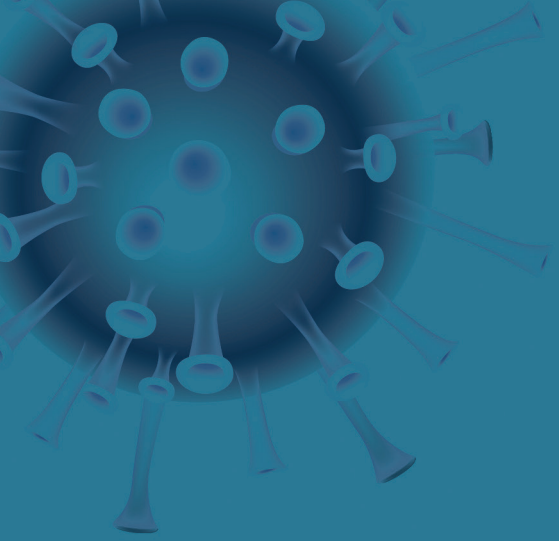

Position Paper on the Status of Sexual and Reproductive Health Rights of Women with Disabilities during the COVID-19 Pandemic in Zimbabwe

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Executive Summary

In 2020, Zimbabwe like many other countries in the world was plagued by the COVID-19 pandemic. Following the identification of the first COVID-19 case in March 2020, the Zimbabwe government adopted various measures that sought to contain the spread of the disease. These remain in place albeit their application may be eased or intensified depending on the magnitude of the disease at any given time. The measures that have been adopted include lockdowns, curfews, and travel restrictions amongst others. These measures whilst having good intentions of curbing the spread of the disease, have had some negative unintended and unforeseen consequences on citizens generally and persons living with disabilities particularly. Amongst others, the measures have affected free movement of citizens, affected access to income and access to public goods and services. For women with disabilities, The United Nations Population Fund (UNFPA) notes that the COVID-19 crisis and ensuing restrictions have complicated access to essential sexual and reproductive health information, services and goods. Zimbabwe is a state party to the Convention on the Rights of Persons with Disability (CRPD), where in Article 25 States are mandated to provide persons with disabilities with the same range, quality and standard of free or affordable healthcare programmes including in the area of sexual reproductive health. Furthermore, Article 11 directs State parties to take all measures to ensure the protection and safety of persons with disabilities in situations of risk such as we are experiencing during this COVID-19 pandemic. At the national level, the constitution of Zimbabwe enshrines the principle of equality as articulated in section 56 and goes further to specifically provide for the right to health[1] as well as spell out the rights of persons with disabilities specifically[2]. Cognisant of these commitments by the

Zimbabwe Government, Women and Law in Southern Africa (WLSA) in partnership with Deaf Women Included (DWI) commissioned a study to assess the status of reproductive health rights of women with disability in selected parts of Mutare urban and rural districts as part of its efforts to ensure inclusivity in the advancement and promotion of the rights of all women in the country. The study sought **to understand the challenges, gaps and constraints that women with disabilities are experiencing in realising their sexual and reproductive health rights during the COVID-19 emergency context** by documenting the lived realities of women with disabilities in the selected areas[3]. This position paper summarises the key findings of the study and outlines proposed recommendations on how some of the identified challenges may be addressed by all key stakeholders.

Background

An estimated 15% of the world's population live with disabilities with many of them being disproportionately affected by poverty.[4] Studies have noted that people with disabilities face all forms of exclusion and discrimination from social cultural, political and economic life of their communities. General Comment 6 on equality and non-discrimination (Article 5) of the CRPD states that women are among those groups of persons with disabilities who most often experience multiple and intersectional discrimination associated with gender and disability. Women with disability thus experience greater exclusion than men with disability or women without disability. The exclusion compromises life outcomes for women with disability in various areas including health generally as well as sexual and reproductive health.[5] In a context such as Zimbabwe patriarchy compounds the problem with its notion of seeking to assert control over women's bodies.

When a crisis happens it escalates the pre–existing challenges in a given context and the COVID-19 crisis has done exactly that in many facets of people's lives in Zimbabwe. UNFPA has noted that the pandemic has had a significant impact on women rights that include among other a higher incidence of gender-based violence (GBV) and loss of access to life giving health services.[6] The former has already been witnessed in Zimbabwe where it is reported that the lockdown saw an upsurge in the number of domestic violence cases reported. For instance, between April and May 2020 non-governmental organisations who provide services to survivors of gender-based violence (GBV) reported recorded a 38.5% increase in the number of cases of violence against women and girls.[7] UNFPA further notes that persons with disabilities face more barriers to accessing information, education and health services and they are often overlooked in the emergency response.[8]

Against this backdrop, WLSA and DWI in the spirit of ensuring inclusivity in the enjoyment of rights by all women, commissioned a study that investigated the status of enjoyment of women's sexual and reproductive rights during the COVID-19 induced emergency. The ambit of the sexual and reproductive rights investigated included:

- Access to maternal healthcare services (antenatal care services, birth delivery services and postnatal care services);
- Access to family planning services including contraceptives;
- Access to menstrual hygiene products;
- Availability and accessibility of GBV prevention and response services; and
- Access to SRHR information in accessible formats.

The study was carried out in selected wards of Mutare urban and rural districts. Women with disabilities were identified as key respondents for the study. The interviews were held upholding ethical considerations of free and informed consent and confidentiality whilst also having due regard to compliance with COVID-19 regulations. Service provider perspectives were also sought on the subject matter.

Unpacking the Emerging Challenges in Access to SRH by Women with Disabilities.

In assessing the status of access to sexual and reproductive health rights by women with disabilities in Mutare district, WLSA relied on the framework for assessing health rights that is articulated by general recommendation 14 on the Right to the Highest Attainable Standard of Health (Article 12) of the International Covenant on Economic Social and Cultural Rights. The framework identifies four key components that are critical in assessing the right to health namely **availability, accessibility, acceptability and quality**. Below is a summary of the key emerging findings of the study on each of the said criteria.

a. Availability

In urban areas the health centres are within close proximity to the community but in rural areas the nearest health centres are fewer and are not equipped to deal with complicated cases and referrals have to be made to bigger hospitals better equipped to deal with complex cases.

b. Accessibility

This component examined 4 distinct criteria outlined below-:

i. Non Discrimination

There is pervasive attitude in society that perceives women with disabilities as asexual.[9] Women with disability report experiencing negative attitudes from health staff when they present at health institutions especially when they present with issues of sexual and reproductive health.

ii. Physical accessibility

Physical accessibility of health centres has been a challenge for women with disabilities during the pandemic. Accessibility of the health centre itself generally is inhibited by the absence of ramps for wheelchair users. The inaccessibility during the COVID-19 pandemic is manifesting itself in the following ways:

In rural areas, a major challenge is transport for women needing referrals to major hospitals, e.g. in the case of pregnant women with complications. The existing ambulances may at times be malfunctioning or not having fuel to transport the patients while in some areas there are none. Whilst private transport may be organised, medical professions are not allowed to accompany patients in private vehicles. This poses a serious risk to the lives of pregnant women and their unborn children.

In the urban areas, women with disabilities noted the use of the ZUPCO buses as not user friendly for wheel chairs users as the buses do not have ramps for ease of entry. In addition, the scarcity of buses means that when the buses do become available women with disabilities are outmanoeuvred by able bodied persons who force entry into the buses ahead of them.

Sexual and reproductive health rights have not been prioritised as essential and where one needs to produce exemption letters to allow one to travel in the case of illness or gender-based violence to the nearest service centre they are unable to do so.

iii. Economic accessibility

Historical inequities in access to education and employment mean that most women with disabilities are employed in the informal sector. The COVID-19 imposed lockdown resulted in the closure of the informal sector resulting in loss of income for women with disabilities and the general population at large. Whilst government unveiled a COVID-19 cushion fund, all respondents reported to not having received any support from the fund. Only recently has the United Nations Partnerships for the Rights of Persons with Disabilities indicated that they are giving the equivalent of $18 United States to persons with disability if they register with their district offices. The scheme is little known by many of the intended beneficiaries. In addition, some find it challenging to access the district office for the registration process due to limited mobility and COVID-19 imposed restrictions on movement.

Whilst health services are free at public health institutions, the unavailability of drugs including contraceptives requires that patients purchase these from private pharmacies. With the lockdown in place, economic activity curtailed and aid not forthcoming, women with disabilities reported experiencing challenges in accessing contraceptives as they could not afford to purchase these from private pharmacies.

Women with disabilities also reported experiencing challenges in purchasing sanitary wear and diapers whilst women with albinism reported experiencing challenges accessing sunscreen lotions. Where humanitarian support was availed it did not cater for sanitary wear or diapers. In the case of sun screen lotion, even where these were donated they were often misappropriated and sold for personal gain.

iv. Information accessibility

Women with disabilities interviewed shared that community members are their primary sources of information at platforms such as vending stalls, schools, churches amongst others. Service providers particularly NGO's have not been conducting GBV awareness activities at community level resulting in limited access to information. With the lockdown firmly in place, services providers migrated to digital platforms to share information. Whilst on the face of it this appears a very innovative gesture, for women with disabilities the strategy had its short comings. Whereas most women with disabilities may have mobile telephones, not all of them have smart phones that enable them to access information shared through the digital platforms. In addition, many of the women with disabilities professed having been disenfranchised of their livelihoods and thereby rendered unable to afford data costs. This is particularly challenging for deaf women who can only communicate digitally with service providers through video calls failing which they will need to use an interpreter.

The accessibility of information on sexual and reproductive health rights remains constrained even with the use of the mainstream media i.e. radio and television. Deaf and blind women still do have their needs covered. Whereas the COVID-19 guidelines require the wearing of masks this presents a challenge for deaf women who understand language through lip reading and thus further limits their access to information.

c. Acceptability

Health institutions are not equipped to fully cater for the needs of women with disabilities particularly in relation to their sexual and reproductive rights. By their own admission, the hospital personnel interviewed admitted to lacking training on how to deal with patients who present with disabilities. This is particularly problematic for deaf women who may require services of an interpreter whereas government does not cater for this. Women with disabilities rely on having family members interpret for them but they argue that this presents problems of confidential particularly in relation to sexual and reproductive health matters.

d. Quality

A quick scan of the COVID-19 policies in existence shows that they do not specifically address the needs of persons with disabilities generally and the rights of women with disabilities specifically. The participation and representation of women with disabilities in policy formulation and decision making platforms remains very limited resulting in policies being blind to their specific needs. A case in point is the Ministry of Finance's Details on the COVID-19 Economy Recovery and Stimulus Package that sought to provide humanitarian support to all vulnerable households. The policy does not segment the population rendering it blind to specific vulnerable groups that exist within the population such as persons and women with disabilities.[10] The various statutory instruments made on the lockdown have also not dealt specifically with issues pertaining to persons or women with disabilities or to sexual and reproductive health rights.

Health personnel highlight that the COVID-19 pandemic has put pressure on the already constrained health sector. Health institutions were already grappling with accessing potable clean water, gloves and sanitary wear and the pandemic added to the dilemma with the quest for safety clothing and equipment such as the personal protective equipment taking centre stage. Furthermore, the COVID-19 response has led to a de-prioritization of other ailments and general services such as those on women's sexual and reproductive health have become peripheral.

What needs to be Done: Conclusion and Recommendations

The fight against the COVID-19 pandemic is a protracted one. Whilst all efforts aimed at curbing the spread of the disease must be pursued, this must not be at the expense of the rights of citizens particularly the marginalised and vulnerable such as women with disabilities. UNFPA exhorts States to ensure that a prepared response must pay attention to ensuring the continuation of basic services such as maternal and new born health, family planning and sexual and reproductive health services and supplies.[11]

At the centre of ensuring that the response by government and stakeholders provides a holistic and sound response to the sexual and reproductive health rights of women with disabilities, there is need for reform in policy formulation and implementation. Policy formulation on COVID-19 response measures in both the public and private sector should specifically articulate the sexual and reproductive health rights of persons with disabilities generally and women with disabilities specifically. This entails ensuring

greater representation and meaningful participation of women with disabilities in policy formulation task forces, working groups and other technical teams. Stakeholders must make a conscious effort to mainstream disability and gender in all their interventions. Once this is achieved, it will be easier to address all the attendant challenges that women with disabilities face in accessing rights generally and sexual and reproductive rights specifically.

The study identifies tangible steps that government and stakeholders can do to improve the attainment of sexual and reproductive health by women with disabilities following the requisite facets of availability, accessibility, acceptability and quality by addressing the following:

a. Health financing should ensure that sexual and reproductive health needs are adequately provided for at health institutions. Contraceptives and sanitary wear must be readily available at all public health institutions.

b. There is need to improve the availability of conducive transport for women with disabilities. i.e. availing transport that can be easily accessed by wheel chair users and making transport generally available to avoid congestion especially during the COVID-19 pandemic. Ambulances must also be availed in rural communities.

c. Access to sexual and reproductive health services must be considered an essential service that women and women with disabilities must be able to access.

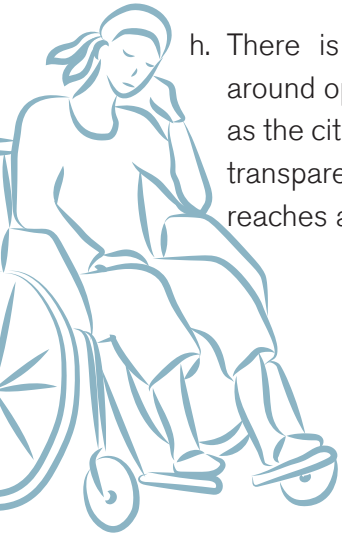
d. Safety nets must be availed and prioritise for women with disabilities during humanitarian crises such as COVID-19 induced lockdown to mitigate poverty and reduce their vulnerability. A comprehensive database of all people with disabilities must be readily available in each community and should be used in rolling out support and avoid incidences of calls for repeat registrations.

e. Improve availability of information on sexual and reproductive health rights in formats that are accessible by women with disabilities such as braille, sign language, large print, easy to read and audio formats.

f. Staff at health institutions must be trained to assist persons with disabilities. Government must ensure confidentiality of patients is respected and negative stereotypes are eliminated. Government must also avail interpreters for deaf women at public health institutions.

g. Humanitarian support must mainstream gender and disability and ensure that aid packages also include sanitary wear and diapers.

h. There is need for greater accountability of governments around optimal use of COVID-19 funds and resources. CSOs, as the citizenry, must exert duty-bearer accountability to report transparently on both resource usage to ensure that support reaches all the intended beneficiaries.



Endnotes

1 See section 76 of the Zimbabwe Constitution

2 See section 22 (3) and section 83 of the Zimbabwe Constitution

3 The full report is entitled ' Report on COVID-19 and SRHR for women and girls with disabilities in Mutare urban and rural areas' WLSA (2020) (unpublished)

4 WHO, World Bank. World Report on Disability. Geneva: WHO and The World Bank; 2011.

5 Lee, K., Devine, A., Marco, M.J. et al. Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines. BMC Women's Health 15, 87 (2015). https://doi.org/10.1186/s12905-015-0244-8 Accessed 01/02/2020

6 UNFPA, (2020) Pandemic heightens vulnerabilities of persons with disabilities https://www.unfpa.org/news/pandemic-heightens-vulnerabilities-persons-disabilities Accessed 01/02/2020

7 SAFE Zimbabwe Technical Assistance Facility (2020) Violence against Women and girls : Analysis of practice based data from Women's Coalition of Zimbabwe, Ecorys, London

8 Ibid note 5

9 Rugoho T. and Maphosa E (2017) Challenges faced by women with disabilities in accessing sexual and reproductive health in Zimbabwe : the case of Chitungwiza town, African Journal of Disability 6: 252

10 See paragraph 30

11 UNFPA, Coronavirus Disease (COVID-19) Preparedness and Response - UNFPA Technical Briefs V March 23_2020

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