Youth Development Initiative Trust

A Review of Sexual and Reproductive Health Rights and Persons with Disability in Zimbabwe

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Acronyms

AGYW - Adolescent Girls and Young Women
ASRH - Adolescent Sexual & Reproductive Health
AYP - Adolescence and Young Persons
CRPD - Convention on the Rights of Persons with Disabilities
EGPAF - Elizabeth Glaser Paediatric AIDS Foundation
FP – Family Planning
GBV - Gender-based violence
HIV - Human Immunodeficiency Virus
HTS - HIV testing services
LEA - Legal Environment Assessment
MOHCC - Ministry of Health and Child Care
NASP - National Archery in the Schools Program
NDS - National Development Strategy
NHS - National Health Strategy
PEPFAR - The U.S. President's Emergency Plan for AIDS Relief
PLHIV - People living with HIV
PSAM - Public Social Accountability Monitor
PWDs - Persons with Disabilities
RISDP - Regional Indicative Strategic Development Plan
SADC - Southern African Development Community
SAPST - The Southern African Parliamentary Support Trust
SDG - Sustainable Development Goals
SGBV - Sexual and Gender-Based Violence
SRH - Sexual and Reproductive Health
SRHR - Sexual and Reproductive Health and Rights
STI - Sexually Transmitted Infections
TB - Tuberculosis
TFZT – Tariro Foundation of Zimbabwe Trust
UNCRPD - United Nations Convention on the Rights of Persons with Disabilities
UNICEF - United Nations Children's Fund
UN - United Nations
WHO- World Health Organization
YDIT – Youth Development Initiative Trust
ZNASP – Zimbabwe National HIV/AIDS Strategic Plan

1.0 INTRODUCTION

This desk review was undertaken by the Southern African Parliamentary Support Trust (SAPST)[1] as part of the *"Using Research-Based Advocacy in Enhance PWDs, Duty Bearers, and Civic Engagement in advancing SRHR for all PWDs in Zimbabwe by 2025"* project, funded by Amplify Change[2] and implemented by Youth Development Initiative Trust (YDIT)[3] and Tariro Foundation of Zimbabwe Trust. The review aims to identify gaps and weaknesses in existing policies, legislation, and programs in Zimbabwe regarding the mainstreaming of SRHR for PWDs. This desk review focused on analysing critical existing documents, national plans, policies, legislation, and key programs that are currently implemented in Zimbabwe. The findings of this review will be used to inform the project's advocacy efforts and contribute to the broader goal of advancing SRHR for all PWDs in Zimbabwe.

Like many countries in Southern Africa, Zimbabwe is a signatory to international and regional instruments that guide the progressive realization of health rights for its population. Beyond this, Zimbabwe is also a signatory to specific instruments that call for the respect and fulfilment of the rights of specific vulnerable groups, including persons with disabilities.

Zimbabwe is implementing the Sustainable Development Goals (SDGs), which provide important opportunities for realizing reproductive health and rights for all, including key and vulnerable populations, as well as promoting progress towards enhancing equitable access to and quality coverage of SRH services. At the SADC level, the SADC SRHR Strategy (2019-2030) guides how countries in the region can improve their approaches to SRHR as well as ensure that these approaches are holistic.

The health sector in Zimbabwe requires SRHR-supportive laws and policies that promote the elimination of stigma, discrimination, violence, coercion, and exclusion in health care. Such laws and policies create a safe and supportive enabling environment that meets the SRHR needs of all people, especially key and vulnerable populations. Harmful laws need to be amended, and damaging practices need to be countered at all levels.

Zimbabwe's 2022 census reveals that the country has a growing youthful population of over 60%, with 52% of this population being female. The census also revealed that the national disability prevalence is 1.6% of the population. In addition, statistics also show that prevalence is higher among females as opposed to males in both rural and urban areas. The prevalence of disability among females is 2.2% and 1% in rural and urban areas, respectively[4]. While males' prevalence stands at 1.8% and 0.8% in rural and urban areas, respectively . These demographics call for policy direction and resource prioritization that responds to the various SRHR needs of persons with disabilities.

Zimbabwe is a signatory to the UNCRPD and its Optional Protocol, and the country has recently (May 2024) signed the African Disability Protocol. The UNCRPD provides for provisions that aim to promote, ensure, and protect the rights of persons with disabilities. Article 1 of the UNCRPD defines persons with disabilities as including those who have long-term physical, mental, intellectual, or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. Article 16 of the CRPD provides that state parties should take all appropriate legislative, administrative, social, educational, and other measures to protect persons with disabilities both within and outside the home from all forms of exploitation, violence, and abuse, including their gender-based aspects.

The African Protocol on Disability also includes aspects that are unique to Africa by addressing specific issues such as customs, traditional beliefs, harmful practices, and the role of the family, caregivers, and community. It also deals with community-based rehabilitation and minority groups within the African disability community, including people with albinism.

1 https://www.sapst.org/
2 https://amplifychange.org/
3 https://yditrust.org/
4 https://www.zimstat.co.zw/wp-content/uploads/Demography/Census/2022_PHC_Report_27012023_Final.pdf

Zimbabwe has gone ahead to design SRHR policies as well as adopt a national disability policy and the proposed disability bill, which at the time of this report is undergoing parliamentary processes.

Despite the progress made from a policy and legislative perspective, women and girls with disabilities continue to experience high rates of gender-based violence (GBV) and limited accessibility to SRHR services.

The increase in violence against women with disabilities has been attributed to their increased poverty, vulnerability, and dependence on their abusers. Women and girls with disabilities, particularly those in rural areas, face additional barriers to accessing SRHR, including GBV services[5].

Against this background, YDIT, TFZT, and SAPST commissioned a national-level study to analyse the extent to which SRH services are being prioritized through policy and resource allocation and expenditure, with a particular focus on persons with disabilities. The research reports consolidate an analysis of the Zimbabwe health sector and disability sector at a national level. The report covers the methodology of the research, a situational/context analysis, and key findings and recommendations based on the key questions of the research, which relate to the policy frameworks that exist on SRHR and the extent to which they are inclusive of persons with disabilities; the extent to which policies and programs integrate persons with disabilities on SRHR matters; and the strengths and gaps existing in Zimbabwe with regards to mainstreaming SRHR and PWDs.

2.0. Methodology

The research adopted was mainly desk research. A literature review was conducted for the research to collect background information on the state of the Zimbabwe health sector, with a particular focus on SRHR and persons with disabilities and how policies mainstream PWDs. The main sources of information for the literature review were key government policies, research documents, existing reports on the current SRH and persons with disabilities, Ministry of Health strategic documents, and Ministry of Public Service documents. Reports by development partners such as UNICEF, WHO, and local civil society organizations also provided important background information for the research.

3.0. Situational Analysis/Context

The health sector in Zimbabwe continues to face numerous challenges that have resulted in a deplorable state of the health facilities, slow progress towards achieving health outcomes, and a general lack of access to health services through the public health system. The sector is operating in the face of underfunding, shortage of health personnel, lack of drugs and equipment, and deteriorating or lack of infrastructure in most cases. While the state of the health sector mirrors the state of the national economy, it is also a reflection of the impact of a lack of prioritization and missed opportunities in harnessing resources that could be used for the development of the national economy, whose benefits would also be felt in the health sector and health outcomes for all groups of society.

5. *Christine Peta and Admark Moyo, The Rights of Persons with Disabilities in Zimbabwe*

The state of the health sector was exposed during the COVID-19 pandemic due to its inability to cope with the pressures imposed by the pandemic. While specific resources were set aside for the response to the pandemic for the acquisition of vaccines and other materials, the nation then learned of some serious gaps in the healthcare system for handling COVID-related illnesses, but also in terms of continuing to provide other primary healthcare services and specific services such as SRH.

Zimbabwe's public health sector is largely funded through the national budget, which is passed every year based on the spending plans of the Ministry of Health as well as the resource ceilings advised by the Ministry of Finance. Inadequate resourcing to the sector has seen a deterioration in the provision of basic health services at all tiers of the health delivery system. The deterioration in service delivery is observed through poor infrastructure, a lack of equipment, a shortage of drugs, and a shortage of health personnel. The deterioration in the economic environment has affected allocations by the Ministry of Finance to the sector, which in turn has had the consequence of increasing the cost of access to health care by citizens due to user fees.

SRH programs have also been affected by the inadequacy of resources despite the growing need for these services, with over 60% of the national population being made up of youths, 52 percent of the population being made up of females, and a 1.6% prevalence of disability in the country.

According to the World Health Organization (WHO), sexual and reproductive health rights "encompass efforts to eliminate preventable maternal and neonatal mortality and morbidity, to ensure quality sexual and reproductive health services, including contraceptive services, and to address sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and sexual and reproductive health needs.

The demographics in Zimbabwe demonstrate the urgent need to give SRH and HIV priority. In Sub-Saharan Africa, Zimbabwe has the highest rate of teen pregnancies. Adolescents from tribes that participate in cultural initiations and adhere to specific norms have higher rates of HIV and AIDS in the country, which is estimated to be 12% (18 and 13.6%, respectively) in Zimbabwe.

Gaps still exist in Zimbabwe as far as improving access to SRH services, particularly for persons with disabilities, to go a step further to achieving the SDG targets. The allocation of resources to SRHR through the national budget has not adequately responded to the needs on the ground. Resources have also not reflected an intention to attend to the need to promote access to SRH services for persons with disabilities. While donor support has provided significant financing to SRHR programs, this has also remained short of addressing the full extent of the challenges. The Zimbabwean economic environment has also negatively impacted the real value of allocated resources, with the Ministry of Finance resorting to supplementary budgeting, which nominally exceeds the initially budgeted amounts due to exchange rate losses. The exchange rate has also been responsible for overpricing goods and services procured by the Ministry of Health as suppliers' price their products in anticipation of exchange losses that take place before payment processes are completed. This, however, has also opened up irregularities in public procurement, which have led to observations of mismanagement of resources.

The situation of persons with disabilities regarding access to SRHR remains challenging. Policies on SRHR and policies for persons with disabilities remain disconnected as far as clearly spelling out clear policy measures and programs targeted at persons with disabilities. The inclusion of persons with disabilities within policies on SRHR does not go further to include specific interventions and programs that address access for PWDs concerning the challenges they face.

Despite being signatories to several international and regional protocols that promote and protect the rights of persons with disabilities, and in particular women with disabilities, a review of the literature, the sentiments of persons with disabilities, and the views of disability human rights defenders shows that **implementation** is a major challenge in Zimbabwe.

In Zimbabwe, negative attitudes of healthcare staff towards the sexual and reproductive health of PWDs have been reported. Some health care practitioners believe that PWDs are sick people who should consult specialist health care centres for issues related to their illnesses or disabilities alone. However, PWDs have a right, just like everyone else, to access health care for reasons that go beyond disability, such as sexual and reproductive issues. The work ethic of medical staff is usually that of *knowing best'*, with the result that PWDs are rarely consulted, even about their own bodies[6].

Women with disabilities in Zimbabwe face numerous challenges in accessing sexual and reproductive health. Cultural beliefs still regard them as not sexually active. The government has also not adequately promoted policies that facilitate access to sexual and reproductive services for women with disabilities[7].

Women with disabilities require more access to sexual and reproductive health services than their able-bodied counterparts, according to the WHO (2013) and Groce et al. (2009). Additionally, because of their condition, they are more susceptible to sexual assault (Rugoho & Maphosa, 2015). According to Groce et al. (2009), there is sufficient data to conclude that women with impairments have a threefold increased risk of experiencing physical, emotional, and sexual abuse. Despite the overwhelming evidence, governments have not developed policies to improve women with disabilities' access to sexual and reproductive health (Groce & Trasi 2004).

Research by Job (2004) and Prilleltensky (2004) revealed that in comparison to their peers, adolescents with disabilities are not given the chance to learn about sexual and reproductive
health because educators, parents, and counsellors are afraid to bring up the subject with them because they think they are not sexual. Because of this, individuals lack the fundamental vocabulary to explain physical changes in their bodies (Groce, Yousafzai, & Maas, 2007; WHO, 2009). Women who are physically disabled and those who are deaf have comparable difficulties (WHO, 2009).

In developing nations, it is still difficult to generate literature in Braille and other media. According to Roberts (2006), because it can be difficult for deaf women to communicate in sign language, they typically do not receive accurate information. It's also noted by Fedorowicz (2006), Heyederick (2006), Wilson & Monaghan (2006), and Groce et al. (2007) that there isn't much information on sexual and reproductive health available for deaf women. When deaf women attend health centres, medical professionals in underdeveloped nations frequently find it challenging to interact with them since they are not trained in sign language (Margellos-Anast, Estarziau, & Kaufman 2006).

6 Christine Peta and Admark Moyo, The Rights of Persons with Disabilities in Zimbabwe

7 Rugoho, T., and Maphosa, F. (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(0), a252. https://doi.org/10.4102/ajod.v6i0.252

8 Rugoho, T., and Maphosa, F. (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(0), a252. https://doi.org/10.4102/ajod.v6i0.252

Summary of barriers to accessing SRHR services for women with disabilities in Zimbabwe[8]

Attitudinal barriers: negative attitudes towards women with disabilities continue to persist in Zimbabwe, and this discourages them from seeking information and services on sexual and reproductive health.
Physical barriers: distance from health centres remains a challenge, particularly for women in rural areas. For PWDs who rely on personal aid for mobility, the process of accessing the nearest health facility is expensive as they have to pay for themselves and their assistant.

The cost of services—consultation fees to access health services even in government and local authority facilities—remains a barrier. Before the economic challenges that began in 2000, women with disabilities used to receive social grants from the disability fund administered by the Ministry of Social Welfare. The disbursement of the grant has become increasingly erratic, with some beneficiaries not having received any payment for the past 10 years.

Lack of privacy: privacy for women with disabilities remains a deterrent for women with disabilities while visiting health centres. Women with disabilities have reported that their privacy is often violated by health staff.
Restricted access to information: Women with disabilities can access information on sexual and reproductive issues from various sources, including health institutions, schools, parents, social media, and peers. However, most of these sources of information have aspects that make them inaccessible to women with disabilities.

Lack of sign language: The absence of sign language in health facilities has meant that some women with disabilities cannot communicate effectively with health personnel and hence limits their access to SRHR. In Zimbabwe, most of the professionals do not have sign language training.

4.0. Policy frameworks on SRH in Zimbabwe and their level of integration of persons with disabilities

Zimbabwe's policies on SRH are guided by international and regional instruments, including the SDGs and the SADC SRHR Strategy (2019-2030). The strategy supports the vision of the SADC Regional Indicative Strategic Development Plan (RISDP) 2015–2020 by providing a policy and programming framework to improve the sexual and reproductive health and rights (SRHR) of all people living in SADC and contribute towards Member States meeting the SDG and related commitments. The adolescent birth rate indicator under target 3.7 is stated as: By 2030, ensuring universal access to sexual and reproductive healthcare services, including family planning, information, and education, and the integration of reproductive health into national strategies and programs reducing adolescent fertility and addressing the multiple factors underlying it are essential for improving sexual and reproductive health and the social and economic well-being of adolescents. Goal 10 of the SDGs strives to reduce inequality within and among countries by empowering and promoting the social, economic, and political inclusion of all, including persons with disabilities. Zimbabwe has made strides with disability policy through the adoption of a disability policy and the review of disability legislation.

This section of the report explores the existing policies in Zimbabwe concerning health and SRHR in particular. Broad national policies as well as specific SRH policies will be explored in this section to identify the inclusion of disability issues within policy and the level at which it is mainstreamed, particularly in SRH frameworks.

4.1. Zimbabwe's Vision 2030

The provision of an efficient, integrated, and quality healthcare system is recognized in Vision 2030, with priority given to preventive care at community and household levels. The vision also recognizes the need to harness the youth dividend through the provision of adequate health care, among other things. In line with Vision 2030, the Ministry of Health and Child Care seeks to accelerate the attainment of Sustainable Development Goals to ensure universal health coverage and major event reforms resulting in efficiency, transparency, and integrity of health service delivery.

Vision 2030 recognizes that vulnerable groups, such as "people with physical challenges," will require special support to enable participation in policy formulation, decision-making processes, and the realization of their potential to contribute to Zimbabwe's development. This requires improved awareness, overcoming discrimination, and ensuring equitable access to resources. According to Vision 2030, programs for safety nets targeted at the protection of vulnerable groups will benefit households with orphaned children. Elderly, and other special groups in need of support, thereby avoiding the poverty dangers arising out of exclusion[9].

Vision 2030, in line with the constitutional provisions for persons with disabilities in Zimbabwe, is clear in terms of its recognition of this specific group as key to the development of the nation. The Vision recognizes that the participation of persons with disabilities in all spheres of the country is important and that this will require support for this vulnerable group for them to thrive in Zimbabwean society. While SRH is not specifically mentioned in this broad national vision, the identification of persons with disabilities as a vulnerable group indicates Zimbabwe's priorities to ensure that persons with disabilities are not left behind. The Vision raises the expectation that any sector-specific policy frameworks for Zimbabwe will specifically recognize the needs of persons with disabilities within the spirit of the Vision—in terms of participation, equitable access to resources, awareness, and non-discrimination.

4.2. National Development Strategy 1 (NDS1)

The NDS1 was launched in November 2020 under the theme "Towards a prosperous and empowered upper middle-class society by 2030". The NDS1 succeeded the Transitional Stabilization Plan (2018 – 2020), which was a first step towards Vision 2030. The overall outcome of the health and well-being priority area during the NDS1 period is to improve quality of life and increase life expectancy at birth, benefiting from underlying strengths within the health system that include a skilled, knowledgeable, and professional health workforce, firm foundations of primary health and hospital care, and improved quality of public health expenditure.

The NDS1 also recognizes the importance of reproductive health as a key programme under the initiatives of the development plan. Youth, gender equality, and persons with disabilities are also recognized as cross-cutting issues. During the strategy period, the government proposes to implement measures to improve livelihoods for the poor and vulnerable. According to the development strategy, the target will be to: increase the number of people with improved resilience (adaptive, absorptive, transformative) and disaggregated by gender, age, and disability from 2% to 10%; increase the number of households supported with livelihood initiatives from 5% to 25%; and increase the number of households with improved sources of livelihoods from 2% to 15%. This broad national strategy again draws from the Constitution and recognizes vulnerable groups, including persons with disabilities. Specific mention of reproductive health under key programs in the health sector is visible.

9 Zimbabwe Vision 2030

Disability as a cross-cutting issue implies that each specific sector will be expected to pay attention to the needs of persons with disabilities and propose appropriate interventions for the same.

4.3. National Health Strategy (2021-2025)

The National Health Strategy (NHS) (2021–2025) is a deliberate effort by the Government of Zimbabwe to improve the health and wellness of the population and to ensure universal access to health services. The Investment Case for the National Health Strategy (2021–2025) calls for efficiencies in the utilization of available health resources. The Health Sector Coordination Framework consolidates and coordinates shared efforts by the Ministry of Health and Child Care and all key stakeholders to improve sector governance and oversight. The policy includes a strategic priority under Improved Reproductive, Maternal, New-born, Child, and Adolescent Health and Nutrition. Some of the actions under this priority point to the government's commitment to promoting access to SRH services through addressing limited access to SRH services, inferior quality services, inadequate community involvement, and accessibility to youth-friendly services.

Concerning the inclusion of PWDs, the NHS recognizes the need to address social inclusion themes, including having a gender-sensitive lens in programming and mainstreaming disability, to ensure equity in access to services and the realization of positive health outcomes. While sexual and reproductive health is recognized quite clearly as a strategic priority, the strategy amplifies the needs of adolescents and young people concerning access to SRHR services. The strategy assumes that the call to mainstream persons with disabilities will be adopted in all interventions, including those related to increasing access to SRHR. This is likely because of the broad nature of the strategy (it covers the whole health sector). Persons with disabilities are amplified concerning prevention and medical rehabilitation services.

4.4. National Adolescent and Young People Sexual and Reproductive Health Strategy (2020-2025)

Zimbabwe has made progress in the development of specific policies targeted at adolescents and young people with access to SRH services since 2010. The first policy on adolescence and reproductive health (ASRH I) was implemented between 2010 and 2015. A review of ASRH I led to the development and implementation of ASRH II (2015-2020). ASHR II includes concerns for persons with disabilities as follows: Outcome 2: Increased uptake of quality, youth-friendly integrated SRH and HIV services. Output 2.2 aims to increase the affordability of quality, youth-friendly services. The strategy identifies, through mapping exercises, adolescent localities, and the target groups, particularly those in underserved and hard-to-reach areas. The at-risk populations (persons with disabilities, HIV positives, homeless sex workers, and young prison inmates) are particularly targeted. According to the evidence base, appropriate and cost-effective methods and approaches are prioritized in the strategy to ensure maximum access (this includes establishing secondary delivery points using existing infrastructure, mobile outreach, and decentralized services such as HIV testing). According to the strategy, this is aimed at reducing service utilization costs for the youth, the majority of whom are unemployed with no other livelihood options[10]. The strategy also prioritizes:

10https://platform.who.int/docs/default-source/mca-documents/policy-documents/plan-strategy/ZWE-AD-25-01-PLAN-STRATEGY-2016-eng-Final-ASRH-Strategy-M-E-Framework-2016-2020.pdf

- The expansion of youth-friendly integrated ASRH and HIV services to hard-to-reach areas and underserved at-risk populations (living with disability, HIV positive, living on the street)
- Targeting the most vulnerable: these include orphans, adolescents living with disabilities, adolescents living positively with HIV, adolescents living in the streets, teen mothers, adolescent inmates, and adolescents in sex work.

The strategy also notes that while it promotes specific targeting of vulnerable groups, it is also cognizant of the negative externalities this could present. For example, literature has shown that interventions that target specific groups, e.g., boys only or girls only, hurt the excluded group. Based on such evidence, the ASRH strategy does not promote interventions that only target one group of adolescents, hence the motivation for comprehensive and integrated interventions that reach all relevant vulnerable groups.

Zimbabwe is currently developing the National Adolescent and Young People SRH Strategy (2020 – 2025). It is expected that the new policy considers developments that have taken place concerning promoting SRHR as well as the fact that the country now has a disability policy whose contents can help inform specific strategies or actions that promote access to SRHR for adolescents with disabilities.

4.5. National HIV Strategic Plan (2021 – 2025) (ZNASP)

According to the strategy document, ZNASP IV (2021-2025) represents the aspirations and commitments of Zimbabwe and local and international stakeholders in scaling up HIV interventions towards epidemic control and the eventual ending of AIDS as a public health threat. The strategic shift towards granular targeting of locations and populations and the transition towards a knowledge management-based monitoring and evaluation approach, as well as cost-efficient approaches in this strategy, are expected to enhance its implementation and potential to achieve intended results.

Strategies and interventions proposed under the strategic plan include:

- To increase condom use among high-risk males and females during risky sexual encounters to at least 90% by 2025.
- To increase male circumcision coverage among those aged 10-29 years to 90% by 2025.
- To ensure at least 90% of the key populations receive a defined package of accessible, acceptable, affordable, and high-quality HIV services by 2025.
- At least 50% of people assessed to be at substantial risk of HIV infection are provided with pre-exposure prophylaxis annually.
- To increase PEP uptake to at least 80% for all HIV exposures.
- To ensure at least 90% of AGYW receive a defined package of HIV and SRH services by 2025.
- To achieve and sustain the elimination of mother-to-child transmission of HIV and syphilis by 2025.

Rights-based and gender transformative approaches: In line with the Constitution of Zimbabwe, the national HIV response recognizes and upholds human rights and non-discrimination for PLHIV, key populations, persons with disabilities, youths, women, children, and others who are socially excluded.

The Legal Environment Assessment (LEA) for HIV, TB, and SRH completed in 2019 found that Zimbabwe has protective provisions in existing laws and policies, such as criminal laws protecting women against violence, legal protection ensuring the inclusion of people with disabilities in all sectors, child protection laws that guarantee the rights of orphans and vulnerable children, and laws that protect employees against discrimination in the workplace. Existing laws and policies on health do not adequately protect and support people living with HIV, TB, women, people with disabilities, and key populations, including young key populations, to access appropriate and affordable health and HIV services[11].

In terms of the approach of vulnerable populations during the ZNASP III period, the inclusion of small-scale mineworkers, mobilization of cross-border populations, farm workers, fishers, people with disabilities, and the informal sector is visible. However, the strategic plan acknowledges that there are currently no specific interventions for these populations. Data on HIV burden and vulnerabilities among these populations is expected to be generated to inform the development of programs and the implementation of interventions that target each of these populations. While this approach to the strategy is noble, some gaps exist that limit its implementation. These include inadequate quality data leading to data gaps, including disaggregation and granular data for AGYW groups (such as AGYW with a disability, AGYW in the street, and Key Population AGYW), and limited targeted roll-out of HTS to different population groups, mainly children, adolescents, young people, men, and people with disabilities, among others. The government has, however, made some effort to strengthen the rollout of HIV services through specific approaches that target key populations, such as persons with disabilities. The national key population implementation plan is one such attempt by the government to ensure interventions that respond to the needs of specific groups.

4.6. Zimbabwe National Key Populations HIV and AIDS Implementation Plan 2019-2020

The key populations' implementation plan recognizes that persons with disabilities have traditionally struggled to access comprehensive health care as it has not been sufficiently designed for their specific needs. HIV and health information, education, and communication have not been adapted enough for the visually impaired, the deaf, and the physically and mentally challenged[12]. People with disabilities, while faced with similar risks as the sexually active general population, experience greater barriers to care than their counterparts. These barriers include transportation, provider stigma, and discrimination. Lack of information (in braille and sign language), lack of confidentiality, and affordability. The implementation plan proposes the following interventions for persons with disabilities:

- Package HIV and AIDS prevention and treatment information and education in appropriate forms.
- Braille and audio messaging for the visually impaired
- Sign language messaging for the deaf
- Offer upgrades to select public health facilities to make them physically accessible to persons with disabilities (for example, wheelchair ramps).
- Facility-based peers that can assist PWD in accessing services.
- Train select health care providers in sign language and braille to enhance the provision of services at health care centres.

11 National HIV Strategic Plan (2021 – 2025) (ZNASP)
12 Zimbabwe National Key Populations HIV and AIDS Implementation Plan 2019-2020

4.7. Zimbabwe National Family Planning Strategy (2022-2026)

The **National Family Planning Strategy is being implemented by the Zimbabwe National Planning Council, which exists as a parastatal in Zimbabwe. The implementation of the strategy is meant to:**
Promote improved knowledge, attitudes, and practices that enable all women and men, including adolescents, to access and utilize FP and SRH services, and by doing so, improve knowledge and attitudes towards adolescent FP, SRHR, and HIV services among decision-makers, parents, caregivers, and community leadership.

- **Strengthen male support for women`s FP choices.**
- **Transform gender norms and barriers that undermine people's access to and utilization of FP.**
- **Develop and implement transformative interventions that change the attitude, practice, and behaviours of adolescents towards FP/SRH services.**
- **Strengthen partnerships with media houses on awareness and demand creation on FP and SRH.**
- **Change community leaders' attitudes and perceptions towards FP&SRHR services for adolescents.**
- **Introduce and sustain a comprehensive social and behaviour change strategy targeting parents.**

The strategy promotes the mainstreaming of persons with disabilities. However, the following can be observed:

- **Adolescents and young people, particularly those with disabilities, deserve greater attention and more innovative approaches. There is a need for a clear framework to effectively operationalize the guidelines on integration of FP, SRHR, and HIV/AIDS, as well as a firm commitment and buy-in across the entire healthcare system.**
- **Lack of customized services for persons with disabilities ---Inappropriateness of some of the health facilities, especially for privacy and confidentiality, and for persons with disabilities**
- **Limited building infrastructure affects service delivery (all services in one room, thereby compromising privacy and quality of services offered) and poor access for people with disabilities.**

The strategy proposes to improve the capacity of service providers to provide quality integrated FP, SRH, and HIV services tailored for adolescents, young people, adult women, and men, as well as persons with disabilities (PWDs). Infrastructure and road networks (including disability-friendliness) are also on the cards.

5.0. Observations on the extent of mainstreaming persons with disabilities in SRH policy

All policies on sexual and reproductive health in Zimbabwe reviewed speak about elements of accessibility to a diverse set of SRHR services in Zimbabwe. These policies recognize the need to make SRH services accessible to persons with disabilities; however, they have not been very explicit in providing insight on the how, when, and where questions regarding the implementation of plans to increase accessibility to persons with disability. Policies that focus on adolescents and young people have also been clearly defined as far as promoting access to SRH services for young persons with disabilities. The policies, however, do not describe what is required to ensure that young persons with disabilities have access to SRH.
Most SRH policies were developed before the disability policy, which was adopted in 2021.
While the policies include the needs of persons with disabilities, future policy development will benefit from drawing from the Disability Policy to ensure that beyond the mention of the need for access to SRH for persons with disabilities, the policies can spell out the how, what, and when questions that are key to guiding the

implementation of policies that seek to address the needs of persons with disabilities. Therefore, none of the reviewed documents link to existing disability policies or frameworks.

The policies and frameworks that reach a greater degree of disability inclusion, such as the key population's implementation plan on HIV and AIDS, have undergone an intense process of consultation and engagement with persons with disabilities and civil society and use evidence gathered from this process to identify interventions.

Disability Policy 2021

- Persons with disabilities must have access to free health services in public health care institutions, including in the areas of sexual and reproductive health care and population-based public health programs.
- Persons with disabilities must have their right to free and informed consent respected within healthcare settings; decisions, including sexual and reproductive healthcare, must not be imposed on persons with disabilities, and their consent must not be replaced or substituted by a third party.
- Persons with disabilities must be included in holistic sexuality education programs in schools, rehabilitation institutions, communities, and other relevant forums.
- All sexual health programs must offer accessible physical infrastructure, information, communication, and services.
- Sexual health information, including that of sexual and reproductive health, must be provided in accessible formats, which include Zimbabwean Sign Language and Braille.
- The policy proposes: national guidelines for supporting the sexuality of persons with disabilities

5.1. Some best practices

Incorporating policies is an additional effective way to ensure that everyone has access. Governments and development partners should strive to incorporate issues that impact individuals with disabilities into their policymaking. According to a study conducted by Ahumuza et al. (2014), Uganda's policy addresses concerns affecting women with disabilities' access to sexual and reproductive health. Healthcare providers were able to follow the national policy as a result. The sexual and reproductive health policy of Zimbabwe does not address issues that impact women with disabilities. Recognizing the difficulties experienced by disabled women, the UNCRPD (2007) urged governments to integrate disabled individuals in the implementation of sexual and reproductive health policies.

5.2. Institutional arrangements for the delivery of SRH and HIV services

The Reproductive Health Unit is housed under the Family Health Department in the Ministry of Health and Child Care. The Reproductive Health Unit coordinates the provision of comprehensive sexual and reproductive health services in all public health facilities in the country. The unit is also responsible for developing and implementing policies and strategies that guide the implementation of sexual and reproductive health interventions. It also provides professional and technical leadership, advice, support, and supervision on sexual and reproductive health issues.

The table below outlines the various institutions and departments and their roles in the provision of SRHR in Zimbabwe:

Institution	Role and responsibilities
Ministry of Health and Child Care (MoHCC)	Develops policies and guidelines on SRHR, coordinates and oversees SRHR service delivery, provides technical support to health facilities, and ensures the availability of essential SRHR commodities.
National Family Planning Council (NFPC)	Promotes and provides access to family planning services, develops and implements family planning policies and programs, and advocates for SRHR.
Zimbabwe National Family Planning Association (ZNFPA)	Provides family planning services, including contraceptive methods and counselling, and promotes SRHR through education and advocacy.
Zimbabwe National AIDS Council (ZNAC)	Develops and implements HIV/AIDS policies and programs, coordinates HIV/AIDS interventions, and ensures the availability of HIV/AIDS services.
Ministry of Primary and Secondary Education (MoPSE)	Incorporates SRHR education into the school curriculum and provides guidance and counselling services to students.

5.3. National Budget Allocations towards SRH services

The research observed that Zimbabwe supports SRH services mainly through the Family Health Programmes, which are funded by the national budget. The family health programme focuses on improving reproductive, maternal, and new-born, child, and adolescent health and nutrition services.

The Ministry of Health recognizes that family planning remains a cost-effective reproductive, maternal, and child health strategic intervention to reduce maternal, neonatal, and child deaths. According to the Ministry, Zimbabwe has achieved a reduction in the unmet need for family planning from 14% in 2020 to 10% in 2022 for all age groups. The Government of Zimbabwe has ensured a budget line on contraceptive commodities of ZWL $627 million in 2022 and procured contraceptive commodities worth US$ 1.5 million.

Over the years, the availability of contraceptives in the country has been almost fully dependent on external support. Where the government has supported SRH services, it has been mainly through financing personnel costs as opposed to programme implementation costs. Allocations for family planning programs between 2020 and 2023 show that personnel costs consume more than 90% of the budget.

The funding landscape for the national HIV and AIDS response is dominated by external funding, which accounts for 69% of the expenditure on HIV response, while domestic resources account for 31%. In 2020, the National Aids Council was failing to provide second-line drugs, which they attributed to foreign currency shortages. The biggest funder of the country's HIV response is the Global Fund to Fight AIDS, Tuberculosis, and Malaria, followed by PEPFAR. Domestic resourcing remains a main challenge.

Through this research, civil society organizations highlighted concerns about the lack of clarity on whether donor funding that is readily available for SRH services is budgeted for in the national budget. This lack of transparency and information makes it difficult to assess the extent to which SRH services are prioritized in national planning and resource allocation, and more specifically, the extent to which a portion of the resources is ring-fenced to support access to SRH services by persons with disabilities.

There is a need for improvement in service provision as there are often reports of SRH commodity stock-outs across health centres and the unavailability of AYP-friendly SRH services, with service provider attitude remaining a key barrier to accessing services.

According to the recent SADC SRHR Strategy (2019-2030) Scorecard Implementation Status Update, there was no data on the proportion of the population accessing integrated SRH services. This explains a lot, which might include the unavailability of comprehensive data on that indicator at the national level. The unavailability of data affects the design of interventions that would otherwise be effective in reaching key populations, such as persons with disabilities.

The lack of infrastructure has also meant that most health centres in Zimbabwe do not have stand-alone SRH centres. This means that within the health facility, persons with disabilities and others seeking the same service do not have access to a private space to discuss their SRH concerns with health workers. The lack of privacy has a negative effect as persons with disabilities shy away from the stigma associated with seeking SRH services. In terms of the quality of service provided at the health facilities, the continued lack of reliable equipment to fully and effectively provide services remains a challenge. Equipment such as pregnancy test kits, surgical razor blades, suturing materials (absorbable and non-absorbable), glucometers and kits, cotton wool, and pads are, in some cases, not available.

6.0. Conclusion and possible recommendations

Policy Recommendations:

1. Adequately address disability in national sexual and reproductive health policy, laws, and budgets. While national policies and legislation do acknowledge rights for all, policies need to be intentionally and thoughtfully developed with the specific needs of persons with disabilities in mind.
2. Improve the participation of PWDs in policy-making processes, including legislative processes as well as the national budget process. Inclusion and involvement of PWDs in policy-making processes are key to ensuring that the SRH needs of PWDs are adequately provided for or addressed in national policies and legislation.
3. Adequately budget for inclusion: It is important to note that the costs of not including persons with disabilities far outweigh the costs of inclusion; therefore, government policies and programs must be adequately and realistically budgeted for. Budgets should account for the inclusion of PWDs in all programs, not only disability-specific programs. Budget elements related to SRH should ensure that PWDs are equally included as other groups of society.
4. Increase transparency and information sharing: The government, through the Ministry of Finance and the Ministry of Health, should provide more information on the allocation of resources towards SRH services, including how much of the donor funding is budgeted for in the national budget. This will help assess the extent to which SRH services are prioritized in national planning and resource allocation.
5. Address inequities and expand effective coverage: To reduce reliance on user fees, particularly in impoverished areas, the national health budget should be distributed using a system that gives the poorest districts higher amounts. At the very least, indices for remoteness, population size, the number of children under five, the number of adolescents and young adults, new-born and maternal mortality, and the total burden of disease should be considered in the resource allocation method. The Ministry of Health should conduct equity surveys to gather information on the socioeconomic profiles of those using healthcare services.
6. Draft sustainability plans: For interventions such as the provision of SRH services that rely on donor funding, the Ministry of Health must create phase-out plans. The annual national budget is the sole indicated resource plan for health finance maintained by the MOHCC. There are national stakeholder consultations on the budget that include the private sector, external partners, and other potential funding sources, although these gatherings hardly ever go over the Ministry of Health's future for resource mobilization and spending. Planning for sustainability should be based on an examination of project expenses, funding requirements, and financial returns on government investments.
7. Responding to emerging trends in SRHR: Zimbabwe needs to critically consider the impact of emerging trends on the provision of SRH services. These trends include the following:

- The growing climate crisis: On sexual and reproductive health as well as rights, the climate crisis has a wide range of implications. The lack of resources in disaster-affected communities, the harmful health consequences of heat exposure on expectant mothers, and an increase in sexual and gender-based violence during humanitarian crises or periods of relocation are just a few of them. According to predictions, if the climate crisis gets worse in 2023 and beyond, sexual and reproductive health and rights will decline.

- Increase in gender-based violence: Violence against women and other marginalized groups has increased since the start of the COVID-19 pandemic. Intimate partner abuse, rape, sexual assault, child marriage, and female genital mutilation all increased significantly during what is now known as the "shadow pandemic" of sexual and gender-based violence (SGBV). Although 146 governments and UN observers committed to combating gender-based violence three years ago, the amount of money received for SGBV in UN appeals has declined from 1% of the total in 2021 to 0.5% in 2022.
- Slashed financing for life-saving sexual and reproductive healthcare: SRHR funding is typically the first thing to go when governments or humanitarian relief organizations begin to decrease their budgets. A scarcity of contraceptives that results in up to two million unintended pregnancies could be caused by recent cuts to the sector's funding at the global level.
- A rise in youth-led activism and grassroots campaigns promoting urgent reform. As young, vibrant leaders demand action on topics ranging from reproductive rights to climate justice, youth-led activism is growing all around the world. If given the right leadership and resources (especially digital ones), youth can be significant change agents. If their voices are discounted or dismissed, the desperately required reform of the old ways of working might not occur.

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