusion on the issues under study will be drawn up. The dissertation will end by assessing what has been achieved through investigating ways of ensuring SRH rights for WWDs in Uganda and Zimbabwe. A comparison of the aims and objects of the study against the achievements will be carried out and finally the possible contributions of this research to the fields of women’s SRH rights and development will be highlighted.

1.6 Conclusion
This chapter has summarise has given a brief background on SRH rights and disability. It dealt on highlighting the state of SRH issues in Sub-Saharan Africa and the plight of WWDs in this region. An overview of the goals, objectives and reasons for conducting this study has also been discussed. Chapter two will outline and discuss the different research methods which will be employed in this study.
Chapter 2 Methodology

2.1 Introduction
This chapter will discuss the methodology used to collect, analyse and present data within this research. An outline of the different types of methods used will be discussed and a justification will be given as to why these methods were selected for this particular study. Table 1 on Research methods and approach is a summary of the three methods and the approach the researcher used.

2.2 Methodology
Table 1: Research methods and approach

<table>
<thead>
<tr>
<th>METHOD</th>
<th>APPROACH</th>
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<tr>
<td>Key informant interviews</td>
<td>Telephone interviews were conducted with selected informants who are disability activists and development experts within the United Kingdom, Uganda and Zimbabwe.</td>
</tr>
<tr>
<td>Analysis of policy documents</td>
<td>An analysis of the goals and objective of the Maputo plan of action and the Uganda and Zimbabwe reproductive health policies in light of the specific needs of women with disabilities was undertaken.</td>
</tr>
<tr>
<td>Strength, weakness, opportunities and threats (SWOT) analysis</td>
<td>This tool was used to analyse the environment with regards to policies, participation and organisational partnerships was carried out. This was done through an analysis of policy documents, country profiles and finds from the key informant interviews.</td>
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</tbody>
</table>
2.2.1 Key Informant Interviews

Key informant interviews involve interviewing a selected group of people who are seen as likely to provide needed information, ideas and insights on a certain topics due to the expertise they hold in that topic (Kumar 1989). This research made use key informant interviews to gather information from individuals who have expertise in disability and development, sexual and reproductive health rights and gender issues. The interviews were semi-structured and followed a standardised interview guide with suggested themes but gave the interviewees scope to expand their responses. A total of eight key informant interviewees had been selected, however five respondents managed to provide their time to be interviewed. One of the respondents gave an international overview of disability and development issues and the other four respondents based in Uganda and Zimbabwe shed light on the country specific issues around disabilities, development and women’s SRH. All the respondents work with NGOs whose aim is to address either one or more issues around gender, disability, HIV/AIDS and SRH rights.

This research method has advantages which were seen suitable for this study. Interviews provide an excellent way of gaining factual information such as details on NGO policies and government initiatives (Willis 2006), this proved useful for this study as most of the information need was obtained from representative of NGOs. Key informant interviews also allow the interviewee to speak freely and extensively about the knowledge they have on a certain topic (Plamer 1999). This allowed the responses from the interviewees to be compared given that they were responding a similar set of questions. Contrary, the problem with this is that the answers obtained were vast and often respondents repeated themselves. This disadvantage did not affect the findings of the research but this helped illustrate the inter-linkages in the issues under investigation. Annex 1 is a list of the code
names of the key informant interviews and annex 2 contains the key informant interview guide.

2.2.2 Analysis of policy documents
An analysis of secondary data such as relevant policies on SRH issues and disability was undertaken. The secondary data was obtained from organisations working and dealing with these issues in Uganda and Zimbabwe, library and internet. It is hoped that through the analysis of policy documents, gaps, challenges will be highlighted to provide an evidence base for improved and strengthened policy-making including programming. The Maputo POA for the Operationalisation of the continental framework on SRH, the reproductive health policies of Uganda and Zimbabwe were analysed.

The analysis of policy documents was done through content analysis which is a systematic and replicable technique for making inferences by compressing text into fewer thematic categories (Stemler 2001). In this case policy document were categorised into relevant themes pertaining to WWDs’ SRH rights and analysed to deduce what is relevant within Uganda and Zimbabwe. The advantage of this method is that it can be used to assess and describe the focus of individual, group, institutional and social attention (Weber 1990). As such the analysis of policy document helped assess institutional priorities with regards to SRH rights for WWDs in the study.

2.2.3 SWOT Analysis
The SWOT analysis is usually associated with strategic planning as strengths and weaknesses project the internal environment of an institution and the opportunities and threats are associated with the external environment (Burkhart and Reuss 1993). Although the context of SRH rights within Uganda and Zimbabwe is complex and undertake by various organisations, this analysis largely focused on the country situations as a whole, as such the countries are the institutions. This analysis tool allows
for assessment of what the situation is at present and also projects the future if weaknesses and threats are avoided (Jackson et al 2005). Thus the current situation of WWDs’ SRH rights in countries under study was highlighted and inferences for the future improvements were made. The information used in the SWOT analysis was gathered from policy document, secondary data and findings from the key informant interviews.

2.3 Conclusion
This chapter has indicated the research methods and approaches taken in this dissertation. The three methodologies used were explained and the reasons why these methods were employed were given by discussing the advantages they offer. The next chapter will embark on a review of literature to highlight emerging issues with regards to SRH rights and disability.
Chapter 3 Literature Review

3.1 Introduction
This literature review has been commissioned to analyse the impact of ensuring SRH service among WWDs in Uganda and Zimbabwe. The purpose of this narrative is to lay out the various researches that have been done in the past which relate to the objectives of this study. The review will also highlight pertinent and emerging issues with regards to addressing SRH issues among women with disabilities. The first section of this chapter will look at development and disability as this is the broader discourse which examines the nexus between development processes and disability. Secondly, gender and disability is explored in a bid to highlight the social construction of some norms that determine various perceptions about WWDs. Finally, HIV/AIDS and disability will be discussed to shed light on the implications of neglecting the sexual and reproductive health of women with disabilities. In this way this chapter, will be able to highlight the importance of addressing WWDs’ SRH rights so that they impact on human development.

3.2 Development and disability
Until recently disability has been largely invisible from the development processes (Thomas 2004). This invisibility has resulted in PWDs being excluded and alienated from their own societies as they are not treated as respected citizens (Barron and Amerena 2007). An understanding of the broad range of international development approaches and their evolution is important to help understand disability. However, the approaches that are of significant importance include people centred development, gender and development and rights based approaches as they are the ones which correlate with the topic under discussion (Eade 1997, Barron and Amerena 2007). This is
so because these approaches seek to understand and analyse individuals in their various diversities with regards to sex, gender, abilities, location and needs.

People centred development as an approach seeks to improve the lives of people through capacity building. Interventions under this approach are measured against how they affect people and how meaningful there are to the people concerned (Oxfam 1997). One of these approaches is Community Based Rehabilitation (CBR) which been described as a capacity building approach to disability and it is perceived as a cost-effective mechanism by health professionals in delivering outreach services (Eade 1997). Barron and Amerena (2007) argue that the joint impact of changing attitudes to development and disability which use participatory approaches combined with the voices of PWDs has given rise to rights based approach to disability. The rights approach is seen as a move to assure that people attain all their civil, cultural, economic, social and political rights which are enshrined in the Universal Declaration of Human Rights regardless of their abilities (Mukhopadhyay and Meer 2008). According to Katsui and Kumpuvuori (2007) this approach resonates with the social model to disability as it encourages values of human dignity and concepts of autonomy, self-determination and equality for PWDs.

Lastly, gender and development has been instrumental in exposing ways in which disability influences women’s experiences of being female and how society’s responses to disability are gendered (Maynard 2005). Consequently, these approaches to development have an impact on how SRH rights should meet the concerns of individuals and build their capacity to make informed choices as it is a right for all diverse groups within the population.
A growing body of research addresses the link between disability and poverty (Elwan 1999, Thomas 2004, Hoogeveen 2009). The World Bank’s sourcebook to the Poverty Reduction Strategy Papers (PRSPs) processes has been criticised for placing PWDs, alongside children, old people and the chronically sick who are seen as economically inactive and in need of special care and welfare (Coleridge 2003). This only renders PWDs as objects of charity and not agents of development, who play a role social change, economic growth and poverty alleviation. Also emerging is that nowhere in the MDGs are individuals with disabilities explicitly mentioned (Groce and Trani 2009). On the contrary, Thomas (2004) mentions that “disables people are implicitly included in the MDGs, despite not being mentioned”. The mention of PWDs within MDGs is not of much significance although it would have been useful to indicate inclusion within the development arena.

With regards to omissions within MDGs identified above, what is of importance is that development experts and organisations should mainstream disability issues in their work on MDGs to address various disability concerns. Braithwaite and Mont (2009) highlight that including PWDS in mainstream development programmes such as the MDGs from the onset is an efficient, cost effective and a less stigmatising way of addressing their needs. The Inclusion International has formulated its own set of MDGs for people with disabilities (Inclusion International 2005). There have been studies which indicate that the MDGs affirm sexual and reproductive health as they incorporate many of the stated ICPD goals and targets (Shaw 2006). As such in addressing MDGs and disability, the sexual and reproductive health issues of WWDs will also be conversely considered as well. However, of worrying concern though, are results from studies within Africa which have found that Africa will not achieve the MDGs by 2015 due to numerous reasons such as governance challenges, use of flawed statistics, hunger, climate change, increased
prevalence of HIV, gender inequality and insufficient funding (Satterthwaite 2003, UNECA 2005). This challenge poses a gap in redressing PWDs’ rights more so for WWDs, therefore, there is need for other studies and efforts to compliment the MDGs.

3.3 Gender and disability
It is not clear at what point the separate disciplines of gender and disability were converged within academic studies. However, what is clear is that this convergence of gender and disability has offered a better vision of a common trajectory followed by both disciplines. “The sense that each discipline, in its uniqueness, has nonetheless much to offer the other is inescapable... and this is with regards to the subject matter of the body, inequality, identity and sexuality”(Smith 2004:1). Smith highlights that gender and disability have a lot of common issues or concerns they address, critique and demystify within the societies. This notion is also affirmed by a renowned disability studies scholar Rosemarie Garland-Thomson who concurs that the link between gender and disability is a positive one (Garland-Thomson 2004). This therefore highlights that gender and disability have been used in academic studies as conceptual frames that give meaning to the body (Silvers 2005).

In the light of the above, the importance of gender and disability within development issues and processes cannot be doubted. The body of evidence that is available at a global level which has worked towards linking gender and disability issues to development processes is work by Inclusion International. This work mirrors the MDGs which are linked to efforts aiming at achieving results for PWD (Inclusion International 2005). Inclusion International (2005) has thus expanded the MDG on gender equality to the specific needs of PWDs, who assert that disabled girls and women are doubly disadvantaged in accessing education, health care and employment due to discrimination against their gender and their disability (Inclusion International 2005, Thomas 2005). With
exceptions of a few studies emerging highlighting gender and disability concerns, a challenge of finding literature hampers a lot of progress in this regard (Morris 1994). Abu-Habib (1997) highlights that a dearth in studies and researches on women and disability shows the invisibility of WWDs in communities and a lack of interest by local and international researchers on the topic.

However, the few studies that have been done cannot be debunked as they have ushered in new lines of thought as well as been used to cover a number of milestones (Abu-Habib 1997). The gender and disability approach which has recently begun to be used by writers is a “useful way to assess the economic and social causes of disability and develop policy responses to women with disabilities” (Goldblat 2009:371). This because both gender and disability highlight issues of equality and power struggles within a society, thereby explaining issues of access to resources which impact on human development. Goldblat (2009) further explains that this has been particularly the case with analysis of the impact of poverty and education in determining welfare and social policy in a country. This implies that using gender and disability analysis has help indicate the impact of education in determining an individual’s welfare and escape from poverty. On the contrary, there are studies which have highlighted a range of assumptions about women and men with disabilities that have led to compounded discriminations which include the ideas that disabled women cannot provide care for their children, are unlikely to be in intimate relationships, and are asexual or promiscuous (May 2006). Given this understanding, one can hypothesise that this could attribute to the reasons for silence around sexuality and reproduction issues within the discipline of disability due to such assumptions.

It is fundamental to understand both gender and disability at a country or even community level as they are both influenced by the cultural, geographical and social
contexts (Silvers 2005). In Zimbabwe, a disability scoping study commissioned by the Department for International Development (DFID) stressed that the plight and situation of women with disability is particularly vulnerable as they are subjected to harassment, sexual abuse and exploitation (Lang and Charowa 2007). Lang and Charowa (2007: 7) attribute this to a highly patriarchal structure of the society where disabled women are “less likely to benefit from the scant, inadequate services that are available than men”. In Uganda, the DFID disability scoping study revealed that poverty and disability are entangled and this has severe consequences on girls and women, the lack of access to education for PWD is high among girls and women who fail to complete education where they do gain access (Lang and Murangira 2009). The study further illustrates how poverty has immense consequences on sexual and reproductive health, for example, the fact that literacy rates are low among disabled women has played a part in preventing them from seeking reproductive health information on family planning.

3.4 Sexuality, reproductive health and disability
A link between SRH and disability exists but there is little in medical literature about sexuality and disability (Basson 1998). This is generally as a result of a lack of extensive research on disability which was highlighted above but issues of sexual and reproduction also draw on socially constructed norms and behaviour. Many physical disabilities do not prevent an active sexual and reproductive life but the social messages about incapability are usually discoursing PWDs to explore their potential (Anderson 2005, Coltrane and Schmitt 2005). This has left little attention paid to concerns of PWDs particularly women.

At a global level, the importance of reproduction has been argued and highlighted. Shanner (2005) points out the importance of reproduction as not merely a biological process but it is a process which touches every aspect of human life including significant physical, sexual, economic, social, psychological and ethical ramifications. As such it has
a lot of contribution in different dimension to development approaches and process. The emergence of women’s health within the reproductive health thinking was first deliberated at the United Nations Health Care Conference in 1978 where issues on the status of women, the health of mothers and children and the accessibility of primary health care were setting the agenda (Anderson 2005). Anderson clarifies further that it is only at the ICPD 1994 that the thinking linking reproductive health, rights and social justice emerged. Emerging from the literature is the importance the ICPD set as it recognised that comprehensive sexual and reproductive health, including voluntary family planning is essential for individual and national development and can be used as a cost effective route for alleviating poverty (Hardee, K. Et al 1998, Greer et al 2009). Key points drawn here are the significance of the thinking around reproductive health which bring to the fore the importance of women’s health within economic growth and development as a whole. It is also highlighted that by meeting the SRH rights of WWDs this could be one of the approaches to alleviate poverty which is considered high amongst disabled women.

In the light of the above, deliberations and studies on reproductive health seem to have a gap as there is no indication of the inclusion of women with disabilities in the discourses. Persons with disabilities have the same sexual and reproductive needs as other people (Groce et al 2009). As a result their rights within sexual and reproductive health should be considered. WHO and UNFPA identify the neglect of PWD’s sexual and reproductive health as a result of number of factors which have been identified as the deprivation of their rights and freedom due to marginalisation, the denial to having a right to establish relationships and deciding on when and with whom to have a family in some instances and the assumption that they are not sexually active.
Furthermore, research by the World Bank has shown that PWDs are as sexually active as persons without disabilities (World Bank 2004). Of greatest concern due to these assumptions, is that it has been found that WWDs have been routinely turned away from prenatal, labour and delivery and post-natal services, often being told that they should not be pregnant or scolded because they have decided to have a child (Maxwell et al 2007). A critical analysis of the information available on sexual and reproductive health of PWDs is that most of the information is being provided by international development agencies such as the UNFPA, WHO and World Bank and none has been found from within academic sources. “All too often, the SRH of persons with disabilities has been overlooked by both the disability community and those working on sexual and reproductive health and this leaves persons with disabilities among the most marginalized groups when it comes to these services” (WHO/UNFPA 2009).

Another dimension that is emerging in sexual, reproductive health and disability is the issue of “evolving reproductive and genetic technologies making gender-sensitive analysis of procreation particularly urgent” (Shanner 2005:405). The notion of “genetic prenatal” and “designer babies” which has been enabled by the existence of improved genetic engineering is argued to be a way of discriminating against people living with disabilities as foetus that is seen to have a disability is aborted before birth (Harcourt 2009:182). This has reinforced the idea that society is sceptical about bodies which do not suit the ideal body image, and tries to perfect the undesirable or even eliminate them before they are born. Harcourt (2009) mentions that this technological enhancement is what Canadian professor and disability activists Gregor Wolbring calls ableism. Ableism is a network of beliefs, processes and practises that produce a particular kind of self, body and abilities which are projected as perfect and those that deviate are diminished (Wolbring 2008). This has ushered in an urgent matter of concern which will further
silence efforts to address challenges being face by PWDs, particularly SRH matters. Genetic technologies also further entrench gender inequality amongst women who have always bore the brunt of the socially constructed norm of bearing normal and desirable offspring as they are faced with the heavy decision to consider terminating the pregnancy after a disability has been dictated (Harcourt 2009).

In Africa, studies on sexual and reproductive health have focused on the achievements and challenges of the implementation of the ICDP plan of action (Misra and Chandiramani 2005). The bulk of the studies that have been conducted with regards to reproduction, sexuality and sexual abuse among PWDs are from Western countries (Groce 2005). The relevancy of well established frameworks for SRH has been questioned as their contributions to policy debates in the African context are not yielding much result (Merali 2000). This point highlights a critique of most development processes which have failed to take into account the diverse nature of society and are impose in a top-down approach. Thus approaches that are participatory and bottom up can facilitate the inclusion of the most vulnerable and weak people in society such as the poor, disabled, the elder, woman and children (Chambers 1997). The obstacles to making SRH a reality in the region are compounded by challenges which include encompassing socio-cultural norms, gender inequality, resource and capacity constraints, and unfavourable legal environments (Crichton et al 2006). Thus the SRH arena in the region is still faced with multiple hurdles to overcome and less attention is being paid to addressing the needs of WWDs.

3.5 HIV/AIDS and disability
HIV/AIDS and disability is an area which has received wide attention as larger numbers of studies have been conducted internationally, regionally and nationally. The link between HIV/AIDS and disability was first brought to the attention of the world through a
global survey which assessed HIV/AIDs and disability (Groce 2004). This global survey indicates that AIDS researchers had in the past focused on studying the disabling effects of HIV infection on previously healthy individuals and omitted the effects of HIV/AIDS on PWDs. As stated in the above discussion the assumption that PWDs are not sexually active has played a part in their neglect and marginalisation (Hanass-Hancock 2008). Little is known about HIV/AIDS in populations with disabilities but the handful prevalence studies that are available have raised concerns (Groce 2005). At an international level huge progress towards focusing on disability as an issue in HIV/AIDS was attained in 2008, where the XVII International AIDS Conference (AIDS 2008) and the 15th International Conference on AIDS and STIs in Africa, (Tataryn 2009), held discussions on these issues. The impact of this international level showcase on the two issues highlights that research on disability and HIV/AIDS is available but there is need to consolidate the scattered information in a systematic way which will benefit knowledge distribution (Hanass-Hancock 2009).

A large number of disability and HIV studies have been done in Africa, owing to the fact that Sub-Saharan Africa has the highest HIV prevalence globally. In 2003 Uganda became the first African country to conduct a study on PWDs’ SRH and HIV (Hanass-Hancock 2009). Using sexually transmitted infections (STIs) as a proxy for potential HIV exposure, the study found that 38% of women and 35% of men with disability in her Ugandan reported having had an STI (Mulindwa 2003). In Zimbabwe one of the studies on disability and HIV/AIDS revealed that PWDs have limited access to HIV/AIDS information due to low literacy levels (Choruma 2006). In a systematic review of literature on HIV/AIDS and disability in Africa only 4 studies out of the 36 studies investigate the impact of HIV/AIDS and gender as a major component (Hanass-Hancock 2009). This
makes it difficult to generalise the adverse impact of HIV/AIDS on WWDs as limited research in this area has been conducted.

The availability of a number of studies on disability and HIV/AIDS is important as this has provided a basis for evidence on the importance of providing sexual and reproductive health services for PWDs. For instance, Hanass-Hancock acknowledges that the initiatives and researches that have been done play a significant part in access to HIV prevention and treatment (Hanass-Hancock 2008). However, few studies concentrate on how PWDs conceptualise their body and sexuality (Wazaliki et al 2006). As such SRH initiative for the disabled are made hard to provide as there is not enough empirical evidence to back policy making. However comprehensive studies on HIV/AIDS amongst PWDs can provide sexual and reproductive health information such as sexual behaviour, sexual abuse, and parity in women amongst other issues.

An extensive body of knowledge has been found on issues pertaining disability and gender, disability and development and disability and HIV/AIDS (Thomas 2005, Smith 2005, Hanass-Hancock 2009). This indicates that an interest and research with the discipline of development studies is slowly gathering momentum and has a lot to offer with the various approaches of development (Smith 2005). Emerging from the material found is the notion that most of the studies are less than a decade old pointing to a fairly young body of knowledge. However, the unavailability of extensive studies on the sexual and reproductive health rights of PWDs particularly women indicates a gap within the reproductive health and disability field. As reflected the bulk of the studies available on PWDs and sexual and reproductive health is from the West (Groce 2005), making it difficult to generalise findings from these studies to Africa as there are marked difference in progress towards addressing the rights of the disabled in these regions. This further
reiterates the need for studies and information on the SRH needs of WWDs to influence policy and development processes.

3.6 Conclusion
This chapter has looked at the various approaches and dimensions on studies relating to disability, gender, HIV/AIDS and SRH within the development arena. Emerging from this review is how WWDs are marginalised within society affecting their access to SRH services and information. The lack of studies on disability and development has pointed out the need for more robust studies so as to determine the actual situation on the ground as well as aid policy processes. The next chapter will present empirical evidence to highlight the challenges being faced and policy frameworks which promote SRH rights for WWDs in Zimbabwe and Uganda.
Chapter 4 Results

4.1 Introduction
This chapter seeks to address two objectives of this dissertation which are; to identify if key policies on sexual and reproductive health address the specific needs of women with disabilities and to investigate the scope to which the Maputo Plan of Action on the Operationalisation of the Continental policy framework for sexual and reproductive health (SRH) rights (2007 – 2010) are being used to advance the SRH of women with disabilities in Uganda and Zimbabwe. This will be done through an analysis of key SRH policy documents within the two countries and highlight findings from key informant interviews.

The key themes which emerged from the analysis of policy documents and key informant interviews include challenges faced by WWDs, the role of policy frameworks in enhancing SRH and creating an enabling environment for WWDs to assess SRH services. This chapter will start by giving country profiles of the situation of SRH and WWDs including the policy environment in Uganda and Zimbabwe. An analysis of policy documents and a SWOT analysis will be done to present results of the actions and commitments being done to influence the policy environment. Finally the conclusion will summarise and highlight the key findings of the research.
4.2 Uganda

Table 2: Uganda Country Profile

<table>
<thead>
<tr>
<th>Country Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>32.4 million</td>
</tr>
<tr>
<td>Total population living below US$1 a day</td>
<td>37.7%</td>
</tr>
<tr>
<td>Disability prevalence</td>
<td>7.2%</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

Figure 1: Map of Uganda Source USAID 2008

4.2.1 Disability in Uganda

There are conflicting statistics on the prevalence of disability within Uganda as different authorities have published different figures. The 2002 Population and Housing census estimated that 4% of Uganda’s population is disabled whereas the Uganda National Household Survey of 2005/06 has approximated 7.2% (Lang and Murangira 2009). These disparities have been one of the major challenges in determining the prevalence of disability and there have a profound impact on policy and implementation of programmes targeted at those living with disabilities. However, the prevalence rate that will be used in this dissertation is 7.2% from the Uganda National Household Survey as it is the most recent figure and widely quoted in a number of studies. Mont (2007:1) argues that the variation in disability figures globally is as a result of factors such as the “differing definitions of disability, different methodologies of data collection, and variations in the quality of the study”. While the factors alluded to by Mont (2007) give a general global trend of variations, there are some other factors which are specifically caused by the
local context of a place. Uganda like most developing countries has been kept disability institutionalised and treated as a charity case by religious and charity organisations (Kangere 2003). This rehabilitation of PWDs has resulted in them being hidden from the public eye as well as from different policies and programmes. As such this has been a contributing factor to the disparities in statistics.

In the late 1980s, a disability movement emerged within the Ugandan society and this was due to the activism during the UN Decade of Disabled Persons of 1983-1992 (Kangere 2003). This period raised awareness on disability rights and gave a platform for the voices of PWDs to be heard and considered as it facilitated capacity building and knowledge sharing on the continent (Hanass-Hancock 2009b). Coleridge (2003:26) alludes to this when he asserts that organisations like the UN and World Bank “control funding, they are extremely powerful and must remain the principal target of lobbying and advocacy, by other groups in the disability debate”. This awareness of disability amongst development agencies resulted in the formation of the National Union of Disabled Persons of Uganda (NUDIPU) and to date the disability movement in Uganda is known as one of the most vibrant on the continent (Dube 2005).

Uganda has a favourable policy and legal framework environment which caters for the needs and voices of PWDs to be included in various development policies (Korpinnen 2009). However, some authors have argued that it is at the prima facie level that Uganda adheres to disability rights but the implementation of these policies still needs improving so as to fully mainstream the needs of PWDs (Lang and Murangira 2009). Table 3 below lists some of the notable pieces of legislation which govern and protect the rights of PWDs in Uganda. However, given all this progress in terms of legislation PWDs in Uganda still face a number of challenges. It is estimated that in Uganda households with PWDs are 38% more likely to be poor than those without any disabilities (Hogeveen
2004). This highlights that there is need to go beyond policy and create practical solutions towards the inclusion of PWDs.

Table 3: Legislation addressing disability in Uganda

<table>
<thead>
<tr>
<th>Legislation/Law</th>
<th>Year</th>
<th>Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The constitution of Uganda</td>
<td>1995</td>
<td>Prohibits the discrimination against people with disabilities in Article 21</td>
</tr>
<tr>
<td>Parliamentary Elections Statute</td>
<td>1996</td>
<td>Section 37 of the Parliamentary Election Statutes provides for five seats in Parliament for representatives of persons with disability</td>
</tr>
<tr>
<td>The Local Government Act and the Movement Act</td>
<td>1997, 1998</td>
<td>These two laws increase the representation of disabled people in the public sphere. The Local Government Act allows the representation of people living with disability at various local council levels.</td>
</tr>
<tr>
<td>Traffic and Road safety Act</td>
<td>1998</td>
<td>Prohibits the denial of a driving permit on the basis of disability</td>
</tr>
<tr>
<td>Uganda communications Act</td>
<td>1998</td>
<td>This law provides for the promotion of research into the development and use of new communications techniques and technologies including those which promote accessibility of hearing-impaired people to communication services.</td>
</tr>
<tr>
<td>Workers’ compensation Act</td>
<td>2000</td>
<td>Provides compensation to workers who are injured or disabled through industrial accidents</td>
</tr>
<tr>
<td>National council for Disability Act</td>
<td>2003</td>
<td>This law monitors and evaluates the rights of persons with disabilities as set out in international conventions and legal instruments, the Constitution and other laws</td>
</tr>
<tr>
<td>Legislation/Law</td>
<td>Year</td>
<td>Provisions</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Business, Technical, Vocational Education and Training</td>
<td>2008</td>
<td>Promotes equitable access to education and training for all disadvantaged groups, including disabled people.</td>
</tr>
<tr>
<td>Act No.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National policy on disability</td>
<td>2006</td>
<td>Provides a human rights-based framework for responding to the needs of persons with disabilities.</td>
</tr>
<tr>
<td>Equal Opportunity Act</td>
<td>2006</td>
<td>Both laws prohibit discrimination of person in employment based on disability</td>
</tr>
<tr>
<td>Universal primary Education Act</td>
<td>2006</td>
<td>Makes it financially possible for families to send their children with disabilities to school by providing education to four children in every family including those with disabilities.</td>
</tr>
<tr>
<td>Uganda Vision 2025 and the Poverty Eradication program</td>
<td>2025</td>
<td>Both policies provide a long-term development framework and initiatives aimed at sustaining economic growth and tackling poverty</td>
</tr>
</tbody>
</table>

Source: Korpinen (2009)

Ascertaining the number of WWDs in Uganda has been a challenge as there are no gender disaggregated statistics given on this group within the population. It is worth noting that even though most researches have assumed that women and girls make up more than 50% of people living with disabilities globally (Groce 1999, Barron and Amerena 2007), this group of people is not homogenous. They are characterised by differences in the nature of disabilities, socio-economic status, race and ethnicity as well as the variations that exists in defining disability across societies and countries (Ruosso 2003). In light of this hurdle, the numbers of not only women but men with disabilities has largely remained unclear.
Nonetheless WWDs in Uganda are represented by an organisation called the National Union of Women with Disabilities of Uganda (NUWODU), which is an umbrella organisation that addresses issues of women and disabilities to promote their rights and advocate for equal opportunities for women and girls with disabilities (WOUGNET 2009).

The study found that WWDs are not being fully represented in most development programmes in the country. Critically analyzing this, Uganda has achieved much as far as representation of women in various sectors is concerned but the challenges are the quality of services being rendered to WWDs (Kiapi 2010). However, most women with disabilities especially those at the grassroots level lack the competence to effectively advocate and lobby for their concerns and challenges (Lang and Murangira 2009). To sum up the challenges being faced by WWDs a key informant respondent added that:

*In my county Uganda there a very minimal levels of consideration for women or people with disabilities. There simply is no policy framework to support service provision (special consideration), No level ground with their counterparts, observance of their rights is a problem, No specialised personnel to handle them, no specific facilities to cater for them, you in see public places – a woman on wheel chair for instance cannot access services from a health centre where the service point is on 2nd or so floors (Mpagi¹)*

As highlighted above the challenges that WWDs face stem from failure to access both their strategic and practical needs in society. The strategic needs of WWDs include interventions that are concerned with inadequacies in living conditions such as water and sanitation, employment and healthcare whereas strategic needs have to do with issues of power and control and can be seen in legal rights, domestic violence, equal wages

¹ Key informant, Mpagi, 15 July 2010
amongst other issues that are perceived natural and cannot be challenged (March 2004, Smyth and Mukhopadhyay 1999). This has had an impact on the lives of WWDs and their access to services and information more so in SRH issues. In Uganda both the strategic needs which will enable WWDs to claim their practical needs are not being met and a key informant had this to say about the lack of involvement of WWDs;

_The lack of involvement of women with disability has result in them being less empowered and ignorant of their rights, a situation which should be reversed if universal access to SRH services is to be attained_ (Kulabako²).

### 4.2.2 Sexual and reproductive health in Uganda

In Uganda the provision of sexual and reproductive health services falls under the Ministry of Health (MOH) (Neema et al 2006). Policies and guidelines that guarantee access to reproductive health services and commodities have being put in place by this ministry and these include the National Health policy (1999), Population, Reproductive Health and Development policy (2001), Strategy to Improve Reproductive Health in Uganda (2005-2010) and the National Family Planning Advocacy Strategy (Ivan 2009, Leahy and Akitobi 2009). Services that are provided under the reproductive health department include family planning, post abortion care, maternal health and guidance and counselling.

Despite the relatively favourable policy environment that exists, Uganda continues to struggle with poor reproductive health indices and this could hamper efforts to attain the MDGs by the 2015 (Nambatya 2008). The study found that a number of studies targeting adolescents with regards to their SRH health have been conducted in Uganda compared to those for women as it is assumed that prenatal and maternal health caters for the SRH

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² Key informant, Kulabako, 29 June 2010
rights for women (Ssewanyama and Kasirye 2009). Furthermore, no studies on disabled women’s SRH rights were found. It was noted that the NUWUDO has advocated for WWD’s SRH rights together with other women’s organisation in Uganda and governments (Kiapi 2010). Given this, it is fundamental to ensure access to SRH services by having adequate services, enough health personnel as well as improving access for everyone including vulnerable groups such as WWDs so as to attain good indices.

To sum up, Uganda has made progressive developments with regards to having policies and frameworks which make provisions for the disabled throughout a number of sectors. However WWDs are still excluded from most services including SRH due a variety of barriers that exist. Primarily, the lack of participation within influential decision making positions is seen as a factor that is hindering meaningful mainstreaming of disability into SRH services (Kiapi 2010).

### 4.3 Zimbabwe Country Profile

**Table 4: Zimbabwe Country Profile**

<table>
<thead>
<tr>
<th>Country Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>11.9 million</td>
</tr>
<tr>
<td>Total percentage people living under the under</td>
<td>56%</td>
</tr>
<tr>
<td>Disability prevalence</td>
<td>10%</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

Figure 2 Map of Zimbabwe Source: USAID (2008)
4.3.1 Disability in Zimbabwe

Similar to Uganda, Zimbabwe has conflicting statistics on the prevalence of disability within the country. In the 1997 Inter-Censal Demographic Survey it was postulated that 2% of the population had one form a disability or another, whereas the 2002 Housing and Population census documented 2.9% as the disability prevalence within the population (Choruma 2006). Both figures are slightly outdated and they have been suggestions that the prevalence of disability is likely to have increased in the country owing largely to the effects of the HIV pandemic in the country coupled with inadequate health delivery system due to economic and political turmoil in the country over the past decade (Mpofu and Harley 2002). Recently a study commissioned by the DFID suggested that over a million people live with disability in Zimbabwe (Dube and Charowa 2005).

In spite of the above, Zimbabwe is considered “the breeding ground of some of the most dynamic and influential disabled people in the world who have been in the forefront of the development of the international disability movement” (Lang and Charowa 2007:29). This positive influence has had an impact on the adoption of disability rights within the country. This lead to an early enactment of a legal law to enforce the government to recognise the rights of PWDs in 1992 through the Disabled People’s Act (DPA) which was one of the first with the region (Khumalo 2008). Table 5 below highlights some of the legislations which adhere to the rights of the disabled within the country. On the contrary, failure to provide a conducive environment for the advancement of the rights of PWDs has been a setback. For instance, the country still has not ratified the UN CRDP of 2006 (Choruma 2007). A number of DPOs exist in the country but they have been criticised for remaining small and incapacable of influencing change (Lang and Charowa 2007). However, the National Council of Disable Persons of Zimbabwe was formed in the early 1980s and has been influential in promoting full integration of PWDs by creating an
environment striving for equality (Nyathi 1986). A number of other DPOs were also formed during the 1980s.

Table 5: Legislation addressing disability in Zimbabwe

<table>
<thead>
<tr>
<th>Legislation/Law</th>
<th>Year</th>
<th>Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled Persons Act</td>
<td>1992</td>
<td>To enhance the social and occupational interests of PWDs. A body called the National Disability Board has a mandate to ensure this through policy formulation amongst other things.</td>
</tr>
<tr>
<td>Education Act, Policy No.36</td>
<td>1996</td>
<td>This law ensured that inclusive education is provided, especially special needs education.</td>
</tr>
<tr>
<td>Social Welfare Assistance Act</td>
<td>1998</td>
<td>Public assistance is provided to persons with disabilities through disability grants</td>
</tr>
<tr>
<td>Constitution of Zimbabwe, section 23</td>
<td>2005</td>
<td>Outlaws the discrimination in any regard on the basis of physical disability</td>
</tr>
</tbody>
</table>

Source: Choruma (2007)

Of the few studies on disability within Zimbabwe, it was revealed that PWDs face challenges in accessing services of any kind with the major hindrance being accessibility, exorbitant user fees and limited disability awareness among service providers (Eide et al 2003). A key informant highlighted that:

*There are communication barriers in hospitals as nurses are not trained in sign language for example when conducting HIV testing an interpreter is sought thus compromising confidentiality. Depending on nature of disability, some people need catheters and these are expensive as they are disposed after every use. In a week, one would need approximately $10 for catheters. Being disabled in Zimbabwe means an expensive lifestyle for example in getting onto public transport I have to budget my own fare and*
also some money for my wheel chair. The transport system is also not friendly. Unlike in SA where commuter omnibuses are said to be unfit for road if there is no space for people with disability, here in Zimbabwe it’s a different case. (Fadzai\(^3\))

This indicates that PWDs still face a lot of challenges in accessing essential services including SRH information.

According the 2002 Household and Population Statistics there, women make up 55% of disabled people in Zimbabwe (Lang and Charowa 2007). However WWDs in the country are double marginalised and discriminated due to cultural, social and economic reasons which undermine the rights of women (Charowa 2005). It was found that relatively few studies on WWDs in Zimbabwe have been carried. This made it difficult for the study to come up with the analysis of the situation of WWDs in the country. An organisation called Disabled Women’s Organisation (DWSO) represents and advocates for the rights of women and girls in Zimbabwe, the organisation has 1617 members and has programmes which include HIV/AIDS education, wheelchair distribution and economic empowerment and counselling. Given that WWDs constitute close to 600 000, the membership of DWSO is very low as its works with over less than 3% of WWDs, a number far less to cover the needs of all disabled, if required.

4.3.2 Sexual and reproductive health in Zimbabwe
Reproductive Health (RH) in Zimbabwe is managed by the Ministry of Health and Child Welfare (MOHCW). According to the National Reproductive Health Policy of Zimbabwe (2006) the reproductive health department offers services such as maternal health, family planning, STIs including HIV/AIDS and adolescent reproductive health. A parastatal organisation called the Zimbabwe National Family Planning Council (ZNFPC) was

\(^3\) Key Informant, Fadzai, 27 July 2010
formed in 1984 with a responsibility of guiding family planning policy development on behalf of the MOHCW (Maggwa et al 2001). Relatively few studies have been commissioned on SRH and WWDs' rights in the country. Those that were found address the needs of the youth and women living with HIV (Wilcher and Cates 2009).

Conclusively, Zimbabwe has not made progressive efforts to mainstream the rights of WWDs into SRH services and information. Compared to Uganda a few policy frameworks have been put in place to mainstream disability issues across sectors. The DPA of 1994 which the country has been applauded for is elusive and has yielded less progress for WWDs (Khumalo 2008, Lang 2009).

4.4 Maputo Plan of action: Does it offer any hope for women living with disabilities?

The Maputo Plan of Action (POA) was born out of an Head of African States meeting which emphasised the need improve the delivery of reproductive health on the continent. This policy sets out clear goals, objectives, outcomes, timelines and funding set to guide the actions of African countries in any reproductive health activities undertaken. The Maputo POA falls under an array of other policy documents and guidelines which have been produced to guide and assure access to reproductive health issues. However, a continental document targeted specifically at Africa had not yet been developed.

The Maputo POA (2007-2010:3) outlines its main goal as urging “African governments, civil society, the private sector and all development partners to join forces and redouble efforts, so that together the effective implementation of the continental policy including universal access to sexual and reproductive health by 2015 in all countries in Africa can be achieved”. This action was taken as a result of various negative factors, such as high maternal death rates, lack of access to contraceptives, inadequate post abortion care amongst other factors which continue to hinder individuals from accessing SRH
services in the continent. It is fundamental to assess closely why universal access to SRH services and information is such a crucial issue for the continent as there are a number of entwined factors.

The goal of the POA does not mention those living with disabilities in its target populations which makes it disability blind. The Margaret Sanger Centre International (2008:28) emphasises the need to for “key populations in which the change will occur to be mentioned” within the elements of a well-written goal in the organisation’s module on engendering SRH rights programmes. The POA makes no mention of WWDs later alone PWDs within the document, it misses this opportunity on a number of occasions where it mentions “vulnerable groups”. For instance, in the introduction it is mentioned that “The plan learns from best practices and cost-effective interventions and responds to vulnerability in all forms, from gender inequality, to rural living and the youth, to specific vulnerable groups such as displaced persons, migrants and refugees.” (Maputo POA 2007-2010:2). It has been argued that it is common to branch people living with disabilities into the “the vulnerable group” in most development projects and programmes and this imposes a challenge of treating the needs of the people in the group in a similar way when they are not similar (Coleridge 2003). Therefore, the Maputo POA should single out PWDs if the policy is to be effective and targeted at all groups in society.

The analysis found that POA could see WWDs being omitted as it emphasises that the plan’s objectives are to be financed through domestic resources and the shortfall is to be mobilised. Development assistance for PWDs is not yet fully realised within Africa as assistance is still based on charity and medical models of disability which do not take into account the autonomy of the disabled as well include them in national development (Kabzems and Chimedza 2002). Thus precedence is given to funding rehabilitation
initiatives at the expense of other projects which will empower PWDs and this should be altered.

4.4.1 SWOT analysis of mainstreaming disability into development programmes
Strength, Weakness, Opportunities and Threats (SWOT) analysis will be used to critical review the implications of mainstreaming disability within SRH activities in Uganda and Zimbabwe. A SWOT analysis is a useful tool in the assessment of different aspects of development programmes which is generally associated with strategic planning to inform future direction (Burkhart and Reuss 1993). This analysis will be based on the provisions of the Maputo POA, key national policies on SRH and responses from the key informants. Table 6 on SWOT analysis on mainstreaming disability in Uganda and Table 7 title SWOT analysis on mainstreaming disability in Zimbabwe will highlight the SWOTs in both countries.

Table 6 SWOT analysis on mainstreaming disability in Uganda

<table>
<thead>
<tr>
<th>SWOT analysis for mainstreaming disability with the SRH sector in Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Uganda has laid out a number of legislation across sectors to facilitate the mainstreaming of disability. This will give an opportunity for disabled women’s SRH rights to be mainstreamed.</td>
</tr>
<tr>
<td>Four members of parliament seats are reserved for PWDs, one of the seats is to be filled by a disabled woman. Political representation of WWDs is crucial for their concerns to be redressed.</td>
</tr>
<tr>
<td>Civil society and disability activism are strong as there are organisations in place to.</td>
</tr>
<tr>
<td>Exclusion of PWDs especially women from planning and development processes.</td>
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</tbody>
</table>
### SWOT analysis for mainstreaming disability with the SRH sector in Uganda

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>The awareness of disability rights on a global level allows for more issues on disability to be resourced and given priority.</td>
<td>A lack of coordination amongst the public sector can hinder the effective implementation of disability rights legislation.</td>
</tr>
<tr>
<td>The UN CRPD provides an opportunity for disability rights to be viewed as a fundamental human right.</td>
<td>Need for increased political will and commitment to adopt a rights based approach to mainstreaming disability issues.</td>
</tr>
<tr>
<td>The use of the rights based approach within development projects and research will facilitate WWDs’ rights to be adhered to.</td>
<td></td>
</tr>
<tr>
<td>Access to SRH services has been made a universal goal with the MDGs and this lays a platform for ensuring the health of all populations.</td>
<td></td>
</tr>
</tbody>
</table>

None of PWDs are receiving any social assistance such as cash or food transfers from the government.

Sources: Lang and Murangira (2009)

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### Table 7 SWOT analysis for mainstreaming disability within the SRH sector in Zimbabwe

| SWOT analysis for mainstreaming disability with the SRH sector in Zimbabwe |
|-----------------------------|-----------------------------|
| **Strengths**               | **Weaknesses**              |
| There is political representation of PWDs as one Senate seat is set aside and a National Disability Board has been established to advice and work with the Ministry of Public Health, Labour and Social Welfare on disability issues. | Lack of financial resource to sustain national disability projects and grants. According to Lang and Charowa (2007) only 13.6% were receiving this grant in 2006, with a high possibility of limited access by WWDs who lack resources and knowledge to seek such information. |
| Disabled people are entitled to a disability grant. | The implementation and monitoring of policies and laws is poor. There is no implementation or monitoring plan that |
| The Constitution of 2005 enshrines disability as a right and illegalises | |
### SWOT analysis for mainstreaming disability with the SRH sector in Zimbabwe

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>discrimination upon this basis.</td>
<td>guides the implementation of the DPA.</td>
</tr>
<tr>
<td>There are vibrant NGOs which work with PWDs in both rural and urban areas.</td>
<td>There are no Members of Parliament to represent the needs of PWDs represent the needs of PWDs in government.</td>
</tr>
<tr>
<td>A number of policies and laws have been put in place to represent the needs of PWDs. The DPA of 1994 prohibits the denial of disability rights in access to public service, employment and education.</td>
<td>There are few programmes set aside for WWDs who constitute more than half the population of PWDs.</td>
</tr>
<tr>
<td></td>
<td>There is no legislation which promotes the mainstreaming of WWDs’ concerns into SRH services.</td>
</tr>
</tbody>
</table>

#### Opportunities

There are platforms which governments and civil society organisation should take advantages of in terms of capacity building, knowledge sharing and information documentation.

The availability of legislation and disability allowances can facilitate the realisation of disabled women’s SRH rights.

Prioritisation of disability issues amongst regional and international development agencies, bi-lateral organisation and NGOs offers a good opportunity for WWDs’ SRH issues to be mainstreamed and resourced.

The current constitution making process within the country which end at the end of 2010 offers a platform to review and reaffirm further the rights of PWDs, particularly women.

#### Threats

The political and economic instability within the country hinders sustainable commitment to disability issues. This has placed the country in an unfavourable spot as international relations with other countries have been broken.

The decline in development assistance internationally due to the Global financial crisis in 2008 and other factors will have a negative impact on getting disability programmes funded and implemented.

**Sources:** Lang and Charowa (2007), Lang (2009)

The SWOT analysis revealed that Uganda has more weaknesses than strengths in terms of addressing disability issues in SRH rights. The weaknesses largely point out to a lack
of coordination and resources to effective mainstream disability rights. Efforts to counteract these weaknesses and threats will ensure WWDs have adequate access to SRH information and services. On the other hand, Zimbabwe has more weakness and opportunities. The opportunities found indicate that there has been a period of stagnation or relatively less activism in the disability movement but if this is revived issues of WWDs can be taken on board.

In both countries opportunities outweigh threats, indicating that there is more room for growth with regards to adopt desirable changes within the SRH and disability sector in both countries. Valkanos et al (2009) articulate that when such an environment where opportunities outweigh the strengths is created this indicates a possibility of growth and future action should be base towards adopting a growth strategy. Therefore, the situation of WWDs’ access to SRH rights can be improved if the presented opportunities are utilised accordingly.

4.5 Conclusion
The results in this chapter conformed that WWDs are facing challenges in accessing SRH information and services in Uganda and Zimbabwe. A good indicator is that the policy environment within both countries is favourable but failure by continental and national SRH policies to set aside the needs of disabled women is a setback. The study revealed that the Maputo POA is gender blind as it doesn’t articulate the needs of WWDs. The next chapter will integrate these findings and emerging themes from the literature review to discuss the implications of not ensuring the SRH rights of WWDs.
Chapter 5 Discussion

5.1 Introduction
This chapter will discuss how WWDs are marginalised and excluded from SRH services and information. The arguments raised in this discussion will seek to address how the findings from the research relate to the issues raised within the literature review. Recommendations on how to ensure the rights of WWDs are realised within SRH practices and policies will be discussed. The chapter will conclude by highlighting questions for further research in relation to SRH rights for WWDs in Uganda and Zimbabwe.

5.2 Women with disabilities are marginalised from sexual and reproductive health services and information
Women with disabilities are marginalised from SRH issues as they are faced with numerous challenges in accessing information and adequate services. These challenges which include socio-cultural, political, economic and structural factors. Figure 3 below outlines some of these factors which can be understood as social and technical barriers. Social barriers refer to factors that hinder access to resources within a community and these vary in context and they are wide ranging (Bailey and Groce 2010). Socio-cultural, political and economic factors fall under this category. Technical barriers are structural difficulties or factors faced by PWDs in accessing resources (Pradhan 2008). An environment which enables legal and regulatory frameworks to be fully utilised, allows organisational strengthening and institutional development and enhances the participation of private and civil society as vital actors, should be created for the SRH rights of WWDs to be realised (Chaudhry 2005). Such an environment will be catalytic to the participation of WWDs in issues that concerns their various rights and enable them to fully participate in development and live a wholly functional live.
With regards to political factors, the research findings highlighted that Uganda and Zimbabwe have a number of legislation put in place, with Uganda having twelve different forms of legislation and four for Zimbabwe (Korpinen 2009, Choruma 2007). In addition, other regional and international regulatory frameworks such as the UN CRDP have been put in place (Lang 2009). Most governments in Africa including Zimbabwe have not signed this international instrument (Kwenda 2010). Conversely, Uganda has been applauded for being amongst one of the first countries to sign this instrument into effect. However, despite the existence of these systems and frameworks in both countries, WWDs still find challenges in accessing SRH services and information.

Additionally, it should be emphasised that beyond disability-specific instruments, core human rights conventions also seek to address the rights of PWDs as well (Lord et al
2010). For instance the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), seeks to address the need of all women regardless of them being having a disability or not (Blanchfield 2006). This understanding has however been overlooked by most development practitioners who assume that PWDs will benefit from any projects that assumes a human rights approach. This presumption is expounded by Guzu a gender and disability activist in Uganda who states that although a wide range of disability planning frameworks exits and the constitution enshrines the rights of PWDs, there are no deliberate efforts to integrate reproductive health concerns (Guzu cited in Kiapi 2010). Thus SRH rights of WWDs are not addressed in important legislative instruments.

Failure to assess SRH services and information as a consequence of social and technical barriers puts disabled women at risk of HIV infection, gender based violence, abuse and exclusion from development programmes. A number of arguments have been put across by various scholars on how PWDs particularly women are made vulnerable to HIV/AIDS. A point worth noting is the consensus that impairments do not make PWDs biologically vulnerable to HIV infection but it is societal responses to impairments which make PWDs an easy target for HIV infection (Nganwa et al 2001, Groce 2004). This understanding highlights the stigmatising attitudes which society holds and these consequently increases the risk of HIV infection for PWDs. It has been indicated that overprotection and internalised societal expectations make WWDs more vulnerable to psychological pressure for intimacy (Nosek et al 2001). This is as a result of the few opportunities presented by society for WWDs, especially young girls, to learn and talk about their SRH rights, as they are viewed as asexual and do not need to be equipped with SRH information. Studies from WHO show that sex education delays the onset of
sexual activity and increases safer sex practices as well as equips young women with the knowledge, skills and assertiveness to make safer decisions (Groce and Trasi 2004).

Negative socio-cultural beliefs and norms have also resulted in increased HIV/AIDS incidences for disabled women. WWDs fall victims to practices like “virgin rape” as rape is perpetrated in the belief that having intercourse with a disabled woman will cleanse the virus and transfer it to them (Groce and Trasi 2004:1). WWDs are primary targets to such abuses due to beliefs that women with disabilities are asexual and therefore, they are virgins. Additionally, men and women with disabilities are highly likely to be unable to obtain police intervention, legal protection or prophylactic care (Groce and Trasi 2004). This is due to constraints in accessing transport and buildings moreover service providers might not comprehend disability issues well, more so in the case of women who are deaf, have intellectual and mental disabilities (Sobsey 1991, Mental Disability Rights International 2002). It is therefore clear that there is a correlation between the existence of different barriers that hinder WWDs’ access to SRH rights with HIV infection.

Both countries under study have relatively high HIV prevalence rates but have been experiencing steady declines within the last decade. Uganda is known as undoubtedly the most cited best practise in the case of HIV infection reduction through its well-coordinated efforts and national policies and has recently been working towards the inclusion of PWDs into its responses as evidenced by the revision of the National strategic plan of 2007/8 – 2011/12 (Stover et al 2006, Babu 2007). However, the recent corruption challenges facing the national coordinating machinery, Uganda AIDS Commission, is likely to impact negatively on the little progress that has been gained towards inclusion of PWDs into national HIV/AIDS programmes.
Zimbabwe’s HIV prevalence rate decline within the decade has been largely attributed to behaviour change attitudes and programmes (Gregson et al 2010), see Figure 4 below. Unfortunately, there are no known studies which estimate the number of disabled people or women living with HIV in Zimbabwe (Choruma 2006). However, there have been studies which indicate risk perceptions among PWDs, it was highlighted that 75% of PWDs in urban areas regard themselves as highly exposed to risks of HIV infection (Hanass-Hancook 2009). Therefore, given this the inclusion of PWDs into national programmes and projects is still lagging behind within the country and this has adverse effects on the health concerns of disabled women. For instance, the low status accorded to disabled women and girls has often resulted in them being the objects of abuse and discrimination, thereby, highly exposing them to risks of contracting the HIV virus (Choruma 2006).

There are positive and replicable lessons from the field of gender and development that can contribute towards mainstreaming disability into development. To begin with, both gender and development are social constructs (Morris 1994, Smith 2004, Miller and...
Albert 2005). This illuminates that perceptions on disability are influenced by hegemonic views which assume a superior view over others groups and this results in marginalisation of the other groups (Silvers 2005). This research revealed that women with disabilities are further marginalised compared to their male counterparts putting them at a greater risk of invisibility within the development arena. Melo (2010) explores this fact by stating that if WWDs are discriminated against and treated differently from men, this puts them at a higher risk of other SRH rights violation such as sexual violence, forced sterilization, forced abortion and exposure to HIV/AIDS. Arguable, WWDs face these challenges as they have limited opportunities to gaining an education, accessing rehabilitation services, being economic dependent amongst other limitations (Erb and Harriss-White 2002). Thus addressing gender inequality issues in society will have an impact on the inclusion of disabled women who are “doubled marginalised” (Thomas 2004:6). It is important that both Zimbabwe and Uganda have DPOs which are addressing the issues and concerns of WWDs working in partnership with the women’s movements that exist. It was noted in the research that both countries have such DPOs formed by disable women and these are NUWODU and DWSO.

Secondly, gender and disability have been used to analyse and explain experiences of inequalities in society. Extensive work has been done in analysing the life experiences of women and seeking to change their situations in patriarchal societies. It has only been until recently that the work on disability borrows concepts and strategies from gender to be used in development work. An illustration is the work by Miller and Albert (2005) on mainstreaming disability into development. Miller and Albert (2005:4) argue that a lot of lip-service is being done with regards to the inclusion of PWDs but in actual fact disability has not yet “found a home in the development policy and practice mainstream”. Such is the case with SRH rights of WWDs as reflected by the dismal failure of the Maputo POA
to specifically mention PWDs at one point within the document. It is such invisibility which has kept the SRH rights of WWDs unmet.

Therefore, mainstreaming disability is one of the ways which could be used to ensure that the rights of women with disabilities surface within SRH issues. There is no precise definition to point out what mainstreaming disability in development means, despite this, the understanding of gender mainstreaming is adopted to understand disability mainstreaming (Miller and Albert 2005). ECOSOC Agreed conclusion (1997:56), define gender mainstreaming as “the process of assessing the implications for women and men of any planned action including legislation, policies and programmes in any area and at all levels. It is a strategy for making women as well as men’s concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated”. Deducing from this definition mainstreaming disability can be understood as a strategy to alter various dimensions of society so that the rights of PWDs are integrated across the whole spectrum. Dubois and Trani (2009:195) reiterate by pointing out that “mainstreaming disability is a progressive and sustainable way of redesigning society in order to be more inclusive of people with disabilities”. As a result, mainstreaming disability in SRH issues will not only improve women’s access to services and information but it will also have an influence towards changing some of the negatives attitudes society holds on the SRH rights of WWDs.

Participation is key in development interventions as it allows target populations to be part of changing and gaining their rights. However, the study found that WWDs where not participating fully in enhancing issues around SRH issues. This is due in part to a lack of WWDs in key strategic positions which influence policy and decision making so that they can rely their concerns. It was ascertained in the study that most NGOs and even
government departments are making effort towards increasing the participation of PWDs in the influential positions. In Uganda the constitution reserves four parliament seats for PWDs and one of these has to be filled by a women (Lang and Murangira 2009).

However, this quarter system is not as effective as well as a lasting solution to actively involving WWDs as a lot still needs to be done. Some criticism has been levelled against development practitioner and donor agencies due to how the notion of participation has been abused by transforming it into a methodological tool rather an agent of empowerment (Hickey and Mohen 2004). Lang and Charowa (2007) concur with this view and give an illustration of this when they indicate that some NGOs have used disability as a means of getting funding for projects but evaluations barely show how the disabled benefited from the activities, such was the case with the partners of DFID funded Protracted Relief Programme in Zimbabwe. As much as participation is key, caution should be taken to ensure meaningful involvement of WWDs, Box 3 on Inclusion of PWDs in Health projects, Gujurat, India shows the success of effective participation by Handicap International. This case illustrates the important role played by communities as well as portrays PWDs as active actors in the process of mainstreaming disability into development interventions.
Inclusion of PWDs in Health Projects, Gujarat, India

This project by Handicapped International and the Department of Health and Family in India Gujarat which aimed at the inclusion of PWDs largely focused on confronting the status quo around attitudinal, cultural and economic challenges which were marginalising those with disabilities. The success of this project lay in the participation of all key stakeholders such as health workers, local disability organisations, participatory rural appraisal and community based approaches were employed to identify existing knowledge, attitudes and practices of the community regarding disability. Most importantly PWDs were selected into key strategic positions as member core coordinating committees in public health project planning within this district and this project has been replicated in other parts of India as well owing to its success.

The fact that SRH is a key facet of human development should not be over ruled. This is because SRH lowers child mortality and fertility rates, decreases incidents of STIs, and in the broader sense contributes to economic development through providing a healthier workforce (World Bank 2010). Despite the important role that SRH can contribute towards development it is still marred in a lot of controversy amongst development practitioners as to how to approach the issue from a development point of view. Some scholars have argued that it is a complex issue which has posed a challenge for certain themes such as sex, abortion and STIs to be freely debated within development frameworks without outcry from conservative religious and cultural communities (Glasier and Gülmerzoglu 2006). This has also been compounded by a decline in SRH funding in the last decade (Patel et al 2009). However, another pool of scholars has highlighted that while there are so many challenges in the midst, positive messages are emerging from
conversations suggesting strategies that reinforce the concept of rights to surface in SRH issues particularly in Sub-Saharan Africa (Crichton et al 2006).

Lastly, the assumption that development will alleviate the various forms of suffering for marginalised and vulnerable groups should not be over emphasised in the case of disability issues, as development is not the panacea to living a fully functional life. While this is true to a certain extent it is also crucial to recognise and acknowledge that development has lead to the polarisation of those who are well place and have the power to take advantage of the new opportunities and those who are less powerful and marginalised are left or further disadvantaged by this situation (Jones 1999). This indictment leads to smaller groups being vulnerable and falling to access the resource brought by the form of development (Hurst 2000). This predicament is highlighted in a Ugandan research where high dropout rates in school from disabled girls who had reached puberty were experience citing inaccessible toilets as their reason for leaving school (Bailey and Groce 2010). This occurred after a project on building school pit latrines was completed. The pit latrine building project did not take into account the specific needs of girls with disabilities with regards to making the toilets accessible and friendly for their needs, thereby this undermined both their right to education and SRH. This negative impact dampened the outcomes the efforts that have been laid out to promote inclusive education programmes and legislation.

The discussion above highlighted and expanded on how WWDs are left out from SRH policies and frameworks in Uganda and Zimbabwe. Discussions were drawn from the thematic areas around gender and disability, development and disability, disability and HIV/AIDS and SRH rights and disability which highlighted in the literature review. A correlation of these themes with the results from this research was highlighted to point
out the main argument of this discussion, which is that WWDs are marginalised form SRH services and information in Uganda and Zimbabwe due to a host of factors that hinder their abilities to access these resources.

5.3 Recommendations
For effective institutionalisation of disabilities issues into SRH programmes, policies and organisations, not only professionals and practitioners must be involved, but also women and men from the communities. Programmes and projects should relate to WWDs’ experiences and their interpretation of reality, their interests and needs must be reflected in making decisions through their active involvement and participation (Lang 2009). Evidence from the research showed that DPOs such as DWSO and NUWODU are having an impact as they promote the participation of WWDs within their organisational structures as well as in the programmes implementation within the communities.

Coordination amongst key stakeholders is effective in addressing the SRH issues of WWDs. The study indicated that efforts within Zimbabwe and Uganda are being made to include disabled women in development processes but these efforts are still uncoordinated efforts amongst NGOs and government activities. Most disability issues have multi-sector implications and they are best redressed effectively if approached from a cross-sectoral approach (Kuehnast and Gacitua-Mario 2007).

A disability perspective should be included into SRH policies programmes in Uganda and Zimbabwe. As indicated in the discussion above, mainstreaming is one of the ways to ensure that disability issues are included within the SRH agenda. Also imbedded in mainstreaming is the capabilities approach which some scholars have advocated for its incorporation into the conceptualisation of disability (Altman 2001, Baylies 2002, Dubois and Trani 2009). This paradigm focuses on the freedoms and choices an individual has to lead the kind of live they so wish to (Sen 1997). Expanded further is the idea that the
availability of barriers hinders PWDs from access even though all the resources are to be put to their disposal this might not be fruitful due to the limited capacities they have. As such by using the capabilities approach focus is placed on analysing the socio-political context which fuels oppression and exclusion within society (Dubois and Trani 2009). Deducing from the above adapting a disability perspective into SRH should go beyond the provision of practical and policy measures but should also focus on shifting the attitudes and perceptions of communities which are biased towards ableism.

A lack of data with regards to disability in the study was one of the challenges faced. As such there is a need for extensive research and documentation of disability data since access to such information is crucial in policy making. Coupled with this, SRH is still an area marred with lots of disagreements which need to be resolved amongst developments practitioners; as such its progress in terms of research and funding lags behind other development indicators. Collection of gender disaggregated data should be prioritised as this gives a clear picture of the various differences found between men and women. Lang (2009) states that the paucity of robust statistics in African particularly Zimbabwe is deplorable and prevents tangible progress in disability and development programmes. However, Lang adds that the UN CRPD has given special mention to the need for appropriate research, data and statistics to be collected so that informed formulation of policies on disability is facilitated. As a result, if more research is done indication on the country situations in terms of the SRH rights of WWDs will be made available. Figure 5 on Actions towards the full inclusion of WWDs into SRH programmes summaries some of the recommendations which should be taken to ensure access to SRH services and information in Uganda and Zimbabwe.
5.4 Conclusion
This chapter began by discussing the reasons why WWDs are marginalised from SRH. It indicated that the social and technical barriers which exist in society in the form of various socio-cultural, political, economic and structural factors hinder WWDs access to SRH. The effects of this marginalisation has drastic consequences which result in WWDs being made vulnerable HIV infection, invisible from development processes and ultimately fail to reach their full potential in life. Additionally the discussion pointed out why SRH issue in general lag behind within development agenda priorities and funding and this further shift the WWDs to the margins. Recommendations were then drawn stressing the need to make WWDs invisible in SRH policies through participation, disability awareness and increasing accessibility. Lastly questions for further research were highlighted and the need for more rigorous research into disabled women’s SRH was pointed out.
Chapter 6 Conclusion

6.1 Introduction
This chapter will start by summarising the achievements that have been accomplished by this research through making a comparison of the aims and objectives against the achievements. Contributions that this research will likely bring to the field of SRH rights and disability will also be pointed out. The chapter will end with a conclusion which will highlight what this study aimed to achieve and the main findings will also be reiterated.

6.2 Summary of what has been achieved by the research
Overall this study managed to achieve what it sought to undertake with regards to analysing the SRH rights of women with disabilities in Uganda and Zimbabwe. To highlight how this was accomplished a comparison of the objectives with the achievements will be done.

The first objective of the study was to identify whether key policies on SRH are addressing the specific needs of WWDs. This was done through an analysis of key policy documents on reproductive health in Uganda and Zimbabwe as well as the Maputo POA which is the overarching continental framework on SRH. The main point from this analysis indicated that disability is largely invisible within policy documents since all policy documents failed to mention disability within their outlines.

Secondly, the research aimed at identifying the scope to which discourses on gender, sexuality and HIV/AIDS are incorporating WWDs through a review of literature on the mentioned discourses. The review outlined that discourses on HIV/AIDS have extensive research work which has been conducted on the linkages with disability, this work was first brought to the fore by Groce (2004) in a global survey that indicated the vulnerability of PWDs and yet they were excluded from most HIV prevention strategies. However, there is relatively little research that has been conducted to assess the impact of
HIV/AIDS amongst women with disabilities although they are deemed more vulnerable to HIV infection than disabled men (Hanass-Hancock 2009). The review also indicated that there are similarities between gender and disability as they both seek to address inequalities within society (Smith 2004). However, relative little work is being done to adopted lessons from gender into disability.

Thirdly, another objective of the research was to investigate the scope to which the Maputo POA is being used to advance the SRH rights of WWDs in Uganda and Zimbabwe. This analysis managed to indicate that the POA is not being fully utilised by both countries as there was little progress being made in terms of meeting its objectives. This was also the case with particular reference to WWDs as the policy document failed to make provision for them. However, this analysis managed to indicate that a good policy environment does exist in Uganda and Zimbabwe for the incorporation of WWDs' SRH needs, if the inclusion and participation of WWDs is facilitated.

Finally, the research also sought to highlight the challenges being faced by WWDs in accessing SRH services and information. This was done through conducting semi-structured interviews with key informants working with NGOs addressing either disability or SRH issues. Although half of the number planned for responded, the information obtained from the interviews gave a clear picture of the various challenges being met by WWDs, although some of the challenges were context specific the majority were found to be the same across the board. However, to effectively achieve this objective there is need to include WWDs in participatory researches and programmes so that they would express and share their own personal experiences.
6.3 Contributions made by the research to the field of women with disabilities’ sexual and reproductive health rights and development
This dissertation is intended to offer modest contribution to literature on disability and development, SRH rights and gender and development issues. The study results maybe of interests to development practitioners, funding partners and donors and the academia whose work involves addressing SRH and disability rights. It is hoped that this research will contribute towards enhancing understanding, support and commitment to WWDs’ reproductive health rights not only in Uganda and Zimbabwe but globally as well.

6.4 Conclusion
This study has shown how WWDs in Uganda and Zimbabwe are marginalised from access to adequate SRH information and services. Firstly, WWDs find themselves at a more disadvantaged position as they are “double marginalised” compared to men with disabilities and this compromises their access to essential human capital asserts such as education, employment and health (Thomas 2004). Secondly society as a whole harbours numerous disabling factors which create social and structural barriers for WWDs to assess their SRH rights (Bailey and Groce 2010). With social barriers, which consist of stigmatising attitudes from family and health personnel WWDs were found to a hindered from accessing SRH services in Uganda and Zimbabwe. Also numerous structural barriers were found to be hindering assess to SRH with inaccessible building and transport and in adjustable maternity bed being a major factor.

Policy implementation and invisibility of WWDs in SRH policies was the main reason deterring efficient access to services and information. Both countries harbour good policy frameworks and there are opportunities to improve the accessibility of SRH services and information through mainstreaming disability into SRH frameworks. However, it should be understood that these policies and frameworks will not be a panacea to SRH rights for WWDs as multi-sectoral action should be taken (Lang 2009).
The main views posed by this research are that the goal of universal access to SRH will not be accomplished without the involvement of disabled women who make up half the population of PWDs in Uganda and Zimbabwe. Participation of WWDs is essential in enhancing their lives and removing the social and technical barriers that hinder accessibility. Groce et al (2009) reiterates that although the trajectory of SRH and WWDs’ right is still unclear within the development arena, it is certain that there are unmet needs in this area which hinder human development. Conclusively, this dissertation argues that ensuring accessibility of SRH rights to WWDs is fundamental and will contribute to development.
# Annex 1

List of Key informant Interviews

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mpafi Mulungunda</td>
<td>15 July 2010</td>
</tr>
<tr>
<td>Kulabako Mombiba</td>
<td>29 June 2010</td>
</tr>
<tr>
<td>Belinda Gwazu</td>
<td>16 July 2010</td>
</tr>
<tr>
<td>Lois Kaheer</td>
<td>10 July 2010</td>
</tr>
<tr>
<td>Fadzai Kunaka</td>
<td>27 July 2010</td>
</tr>
<tr>
<td>Joy Mhlanga</td>
<td>20 July 2010</td>
</tr>
</tbody>
</table>
Annex 2

Interview Guide

**General understanding about disability and development issues**

- What do you understand by the term disability?
- Does your organisation work with people with disabilities? How and in what areas?
- In what ways are people with disabilities being included in development processes?
- In what areas of your work, programmes and projects with women with disabilities have you been successful?
- Do you think that addressing the needs of those living with disabilities will have an impact on development processes and practice?

**Women with disabilities’ sexual and reproductive health rights**

- Does your organisation work towards addressing the sexual and reproductive health (SRH) rights of women with disabilities? If Yes, what kind of interventions are you involved with?
- Why do you think it is important to address women with disabilities’ SRH needs?
- Do women with disabilities face any challenges in accessing services and information on SRH, with reference to Uganda and Zimbabwe? What are these challenges?
- How is your organisation addressing these challenges?
- What are the specific SRH services or information needs that women with disabilities require?

**Sexual and reproductive health policies and action**

- What policies and international instruments are in place to ensure that the rights of women with disabilities are observed?
- Do you think that the SRH rights and needs of women with disabilities are being addressed in various SRH national and international policies in places?
What should be done to ensure that such policies are disability friendly?

How will addressing the SRH needs of women with disabilities impact development?

How can governments, international development agencies and civil society ensure that the SRH rights of women with disabilities are being met?

Are they other actors, institutions and individuals who can ensure this as well? Who are they and what can they do?

Are there any other comments you would like to add?

Thank you so much for your time and valid contributions to this research.
References


Charowa, G. (2005). Body blows: In the thick of Zimbabwe’s current turmoil women with disabilities face hellish prejudice, hunger and rape. New Internationalist Magazine.URL: [http://findarticles.com/p/articles/mi_m0JQP/is_384/ai_n15923347/pg_2/?tag=content;col1](http://findarticles.com/p/articles/mi_m0JQP/is_384/ai_n15923347/pg_2/?tag=content;col1) [28 July 2010]


Among People with Activity Limitations in Zimbabwe, SINTEF, Oslo.


